Herefordshire Council

Agenda

Health and wellbeing board

Date:	**Tuesday 18 July 2017**
Time:	**3.00 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: councillorservices@herefordshire.gov.uk

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Agenda for the Meeting of the Health and wellbeing board

Membership

Chairman	Councillor PM Morgan	Herefordshire Council
Vice-Chairman	Dr Dominic Horne	NHS Herefordshire Clinical Commissioning Group
	Chris Baird	Interim director children's wellbeing
	Simon Hairsnape	NHS Herefordshire Clinical Commissioning Group
	Diane Jones MBE	Lay Board Member, NHS Herefordshire Clinical Commissioning Group
	Councillor JG Lester	Herefordshire Council
	Jo Melling	NHS England
	Martin Samuels	Director for adults and wellbeing
	Ian Stead	Healthwatch Herefordshire
	Prof Rod Thomson	Director of public health

Agenda

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1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

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 7 - 16

To approve and sign the minutes of the meetings held on 16 May 2017 and 13 June 2017.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive questions from members of the public.

Deadline for receipt of questions is 5.00pm on Thursday 13 July 2017. Accepted questions will be published as a supplement prior to the meeting.

6. QUESTIONS FROM COUNCILLORS

To receive questions from councillors.

Deadline for receipt of questions is 5.00pm on Thursday 13 July 2017. Accepted questions will be published as a supplement prior to the meeting.

7. JOINT STRATEGIC NEEDS ASSESSMENT 2017 17 - 172

To approve the Joint Strategic Needs Assessment (JSNA) 2017.

8. BETTER CARE FUND 2016/17 QUARTER FOUR PERFORMANCE REPORT 173 - 194

To review the better care fund 2016/17 quarter four national performance report as per the requirements of the programme.

9. SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP 195 - 288

To adopt the refreshed Sustainability and Transformation Partnership (STP) plan, which has been revised in light of comments received, including from the board.

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Herefordshire Council

Minutes of the meeting of Health and wellbeing board held at Council Chamber - Shire Hall on Tuesday 16 May 2017 at 3.00 pm

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

C Baird	Interim director for children's wellbeing
C Douglas	NHS England
Mr S Hairsnape	NHS Herefordshire Clinical Commissioning Group
Cllr JA Hyde	Herefordshire Council
Dr A Mahmood	Consultant in public health
M Samuels	Director for Adults and Wellbeing

Officers: **Steve Eccleston, John Gorman, Lindsay MacHardy, Alison Talbot-Smith**

112. APOLOGIES FOR ABSENCE

Apologies were received from Cllr JG Lester, Diane Jones, Jo Melling and Prof Rod Thomson.

It was noted that a new chair of Healthwatch had been appointed and was to be invited to future meetings of the health and wellbeing board.

113. NAMED SUBSTITUTES (IF ANY)

Cllr JA Hyde substituted for Cllr JG Lester and Dr A Mahmood substituted for Prof R Thomson

114. DECLARATIONS OF INTEREST

None.

115. MINUTES

RESOLVED
That the minutes of the meeting held on 28 March 2017 be approved as a correct record and signed by the chairman.

116. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions were received.

117. SAFEGUARDING AND COMMUNITY SAFETY

The business manager for the Herefordshire Safeguarding Boards and Community Safety Partnership presented the report, and highlighted the following:

Community safety partnership (CSP)

The CSP met in March and considered its key priorities for 2017 – 2020:

- To reduce harm from domestic violence and abuse
- To reduce sexual offending against children
- To promote community cohesion, address hate crime and prevent radicalisation
- To reduce exploitation of vulnerable people

These priorities were set in the context of a partnership approach to community safety and would be presented in a refreshed strategy to the CSP board in June.

The chairman noted that the updated priorities did not seek to take the focus away from ongoing work with regard to harm from drugs and reducing reoffending; rather it was important to reflect that these areas continued through service contracts and delivery as a matter of course. There was some concern over the performance of the drug service contract provided by Addaction, which had been highlighted recently by the scrutiny committee, and the contract was being monitored closely.

A board member welcomed the fact that the CSP and the health and wellbeing board were working in consultation with each other.

Update on the safeguarding boards' annual reports

An update was provided in response to action points raised at the meeting of the board on 7 February 2017 at which the annual reports of the safeguarding boards:

- Action point 1 – a report was commissioned in order to have a better understanding of incidences of sexual abuse of children coinciding with domestic abuse. The report did not raise any concerns regarding links between the two.
- Action point 2 – a domestic abuse summit has been planned for 24 November 2017 to coincide with National Domestic Abuse White Ribbon Awareness day the following day. The summit would provide opportunity for learning from domestic homicide reviews that have taken place.
- Action point 3 – the CSP and the two safeguarding boards are reviewing the approach to tackling modern slavery and trafficking and domestic abuse as a priority through task and finish.
- Action point 4 – a bid was submitted to the Home Office for funding through the Violence Against Women and Girls service transformation fund, to support an improved response to tackling domestic violence where dementia was a factor. A decision on this was pending.

RESOLVED
That

a) the priorities be confirmed as aligned with the health and wellbeing strategy;
b) the refreshed CSP strategy be presented to the health and wellbeing board at the next available meeting;
c) board members note the domestic abuse summit on 24 November 2017; and
d) concerns regarding delivery of the drug service contract be noted and addressed by continued contract monitoring and review.

118. ADULTS WELLBEING PLAN 2017- 2020 AND LOCAL ACCOUNT

The director for adults and wellbeing presented the adult social care local account 2016 and the adults wellbeing plan 2016.

Adult social care local account 2016

Councils were expected to produce a local account of adult social care performance for the year just gone. The publication was intended to be accessible to consultees including the public. The account set out the financial aspects and showed how the proportion of council budgets allocated to adult social care was increasing progressively, which was a national theme, and was in order to focus on the priority of delivering statutory functions. The budget focused on some 3000 people, a third of whom resided in care homes. It was a challenge to manage 45% of the budget focused on 1% of the population although Herefordshire was performing well with regard to outcomes compared with the national picture. It was noted that significant outcomes were achieved when considering demographics of the county and a projected growth in the number of people aged over 75 as a significant proportion of the population.

Adults wellbeing plan 2017 – 2020

The plan was intended to complement and mirror the children's wellbeing plan in recognition of its success as a system plan and there was a separate plan for public health. Engagement was encouraged from the Clinical Commissioning Group to make it a plan for the county and putting the person at the centre. The focus of the plan was on prevention and enablement, taking an asset-based approach and identifying where needs were not being met. In recognition of the health and wellbeing strategy, the aim was to ensure people had the best possible quality of life and supporting them to have choice and take control.

A board member commended the statement of intent as a good summary of what the council intended to do.

The chairman observed that a small proportion of what was provided was funded by the state and these were the essential services that the council must focus on; there was a range of provision beyond that.

It was noted that the primary care element was presenting a challenge to resources and that a whole-system approach was required with organisational plans aligned to the health and wellbeing strategy. The benefits of developing a partnership plan was noted as promoting a clear sense of the priorities with partners working together. It would also support the direction of One Herefordshire and drive the direction of the joint commissioning board.

RESOLVED
That

a) **it be confirmed that the adult wellbeing plan be aligned with the health and wellbeing strategy; and**
b) **assurance be given regarding the commitment and aspirations for the development of a partnership plan from 2018**

119. PUBLIC HEALTH STRATEGY AND PLAN 2017 - 2020

The consultant in public health presented the public health plan for 2017 – 2020, which identified key priorities and future intentions. The presentations today focused on two key areas, problematic alcohol use in the county, and an integrated programme for children and young people focusing on child dental health and obesity.

Problematic alcohol use

The presentation highlighted that:

- around 30-40,000 people were thought to be consuming alcohol at harmful levels in the county with the trend being towards drinking at home rather than at licenced venues

- it was considered that alcohol was a greater public health risk than smoking, possibly attributed to differing perceptions of risk by consumers
- it was notable that mortality rates were lower despite higher levels of drinking and it was not clear how demographics explained this in comparison with other areas
- alcohol related hospital admissions were reducing, including those connected with road traffic incidents, despite the nature of roads in the county. This perhaps reflected the trend towards drinking at home rather than drink-driving, and it was though that this was attributed to successful campaigns over the past 20 years, although there was still more to do
- outcomes from addressing alcohol consumption were currently below the national averages

A number of actions had been identified to address these issues which included reviewing service delivery and performance of the contract with the current provider (Addaction), working with primary care to extend GP brief intervention work and use of a national toolkit. It was agreed that a briefing note would be provided to board members to show how these action points were making a positive impact.

Over the rainbow - integrated programme for health and wellbeing for children and young people

The health improvement practitioner presented information on this programme, focusing on dental health and obesity in children and young people.
She drew attention to emerging data which suggested that almost 30% of reception age children were obese and that oral health was a serious concern.

The level of dental extractions was noted as a serious concern by board members and discussion took place regarding water fluoridation and potential barriers to introducing this in the county. There were possible alternatives such as fluoride supplements and fluoride varnish treatments which could be explored via national commissioning. It was noted that oral health had been picked up as a safeguarding issue as children were losing significant numbers of teeth, including some 10% under anaesthetic each year. It was noted that levels of dental decay were worsening in the county, with 41% of 5 year olds with dental decay issues.

In terms of obesity in children and young people, there apeared to have been a dramatic rise in obesity of 50% in the last 2 years and there was a danger that this could become normalised amongst the population, and this needed early intervention before children started school. There was a range of programmes and work to address this including looking at food provided in school and nursery settings and at home, and identifying the barriers to healthy eating. The data in terms of obesity and also dental health was going to be checked further by public health officers.

The chairman noted the range of good work set out to tackle serious issues but observed that there needed to be more passion, and asked if there was more merit in focusing on fewer remedies but doing these well.

Board members added that campaigns needed to be more assertive to bring about changes in behaviour and encourage people to talk about the issues in order to address them and to encourage self-care as the norm. There was evidence of good practice within schools to encourage active lives, although there were challenges around parents' perceptions of their children's weight, and establishing the evidence base for GPs to recommend action.

A board member commented in conclusion that these issues were a worry, and were highlighted by the joint strategic needs assessment (JSNA) and prioritised by the health

and wellbeing board. He added, however, that interventions needed to identify what difference they would make.

RESOLVED
That:

a) **the following recommendations be considered to improve achievement of outcomes or alignment with the health and wellbeing strategy, with particular focus on alcohol related harm and dental health in young people:**
   - **explore what interventions would be feasible to achieve fluoridation**
   - **to identify, from the available range, they key initiatives and interventions to focus work to deliver better outcomes**
   - **to develop an assertive approach to bringing about changes in behaviour to pursue healthier lifestyles; and**

b) **that a briefing note be provided to the board showing actions and timeframes for improvements in service delivery by Addaction, with information to show improved performance.**

The meeting ended at 16:53 **Chairman**

Herefordshire Council

Minutes of the extraordinary meeting of the Health and wellbeing board held at Malvern Hills Science Park, Geraldine Road, Malvern, WR14 3SZ on Tuesday 13 June 2017 at 3.30 pm

Present: **PM Morgan (Herefordshire Council) (Chairman)**

Mr S Hairsnape	NHS Herefordshire Clinical Commissioning Group
Dr Dominic Horne	NHS Herefordshire Clinical Commissioning Group
Mrs D Jones MBE	Lay Board Member, NHS Herefordshire Clinical Commissioning Group
J Melling	NHS England
C Price	Healthwatch Herefordshire
M Samuels	Director for Adults and Wellbeing
Prof R Thomson	Director of Public Health

120. APOLOGIES FOR ABSENCE

Apologies were received from Councillor JG Lester, Chris Baird and Ian Stead.

121. NAMED SUBSTITUTES (IF ANY)

Christine Price substituted for Ian Stead as the Healthwatch representative.

122. DECLARATIONS OF INTEREST

None.

123. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions were received.

124. SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

The director for adults and wellbeing introduced the item and explained that the purpose of the report was to highlight to the board the work done to date on establishment of a sustainability and transformation partnership (STP), and to ask the board to consider whether feedback from local public engagement and local implications had been addressed in the development of the STP plan.

The director drew particular attention to paragraph 10 of the report which set out the three key areas to be considered when reviewing the draft plan, namely:

- the requirement to have regard to the health and wellbeing strategy and the joint strategic needs assessment adopted by the board;
- that individual bodies remain accountable and should take account of the STP plan in their own planning; and

- the triple aim of population wellbeing, high quality service delivery and financial sustainability.

As the STP plan was being revised no specific comments would be made in the public meeting. The revised draft would be circulated to members of the board in the next few days. The director of adults and wellbeing would collate detailed comments from board members.

The chairman commented that she felt broadly assured that the STP plan did adhere to the Herefordshire health and wellbeing strategy. The engagement work that had taken place was welcomed and it was noted that there was nothing in the feedback which suggested either the plan or the strategy were awry.

In the ensuing discussion the following points were raised:

- that a lot of detailed planning work had taken place prior to the STP and had been used to inform the plan;
- that Herefordshire could not solve all its challenges alone, there would be a need to work across a greater footprint to tackle some issues, Worcestershire was the prime partner but would not be the only partner engaged with;
- there were no specific areas in the draft plan on mental health or children and young people, it was important these were included;
- there was a close alignment between the One Herefordshire work and STP work, Herefordshire was speaking with one voice to influence the overall direction;
- the approach taken should reassure the board that processes were mutually reinforcing and supportive.

The feedback from the public engagement exercise was noted. There was concern about access to GPs and that information and advice was not as clear as it could be. Concerns about transport were noted but the board was cautioned that this could reflect perceived difficulties rather than actual difficulties experienced by patients. There was a desire from carers for more support and it was noted that while technology could play an important part in providing remote support if the public did not find it easy to use they would not use it. Technology was cited as a good example of the broader role of the council as it led on delivering broadband access and mobile phone coverage across the county.

The healthwatch representative stated that the feedback to the public engagement exercise showed a spectrum of opinions. It was noted that as the STP plan was a high level document and that public feedback had focussed more on what the system looked like now rather than the future direction. The role of healthwatch in supporting the public engagement was welcomed.

The board noted that delivery plans would need to be drawn up to show how the STP plan would be implemented on the ground. These delivery plans should come back to the health and wellbeing board when drafted.

The director of adults and wellbeing noted that it was also difficult at times for staff to embrace the use of technology in delivering care and support as this was traditionally a hands on service. As well as engaging service users with the use of technology, staff would need to change their way of thinking and be comfortable with the tools available.

The board considered the knock on effects of the STP on communities, carers and other services. It was noted that these effects would not necessarily be negative. The STP and the health and wellbeing board would continue to seek out unintended consequences of the plans being put in place.

The board was asked whether the informal briefing held jointly with the Worcestershire health and wellbeing board had been useful. Members felt that it had been a useful conversation, that there were lots of areas where the two counties could work together for mutual benefit and that where it made sense to do so services should be shared. It was noted that discussions had also taken place with Coventry and Warwickshire about sharing ideas, good practice and services where it was beneficial to do so.

RESOLVED

That the board

a) **subject to the comments made, considered that the proposed revisions to the STP plan showed due regard to the Herefordshire health and wellbeing strategy and that the resulting document was likely to fit local needs;**
b) **considered those parts of the emerging refreshed plan that impacted on residents/services in both Herefordshire and Worcestershire, and had highlighted aspects for consideration by the STP as it develops its plan; and**
c) **identified aspects of the STP plan where common approaches were intended across both counties that may have knock-on effects for other organisations , and had sought assurance from partner organisations that these were being appropriately taken into account within Herefordshire.**

The meeting ended at 4.07 pm **Chairman**

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**18 July 2017**
Title of report:	**Joint Strategic Needs Assessment 2017**
Report by:	**Director of public health**

Classification

Open

Key decision

This is not an executive decision.

Wards affected

Countywide

Purpose

To approve the Joint Strategic Needs Assessment (JSNA) 2017.

Recommendation(s)

THAT:

(a) the 2017 joint strategic needs assessment (at appendix 1) be approved;

(b) the board determine whether, in light of the refreshed assessment the adopted health and wellbeing strategy remains fit for purpose;

(c) the board determine area for board focus in the coming year in light of the priorities identified in the assessment; and

(d) seek assurance from all stakeholders that they will develop their commissioning plans around the final list of priorities

Alternative options

1 There are no alternative options. Herefordshire Council and Clinical Commissioning Group (CCG) have a joint statutory responsibility to produce the JSNA annually.

Reasons for recommendations

2 One of the statutory functions of the HWB is to produce an annual JSNA. This work is undertaken through the JSNA steering group.

3 This report aims at ensuring the JSNA is used to inform the strategic planning and commissioning of services pertinent to health & wellbeing by the council, CCG and other stakeholders.

Key considerations

4 The HWB approved that the JSNA steering group be established in October 2016. Since then it has been meeting on monthly basis. The membership includes representatives from each of the council directorates, Herefordshire CCG, Wye Valley NHS Trust, 2Gether NHS Trust, Healthwatch, Herefordshire Carers Support and Herefordshire Voluntary Organisations Support Service (HVOSS). This is chaired by the Director of public health.

5 The JSNA steering group has a remit to oversee the development of annual refresh of the JSNA and to provide a steer for the future JSNA work programme.

6 The JSNA is broad statement of health and wellbeing needs of the population of the county, with a focus on the wider determinants of health. It aims to inform the strategic planning and commissioning of services concerning the health and wellbeing of the local population by stakeholders.

7 In the last few years, the JSNA each year had a particular focus on one area, for example, health inequalities analysis in 2016 and children's needs assessment in 2015.

8 This year, the JSNA steering group agreed to develop a 3-year work programme for the JSNA. Each group member provided a list of key areas of work to be included in the JSNA work programme from their organisation/directorate perspective. Given due consideration to each priority, the steering group agreed that an overall refresh of JSNA in 2017 should be undertaken, in order to address a number of urgent priorities, such as long-term medical conditions, primary care profile, and healthy lifestyle data analysis linked with the agenda of the prevention workstream of the Herefordshire and Worcestershire Sustainability and Transformation Plan (STP). The JSNA 3-year work programme is detailed in appendix 4.

9 The JSNA refresh 2017 process commenced in November 2016 and completed in April 2017. Subsequently, it has been through an extensive process of review and consideration by partner organisations, to ensure that it is of the required quality and addresses key issues appropriately.

Key priorities

10 Taking an overview of the findings of the JSNA, a number of areas stand out as representing key priorities for consideration by the system as a whole:

- Herefordshire has a lower proportion of younger working age population as compared to the national average. Though there are high expectations that the new Herefordshire University in 2018/19 will enable us to retain and develop the county's own young people, talent and skills, this alone will not be enough to

fulfil county's future workforce demand. Therefore, this necessitates strategic planning for a broader workforce development.

- The crude rate of killed or seriously injured (KSI) casualties of all ages (2013-15) on Herefordshire roads (43/100,000 population) is high compared to the regional (33.9/100,000 population) and national (38.5/100,000 population) figures. Though the absolute numbers are small (223 in two years: 2013-15), these are preventable causalities and result in significant cost to health and social care. Therefore, this needs further analysis to determine the underlying factors and to put appropriate prevention measures in place.

- Fuel poverty is a longstanding issue. Latest available data (2014) show that the proportion of households that experience fuel poverty in Herefordshire (15.1%) is higher than the regional (12.1%) and national (10.6%) averages; and in our deprivation decile[1] we have the worst figure and moreover this is the worst figure in England. Fuel poverty is a significant factor contributing to excess winter deaths (225 in total in 2014-15) and alleviating fuel poverty is likely to help saving lives. Therefore, this merits a priority consideration to explore measures to minimise its economic and health impact.

- In 2014-15, in Herefordshire's proportion of 5 year olds with more than one decayed, missing or filled tooth (41.3%) was much higher than the regional (23.4%) and national (24.8%) averages and we have the worst figure in in our deprivation decile and this is the 4th worst figure in England. One public health programme to tackle obesity and poor dental health, the "sugar swap" campaign, is ongoing. Among other specific interventions to improve oral health, such as fluoride varnish (patchy provision in Herefordshire) and targeted provision of tooth brushes and paste (to be re-launched this year), fluoridation of water has the highest return on investment (for every £1 spent the return is £12.71 in 5 years and £21.98 in 10 years). This warrants urgent consideration of fluoridation of water in the county.

- In 2016, in Herefordshire 9.8% of reception year children were obese, while the combined proportion of obese and overweight children was 22.2 %; for year 6 children the prevalence of obesity was 19.8%, while the combined figure for obese and overweight children was 33.8%. These figures are higher than the regional and national averages and we have one of the worst figures in our deprivation decile (4th less deprived) and these are more comparable to the 5th more deprived decile figures. Furthermore, 2016 figures show an upward trend. Excess weight and obesity in childhood is a significant risk factor for developing morbid obesity in adulthood. This in turn potentially withholds individuals from having a productive and fulfilling life. Unhealthy food and physical inactivity are the key factors responsible excess weight, which are modifiable. The public health campaign "Change 4 Life" and the National Child Measurement Programme are ongoing. In addition to strengthening these programmes, further action is needed to avert this upward trend in childhood obesity through working closely with early year settings, schools, parents, communities and businesses.

- Overall prevalence of long term medical conditions (LTCs) in Herefordshire (56.6%) is higher than the national average (54%). This could be attributed to

[1] As per Index of Multiple Deprivation (IMD) 2015, Herefordshire falls in the 4th less deprived decile nationally – 1st is the least deprived and 10th is the most deprived.

the aging population. One LTC of particular concern is high blood pressure (hypertension); local figure is 16% as compared to the national average of 13.8%. High blood pressure is the 3rd biggest risk factor for premature death and disability in England after smoking and poor diet. At least half of the all strokes and heart attacks are associated with high blood pressure and it is a major risk factor for chronic kidney disease, heart failure and dementia. People in the most deprived neighbourhoods are 30% more likely than the least deprived neighbourhoods to have high blood pressure. It is estimated that there are 21,000 undiagnosed cases of high blood pressure in Herefordshire.

- Therefore, primary prevention and early detection & treatment are central tenets of our strategy to combat high blood pressure. Primary prevention involves behavioural change to influence modifiable risk factors – excess salt intake is one of most important modifiable risk factor. Early detection and treatment is through either opportunistic or NHS health checks programme. Between April 2014 and March 2017, NHS health checks programme identified 3,689 new cases of high blood pressure. Lowering systolic blood pressure just by 10mmHg on average in people with high blood pressure can potentially save 273 deaths, and 87 strokes, 75 coronary heart disease and 51 heart failure events in one year in Herefordshire. Therefore, there is case for continuing to invest in healthy lifestyle programmes and NHS health checks.

- There is a life expectancy gap of 4.2 years for males and 2.3 years for females between the most deprived and least deprived deciles of the county population. Three health conditions (circulatory diseases, cancers and respiratory diseases) largely account for this life expectancy gap (77% in male and 66% in female). There are number of modifiable lifestyle risk factors associated with these conditions; Smoking is the largest preventable lifestyle risk factor and prevalence of smoking in Herefordshire (17.5%) is significantly higher than the England best (9.5%). Therefore, influencing people to adopt healthy lifestyles is central to our health & wellbeing agenda and public health has been running "One You" campaign. However, this agenda needs to be owned by all stakeholders and should be embedded as part of the 'strengths-based approach' in their core business.

- In 2015-16 there were over 900 fall related hospital admissions in Herefordshire residents aged 65 and over with almost two thirds being for females. Though in 2015-16 the Herefordshire hip fracture rate in this age group (551/100,000 population) was lower than the national average (589/100,000 population); but this equates to 244 hip fractures in Herefordshire. Each hip fracture could potentially cost over £35k in terms of health and social care costs over a period of two years. We do know falls are largely preventable. Pursuing the Adults and wellbeing directorate prevention agenda a number of measures have been put in place to prevent falls in nursing and residential care homes and in the communities such as postural stability programme and falls response service. However, the council and NHS commissioners need to consider further measures to reduce falls such as early identification of high risk individuals in primary care and other settings, and offering them appropriate intervention to mitigate risk of falls (for example environmental modification, physical activity, healthy eating programme to enhance muscle and bone strength, medicine review).

- 2015-16 Herefordshire data for young people's mental health reflect poorly across a range of indicators: % of 15 year old drinking regularly (7.8%) is higher than the regional (5.5%) and national (6.2%) figures. Under 18 alcohol specific hospital admissions (50.8/100,000 population) is higher than the regional (32.6/100,000 population) and national (37.4/100,000 population) rates. Under 17 hospital admission due to mental health conditions (144.2/100,000 population) is the worst across the West Midlands being higher than the regional (89.8/100,000 population) and national (85.9/100,000 population) rates. Though these rates are based on small numbers, trend analysis shows that Herefordshire rates have consistently been higher than the national rates in the last couple of years with a recent upward trend. This indicates a severity of the local problem. Coupled with this is the persistent high rate of suicide (all ages) in Herefordshire, which is above the national rate.

- Mental health has been identified as number one priority in the Herefordshire Health & Wellbeing Strategy. The public health team has been following a number of actions in order to implementation this strategy:

    - it has been running "5 ways to wellbeing" campaign to promote mental wellbeing

    - the team has just launched "Youth Mental Health First Aid Training" for school teachers to be rolled out across Herefordshire by December 2017. It is hoped that every secondary school in Herefordshire will have at least one school teacher trained by that time. We also plan to support a trainer-training programme, in order to ensure continued rollout and sustainability of the approach

    - health visitor and school nurse workforce training on initial assessment of alcohol and substance misuse and brief advice is planned for 2017

    - Public health, environmental health and trading standards (EH&TS) have been working together to run a campaign to curb underage alcohol sales

    - Herefordshire Council and NHS Herefordshire Clinical Commissioning Group have been working together to develop "Suicide Prevention Strategy".

- Given the young people mental health data, review of current provision of community adolescent mental health service (CAMHS) should be considered to inform future commissioning decisions. Also provision of early identification and brief advice (IBA) to individuals with alcohol abuse problem in primary care should be considered.

Community impact

11 The JSNA provides an overview of Herefordshire population and communities' profiles. It informs the development of Health and Wellbeing strategy and provides the data which underpins a wide range of council and health strategies such as the children and young people's plan, to improve outcomes for residents of Herefordshire.

12 The NHS constitution, the Herefordshire Clinical Commissioning Group constitution and the council's constitution all contain commitments to transparency, accountability and principles of good corporate governance. Being clear about the reasons for

decisions is a key element of these shared principles and the JSNA provides this underpinning data.

13 Health and council commissioners also share a duty to ensure that public resources are used to best effect; a sound evidence base on which resource allocation can be made is essential.

Equality duty

14 One of the purposes of the JSNA is to inform commissioners of the existing inequalities across various sections of the community and to enable them to commission services that are equitable and accessible.

15 Section 149 of the Equality Act 2010 imposes a duty on the council to have due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic (disability being one such characteristic) and persons who do not share it.

16 Public health programmes/services aim to identify and support those who suffer from or are at a high risk of developing physical and mental health problems. Continued improvement and development of these programme/services will support the council in discharging its duty under the Act and will help deliver the three aims of the duty:

- 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

17 The JSNA has no direct financial implications, but its findings are intended to play a significant role in guiding the allocation of resources by all partners in their commissioning plans.

Legal implications

18 The Health and Social Care Act 2012 provides that local authorities have a statutory duty to improve the health of their population. The JSNA is instrumental in enabling the partners to discharge this duty.

19 The Health and Social Care Act 2012 places a duty on health and wellbeing boards to prepare a JSNA and on partners to have regard to its findings in their commissioning plans.

Risk management

20 There is a reputational risk to the council if it fails to discharge its public health responsibilities as set out in the Health and Social Care Act 2012.

21 In the absence of a robust JSNA, decisions on the allocation of resources would be

based on a weaker evidence foundation, such that these might not be directed towards the areas of highest priority.

Consultees

22 Herefordshire CCG, 2gether NHS Foundation Trust, Wye Valley NHS Trust, and Herefordshire Carers Support.

Appendices

Appendix 1 JSNA refresh 2017 report

Appendix 2 JSNA refresh 2017 slides

Appendix 3 JSNA evidence report

Appendix 4 The JSNA 3-year work programme

Background papers

None identified

UNDERSTANDING HEREFORDSHIRE

JOINT STRATEGIC NEEDS ASSESSMENT 2017

APPENDIX 1

CONTENTS

APPENDIX 1

EXECUTIVE SUMMARY – KEY MESSAGES

Population

- Herefordshire is a predominantly rural county, with the 4th lowest population density in England, although the population is growing slowly, largely as a result of international migration to the county.
- Individuals aged 65 and over account for 23 per cent of the population and the numbers are projected to grow at a similar rate as during the last decade, although the number aged 85+ will rise even more rapidly.

Economy

- Herefordshire's economy has improved steadily since the UK economic crash of 2008 and between 2014 and 2015 the number of active small or micro business enterprises in the county increased by one percent
- Herefordshire has a high proportion of older working age adults (mid-forties to the age of 64).
- Average wages in the county are 13 per cent lower than across the West Midlands and 18 per cent lower than for England as a whole; women in Herefordshire earn 16 per cent less than their male colleagues.
- The largest industry sector in Herefordshire is 'Agriculture, forestry and fishing' is the largest industry sector in Herefordshire, accounting for 24 per cent of total businesses, although the industry employs a disproportionately low number of people in the county.
- There are high expectations that the new Herefordshire University planned for 2018/19 will boost the economy, attracting new students from out with the county whilst retaining and developing the county's own young people, talent and skills.

Environment

- Mortality attributable to particulate air pollution is lower in Herefordshire compared to both the West Midlands and England.
- The quality of the county's mains water supply is high, although the quality of private supplies y is more variable.

Community

- There are 5,422 carers registered in Herefordshire of which 24 per were aged between 65 and 80 years.
- Seventy per cent of residents in care homes and those who receive help in their own home are satisfied with the services they receive and feel that the care and support provided increases their quality of life.

Crime and Safety

- Herefordshire is a relatively low crime rate area.
- While the overall rate of reoffending has reduced over time the number of juvenile re-offenders is increasing faster than regionally or nationally.
- Eighty per cent of anti-social behaviour categorised as 'nuisance' offences are committed by young people.

Starting Well: Mothers, Babies and Children

- The proportion of pregnant women in Herefordshire who are smoke has reduced by half since 2006/07 and is below the national ambition of 11 per cent as set by the government's Tobacco Control Plan.
- The perinatal mortality rate in Herefordshire of 8.6 per 1,000 total births is significantly higher than both the national rates, while the local infant mortality rate was similar to those for England and the West Midlands.
- In areas, such as breastfeeding and immunisations, there have been steady improvements in Herefordshire.
- In Herefordshire's 5 year olds the figures for the mean number of decayed, missing or filled teeth and the proportion free from dental decay are worse than those observed nationally and regionally.
- In Herefordshire 9.8 per cent of reception year children are obese, while the combined proportion of obese and overweight was 22.2 per cent; for year 6 children the prevalence of obesity was 19.8 per cent, while the combined figure for obese and overweight children was 33.8 per cent.

Starting Well: Early Help and Protection

- The number of children with protection plans in Herefordshire is falling, although the number of looked after children has increased over the last few years.
- The county provides much needed support for Syrian refugees and unaccompanied asylum seeker children.

Learning Well: Children in Education

- Herefordshire is above the national average for pupils achieving a Good Level of Development (GLD) standard and the county is in the top quartile of local authorities in England.
- Steady improvement has been observed at other levels (Phonics, Key Stages 1 and 2), although a mixed picture is evident for children at key stage 4 attending the county's state maintained schools.

Doing Well: Young People in Education and Training

- Fewer 16 and 17 year olds in Herefordshire are in full time education and training (89.6 per cent) compared to the England average of 91.3 per cent.
- Compared to national figures Herefordshire has a smaller percentages of the 16 and 17 year old cohort engaged in Apprenticeships, Training, Work Based Learning and Part time Education.

Inequalities in Education

- It is estimated that 14.7 per cent of children under 16 in Herefordshire are living in poverty, although this figure is significantly lower than across both the West Midlands region and England.
- Children living in areas of the county with higher levels of child poverty performed below the county average at both Key Stage 1 and Key Stage 2.

Living Well: Adults' Healthy Lifestyles

- Forty six per cent of adults in Herefordshire are estimated to be either overweight or obese and local evidence suggests strong links between likelihood of becoming morbidly obese and social deprivation.
- Recent estimates indicated that 21 per cent of Herefordshire's adults binge drink, particularly amongst people aged 40 years and over.
- Both the hospital admissions rate for alcohol-specific conditions and alcohol specific mortality rate in Herefordshire are significantly lower than the national figures, although the admission rate for those under the age of 18 is higher in Herefordshire than across England as a whole.
- The prevalence of adult smokers in Herefordshire (17.5 per cent) is higher than in England as a whole (16.9 per cent); across the county smoking prevalence is greater in areas of high deprivation.
- In recent years the rate at which individuals in Herefordshire successfully quit smoking has fallen by over 70 per cent.
- While locally the overall prevalence for opiate and crack cocaine usage is lower than the England figure, the rate of intravenous use is higher than that reported nationally.
- The level of physical activity is higher in Herefordshire than the average for comparator counties and unitary authorities, while the local level of inactivity is lower.

Living Longer

- Life expectancy in Herefordshire is 80.4 years for males 83.9 years for females, with both figures being higher than the national figure.
- Healthy life expectancy in Herefordshire is 67.1 years for males and 68.2 years for females which are both higher than the national figures.

Being Well: General Health of Adults

- Over recent years prevalence of cardiovascular disease in Herefordshire has remained stable, although the local figure has been consistently higher than across England as a whole.
- Since the turn of century the number of new cancer cases diagnosed annually in Herefordshire has increased steadily and is greater than the national figure the local cancer mortality rate in has been consistently lower than both the national and regional rates.
- The most common causes of cancer-related deaths in Herefordshire are lung, urological and upper and lower gastro-intestinal cancers.
- People suffering with chronic obstructive pulmonary disease in Herefordshire have increased steadily since 2005/06 and since 2011/12 the local prevalence has been higher than the national figure.
- The prevalence of common mental disorders in Herefordshire is lower than national and regional figures.

Aging Well: People Aged 65 Years and Over

- In Herefordshire life expectancy at 65 is 19.5 years for males and 22.0 years for females, with both figures rising steadily since 2000 and are higher than those recorded nationally
- In 2015/16 there were over 900 fall related hospital admissions in Herefordshire residents aged 65 and over with almost two thirds being for females.
- The rate of fall related admissions are highest in the most deprived areas of the county.
- Across the county 97 per cent of all dementia cases are in those aged 65 and over.
- Over half of all excess winter deaths in Herefordshire are in those aged 85 and over with the most common underlying cause being respiratory disease.
- The Herefordshire prevalence of dementia in individuals aged 65 and over is lower than in West Midlands and England as a whole.

INTRODUCTION

The Joint Strategic Needs Assessment (JSNA) is an assessment of the current and future health and social care needs of the local community in Herefordshire. The JSNA informs the Joint Health and Wellbeing Strategy (JHWS) which describes the plans for meeting the needs identified in the JSNA and also underpins the work programme for the Sustainability and Transformation Plan (STP) which aims to ensure that local NHS services are safe and sustainable for the future. Herefordshire Council and Herefordshire Clinical Commissioning Group (HCCG) have equal and joint duties to prepare JSNAs and JHWSs through the Health and Wellbeing Board established by the local authority. The JSNA is a continuous process and is refreshed annually (as part of *Understanding Herefordshire*) as additional information becomes available. The aim of the document is to provide a shared understanding of the size and nature of Herefordshire's population in one place.

The JSNA is increasingly important as a shared resource through which different organisations across sectors can understand the needs and nature of local communities. In order for the JSNA to be a shared endeavour, Herefordshire's Health and Wellbeing Board established a JSNA Steering Group in 2016 to provide oversight and achieve a balance between professional analysis and engagement from a wide variety of organisations. Chaired by the Director of Public Health, the group has completed the first phase of identifying key areas for research for a three to five year JSNA work programme aligned to the Herefordshire Sustainable and Transformation Programme.

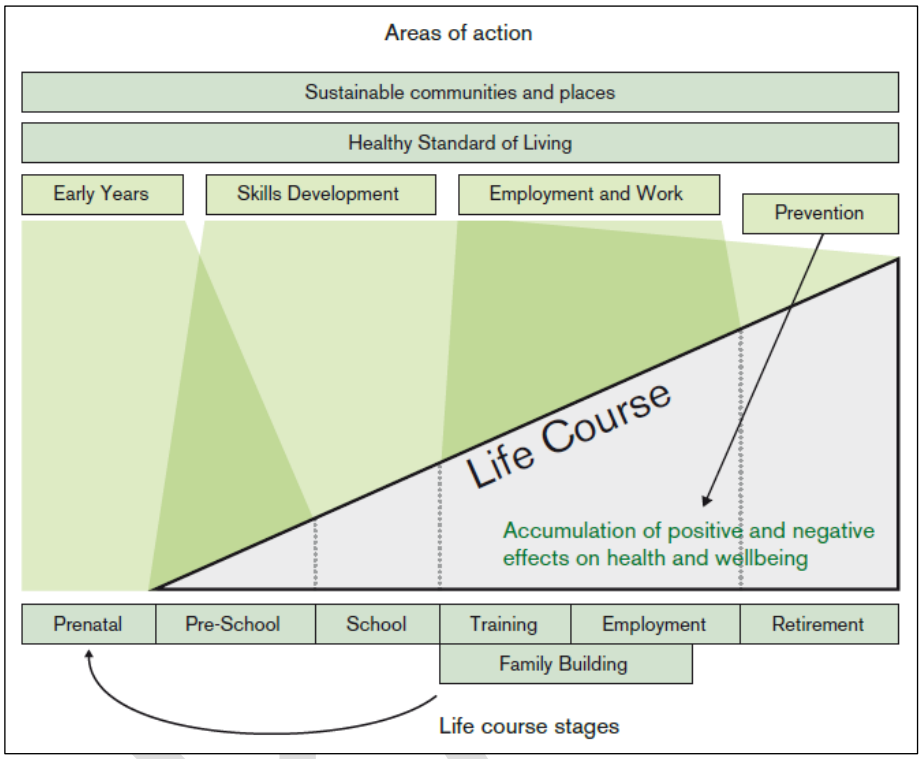
This refreshed 2017 JSNA follows a life course approach as set out in the Marmot review 2010 'Fair Society, Healthy Lives' (see Figure 1) and is based on the understanding that:

> *"Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken"*
> Marmot Review (2010).

The summary report provides an update on some key areas such as health, social care, education and economy, with electronic links to the underlying evidence base. It also reports on several projects undertaken since the last JSNA along with a description of the latest population statistics for the county. Where possible, it has been useful to benchmark outcomes in the county against regional, national and statistical neighbours. Insights will be gained on the wider determinants of health and being (see Figure 2 below). It is important to note that the 2017 JSNA is a refresh of some wider determinants of wellbeing but not all. For example, people's homes are an important factor in their

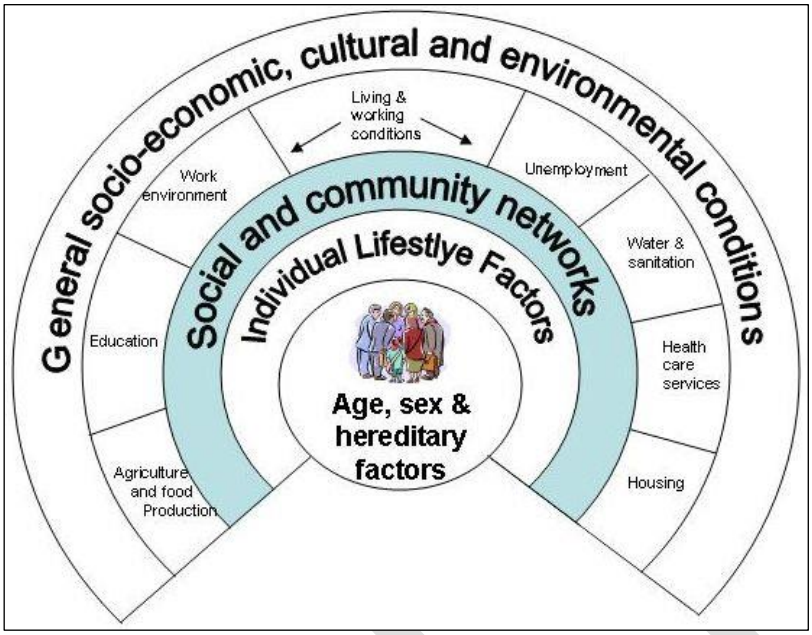
health and wellbeing, however, housing is not reported here but will be later on in the year when a local housing and health profile is due to be completed.

Figure 1: Action across the Life Course



Source: 'Fair Society, Healthy Lives – Marmot Review, 2010

Figure 2: Wider Determinants of Health and Wellbeing (Dahlgren & Whitehead, 1992)



HOW TO USE THE JSNA

Herefordshire Council's and Herefordshire Clinical Commissioning Group's focus is on prevention, early intervention and demand management in order to deliver better outcomes for individuals and the community as a whole, whilst also managing the challenges of scarce public resources. This requires a broad view of health and wellbeing that accounts for the wider socio-economic factors that affect the health and happiness of Herefordshire's children, young people, adults and families.

HEREFORDSHIRE – A PROFILE

Herefordshire is situated in the south-west of the West Midlands region bordering Wales. The city of Hereford lies in the middle of the county and other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington.

Herefordshire has beautiful unspoilt countryside with remote valleys and rivers and a distinctive heritage. The River Wye divides the county, flowing east from the Welsh border through Hereford city before turning south to flow through the Wye Valley '*Area of Outstanding Natural Beauty'*. The Malvern Hills rising to 400m border the east of county, while the south-west is dominated by the western reaches of the Black Mountains with altitudes of more than 600m.

KEY FACTS

Land area = 2,180 square kilometres (km^2)

95% of land area is 'rural' and 53% of the population live in rural areas

2 in 5 residents live in the most dispersed rural areas

Population (mid-2015) estimate = 188,100 residents

4th lowest population density in England: 86 people per km^2

Density varies across county: 13 people per km^2 in areas of the north west and south west of the county to 8,000 per km^2 in Hereford

1 in 3 county residents live in Hereford (60,400)

1 in 5 live in market towns: Leominster – (11,900), Ross on Wye – (11,100), and Ledbury – (9,900), Bromyard (4,600) and Kington (3,300)

From 2001-2015, the county had a low rate of population growth (7.5%) compared to England & Wales (10.6%) and West Midlands (8.9%)

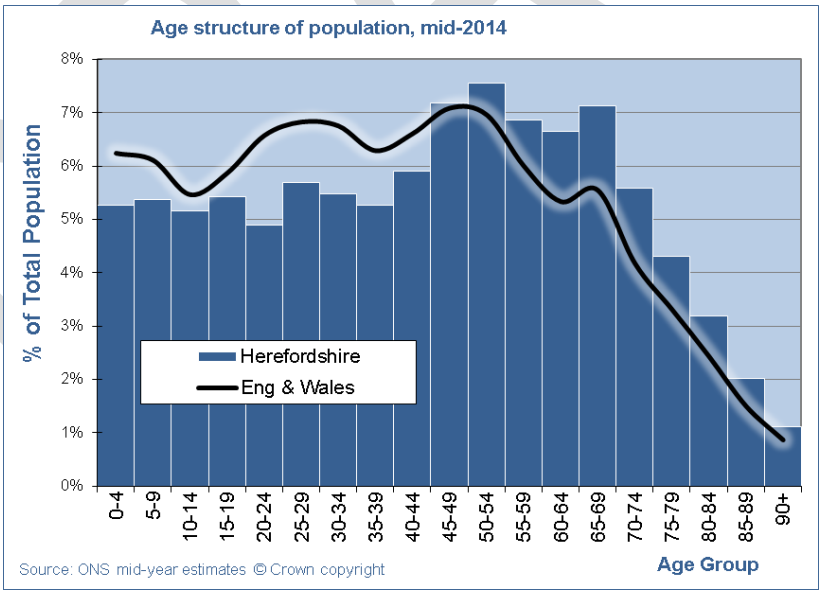
POPULATION

The current (mid-2015) estimate of Herefordshire's resident population is 188,100. This figure represents an increase of eight per cent since 2001which is lower the 11 per cent growth recorded for England and Wales as a whole. The county has an older age population profile than England & Wales**, with 23 per cent of the population aged 65 years or above (43,900 people)**, compared to

18 per cent nationally. This includes **5,900 people aged 85 and over.** There were 30 per cent more people aged 65+ than there were in 2001, compared with a 24 per cent increase nationally - see Figure 3. If recent trends were to continue, this same natural ageing of the population structure would see the total population of **Herefordshire increase from 188,100 people in 2015 to 205,600 people by 2034** (an increase of nine per cent). However, the working age population would fall from 112,500 to 108,900 in 2034 (a decrease of three per cent), with the sharpest decline occurring after 2025 when the second generation of 'baby boomers' (i.e. those born in the 1960s) begin to move into retirement age.

Although the flows of people moving between the county and other parts of the UK (internal migration) are larger than those between the county and abroad (international migration), three-quarters of the county's annual total *net* migration is generated by migration from overseas which has been the case since the expansion of the European Union in 2004. However, in the year to mid-2015 local internal emigration and immigration cancelled each other out to leave immigration of foreign nationals as the sole component of net migration in Herefordshire. In terms of ethnicity, Herefordshire has a relatively small, but growing Black, Asian and Minority Ethnic (BAME) population (6.4 per cent in 2011) which is considerably lower than that recorded nationally (19.5 per cent). People of 'white other' origin (i.e. not British; Irish; Gypsy or Irish Traveller) made up the largest single minority group in the county - 3.9% of the population, of which over half are Polish.

Figure 3: Age structure of Herefordshire population, 2015 mid-year estimates.



ECONOMY

Working age population

Herefordshire has a lower proportion of younger working age adults (from the age of 16 to mid-forties) compared with England & Wales as a whole, but has a higher proportion of older working age adults (mid-forties to the age of 64). There was a sharp increase in the number of 16 to 64 year olds during the middle of the decade, largely due to international migration. However, since 2008 numbers have been gradually declining due to relatively lower migration levels and since 2010 by the post-war 'baby-boomers' moving into retirement age.

Businesses

Latest published data from Inter Departmental Business Register (IDBR) shows that in 2016, Herefordshire's **total enterprise count (that is, overall businesses) totalled 10,070** representing a one per cent increase from 2015 (9,950 enterprises). In line with regional and national figures, the majority (90 per cent) of these were 'micro' enterprises employing 9 or fewer employees, while 8.5 per cent were 'small' (employing 10 to 49 people) and 1.3 per cent were 'medium' size enterprises employing 50 to 249 employees. The enterprises classified as 'large' (employing 250 employees or more) accounted for a very small percentage of businesses (0.2 per cent) in Herefordshire.

By far the **largest industry in Herefordshire is 'agriculture, forestry and fishing'** accounting for 24 per cent of total businesses in the county, but employing the fewest number of employees in the county. The second largest industry is taken up by 'construction and professional, technical activities' (22 per cent) - see Figure 4.

There were more new business start-ups in 2015 than they were at the onset of the recession in 2008, which indicates a steady trend of economic recovery from the recession in Herefordshire. **In 2015 there were a total of 8,290 active businesses** in Herefordshire and it was the third consecutive year in which there were more business births than deaths in the county. The new business registration rate[1] in Herefordshire is lower than that of west Midlands but higher than England as a whole.

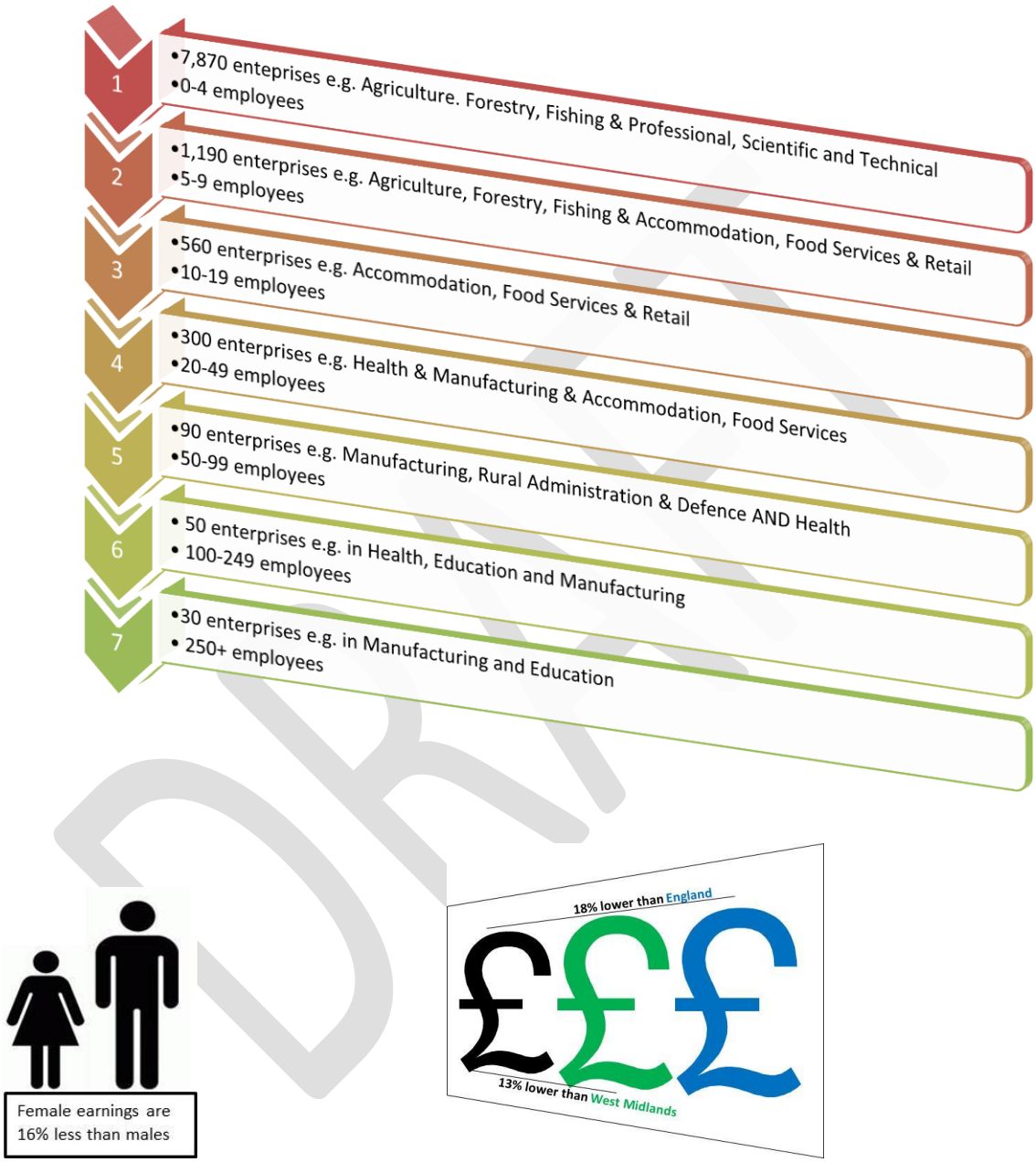
In Herefordshire, there were an **estimated total of 71,200 employees in 2015, an increase** from 71,700 in 2014. Of these, the majority are employed in the private sector (85 per cent) with the remaining 15 per cent work in the public sector, a figure lower than for the West Midlands (19 per cent) but higher than for England and Wales as a whole (17 per cent). Locally annualised[2] earnings were approximately £23,200, a figure 13 per cent lower than the West Midlands (£26,600) and 18 per cent lower than England as a whole (£28,350). In 2016**, women's earnings in Herefordshire were**

[1] The rate of business registrations per 10,000 resident population aged 16 and above.

[2] Only includes earnings of those who are employed in the same job for a year.

16 per cent lower than that for men. While this is considered to be a significant gap is lower than the West Midlands gender earnings gap of 21 per cent and that for England of 18 per cent.

Figure 4: Businesses in Herefordshire by size, industry and employee numbers.



New University

Awarded by the government in its 2016 autumn statement, a £25million bid was successfully made by Herefordshire Council in partnership with the Herefordshire Tertiary Educational Trust for the development of a new engineering university for the county. Known as the New Model in Technology and Engineering (NMiTE) it will be an independent, not-for-profit, world class engineering university

based in Hereford with dedicated student accommodation across the city. With a particular focus on advanced manufacturing, agriculture-engineering, data, defence, resources security and sustainable / smart living technology sectors, the new university is viewed as a game changer welcoming up to 5,000 students to the county over the next decade, potentially, and having a positive economic impact on the county.

On average, around 700 18-20 year-olds leave the county each year than move into it from other parts of the UK[3]. This may in part be explained by Herefordshire currently having no major centre of higher education, coupled with the fact that young people leaving home to start university are generally aged 18-19 and are counted at their term-time address. The new university will potentially enable Herefordshire to attract new students from out of the county whilst retaining and developing its own young people, talent and skills.

The funding for a university in Herefordshire comes on the back of the £43million awarded by government in 2014 for the city centre link road which will open up land for up to 800 new houses, and for the South Wye Transport Package which represents the first section of the Hereford bypass. The new university comes at a time of significant investment for the county as the government has also awarded £3million of funding for a new Cyber Security Centre to be built in the Rotherwas Enterprise Zone; this development will also be part funded and part operated by the University of Wolverhampton.

[3] JSNA 2016, based on the Annual Mid-Year Population Estimates for the UK, Office for National Statistics © Crown Copyright 2016.

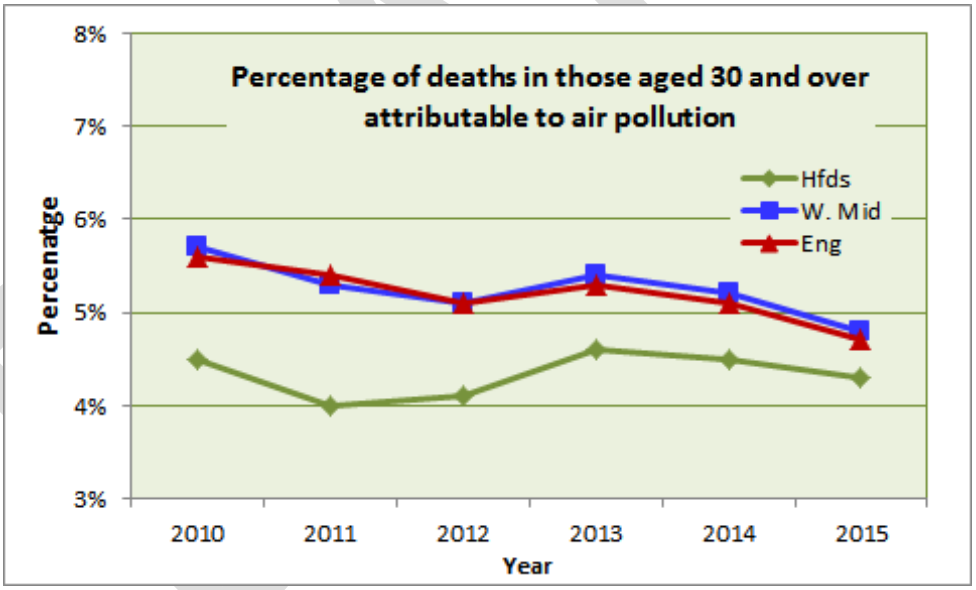
ENVIRONMENT

Generally, the county has low levels of air pollution and carbon emissions continue to steadily decrease. A nutrient management plan addresses water quality in parts of the River Wye and River Lugg.

Air Quality

Poor air quality can have a negative impact on health. Herefordshire has two 'Air Quality Management Areas' (AQMAs) where air quality is actively monitored as it currently breaches Governmental standards for nitrogen oxide (NO), a known pollutant. The level of pollution is a correlated to levels of traffic near housing. Latest figures published for nitrogen dioxide (NO_2) can be found on ADJUSTED Nitrogen Dioxide Data 2015 and the Air Quality Management Areas. Mortality (deaths) attributable to particulate air pollution is a Public Health protection indicator under the wider determinants of health and figures for Herefordshire remained relatively stable between 2010 and 2015 and were less than levels reported for both the West Midlands and England (Figure 5).

Figure 5: Proportion of deaths apportioned to air pollution in Herefordshire, England and the West Midlands, 2010 to 2015.



Water Quality

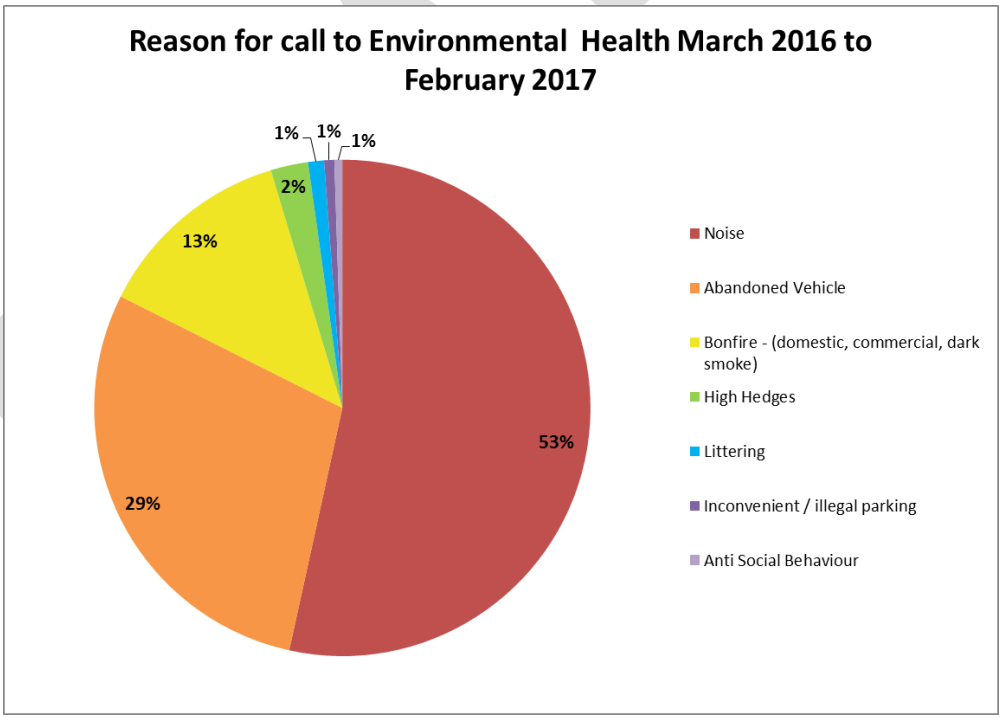
In 2015 there were 2,100 single private domestic water supplies in Herefordshire, in addition to 253 commercially used or large supplies and 143 shared supplies. Most residential homes and businesses are supplied by Welsh Water, although a small proportion utilise non-mains based water supplies, either by choice or because mains supply is not possible. The quality of the county's mains water supply is high, whereas private supply quality is more variable with 9 per cent of samples failing

E. Coli standards and 10 per cent failing Enterococci standards indicating contamination by faecal matter and a higher risk of harmful bacteria being present in the water supply.

Reports to Environmental Health

In the year to February 2017 there were 1,365 reports to Environmental Health (EH) at Herefordshire Council; this excludes reports for fly-tipping as the reporting function for fly-tipping was transferred to an independent provider, although a majority of calls to EH was for the removal of rubbish caused by fly tipping. Not including fly-tipping noise is the most commonly reported problem reported to Herefordshire EH (53 per cent of all reports) with the common causes being music (29 per cent), barking dogs (28 per cent) and people (10 per cent). Figure 6 illustrates reasons for calls to Environmental Health. As consistent location data is not recorded within the dataset it is not possible to map geographical distribution of calls. Noise reports to EH continue to be included in the MATAC delivery group's performance indicators as a specific indicator alongside all reports to Environmental Health.

Figure 6: Reason for contacting Environmental Health in Herefordshire March 2016 to February 2017.



Source: Economics, Corporate and Communities, Herefordshire Council

COMMUNITY

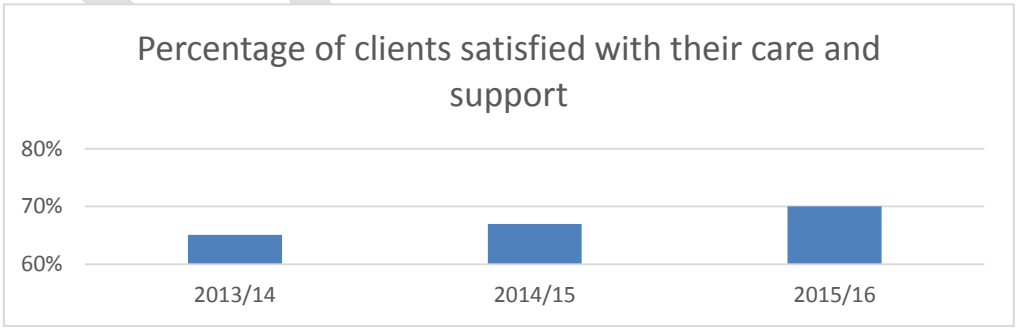
Carers

Recognised as an unpaid workforce, according to the 2011 census carers comprise 11 per cent of Herefordshire's population providing at least one hour of unpaid care a week to family members or friends who are in need of help because they are ill, frail or have a long term disability. As of January 2017 Herefordshire Carers' Support (HCS) had 5,422 carers registered, of which 24 per were aged between 65 and 80 years. Two years ago, the highest proportion of carers were in the 45-65 years age bracket, suggesting that there are likely to be more elderly carers in the future in line with the aging demographic of the county. In line with this Herefordshire Council is developing its Carer's Strategy with the active involvement of carers. For carers in Herefordshire to be 'recognised, valued, and supported'[4] commissioners are addressing the requirements under the Care Act 2014 which strengthened carer's rights from April 2015. Planning future support for the increased numbers of older carers as the population ages is viewed as crucial given the county's aging demographic.

Residents in Care Homes or Living at Home – survey findings

In March 2016 Herefordshire Council conducted a survey of residents in care homes and some who received help in their own home. Out of 888 surveys distributed 430 people responded, which is 48 per cent of those contacted. This is a small increase on the previous year's response and is one of the best response rates nationally. The survey reported that Herefordshire people are more satisfied with the care and support they received in 2016 compared to the previous year, a pattern evident since 2013/14 (Figure 7). People also feel safer because of the services in place. More people said that they had as much social contact as they would like, and that the services they received made their quality of life better.

Figure 7: Proportion of adult Social Care Survey respondents satisfied with their care and support (Source: Strategic Intelligence Team, HC)



Refugees and Asylum Seekers

[4] The National Carers Strategy (25 November 2010) www.dh.gov.uk/publications

The 2016 JSNA reported on Herefordshire Council's agreement with the Home Office to accept the re-settlement of Syrian Refugees (as part of a five year government funded programme) and Unaccompanied Asylum Seeker Children (UASC). Subsequently, Syrian refugees under the Syrian Vulnerable Person's Resettlement Scheme (SVPRS) have been housed in privately rented accommodation in Hereford city, or within 3 miles of the city centre, and provided with an orientation and support service from Refugee Action for the first 12 months. Families who are part of the SVPRS have been granted 5 years Humanitarian Protection status and as such have access to public funds, so consequently can seek work and make relevant benefit claims subject to same checks as other residents in the county.

Unaccompanied Asylum Seeker Children (UASC) are being placed in foster care, supported lodgings or, where appropriate, in shared accommodation. UASC's and those under the General Asylum Dispersal scheme do not have access to public funds whilst their asylum application is being processed. All adults have been offered and are engaging with English Language development classes, and are also supported through Refugee Action English practice volunteers. All school age children in families in the SVPRS and UASC's are allocated places in local schools via the "In Year Fair Access" meetings, or the usual application process. The council is working with local colleges and training providers to develop an appropriate provision for those aged 16-18 to improve their English language and employability skills.

Those under the SVPRS and UASC's are supported to register with GP's and gain access to dental care. Evidence indicates that new arrivals often need urgent dentist and optician appointments due to lack of basic healthcare where they have been living. Organisations and the local community have offered support in various forms to the council's call for assistance for the Syrian refugee families.

CRIME AND SAFETY

Herefordshire remains a generally a low crime rate area and partners work together to ensure that Herefordshire continues to be a safe place to live, work and visit. This section provides some crime statistics for the county reported in the Community Safety Strategic Assessment (2017).

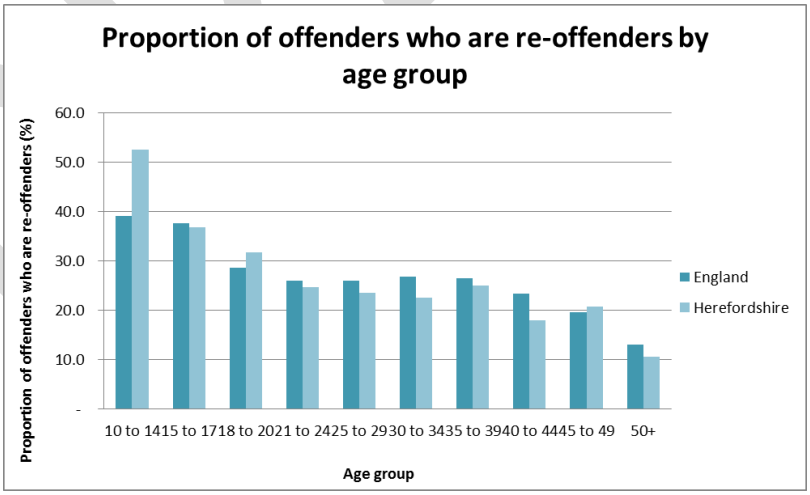
Adult Re-offending[5]

In 2015, of the 4,131 adult offenders in the local cohort, 1,002 reoffended; 25.3 per cent of offenders were re-offenders, a figure similar to both regional (24.2 per cent in West Midlands) and national (24.3 per cent in England and Wales) figures. The average number of previous offences per offender has been increasing locally since 2009. In 2015 offenders had on average 11.4 previous offences, significantly less than the figures reported regionally and nationally of 14.5 and 14.2 respectively.

Re-offending by age

The proportion of juvenile re-offenders to offenders has been increasing faster in Herefordshire than nationally or regionally (see figure 8). However, since 2007, the number of offenders in the cohort, the number of re-offenders and the number of re-offences have reduced over the last decade. However, similar declining trends have been identified nationally and so cannot account for the increasing proportion of re-offenders recorded in Herefordshire compared to that recorded nationally.

Figure 8: Proportion of offenders who are re-offenders across Herefordshire and England and Wales by age group (2015).



Source: Ministry of Justice

[5] Data sourced and analysed from the Ministry of Justice's most recent quarterly *'Proven reoffending geographical data tool'* release (January 2017). This dataset included data from 2006 through to 2015 for the 12 months ending in March.

In 2015, 52.5% of re-offenders are aged 10-14 years, higher than the national figure of 39%.

63 young people aged between 10 and 14 who re-offended in 2015 committed 222 re-offences (on average of 3.5 offences per re-offender

In Herefordshire, there were significantly more male offenders than female offenders in 2015, and a higher proportion of males were re-offenders than females, similar to ratios in England and Wales.

NUMBER OF OFFENCES

Those aged '25 to 29' were responsible for the highest number of re-offences (15 per cent of all re-offences). '15 to 17' year olds were responsible for a further 14 per cent and both '18 to 20' and '30 to 34' a further 13 per cent each.

THE HIGHEST LEVELS OF RE-OFFENDING BY CRIME TYPES - 2015

1. **Theft* - 34.5 %**
2. **Public Order – 32%**
3. **Miscellaneous crimes against society* - 27.5%**
4. **Summary non-motoring – 24.1%**
5. **Drug* – 24%**
6. **Possessions of weapons – 23.1%**

***= The highest number of re-offence**

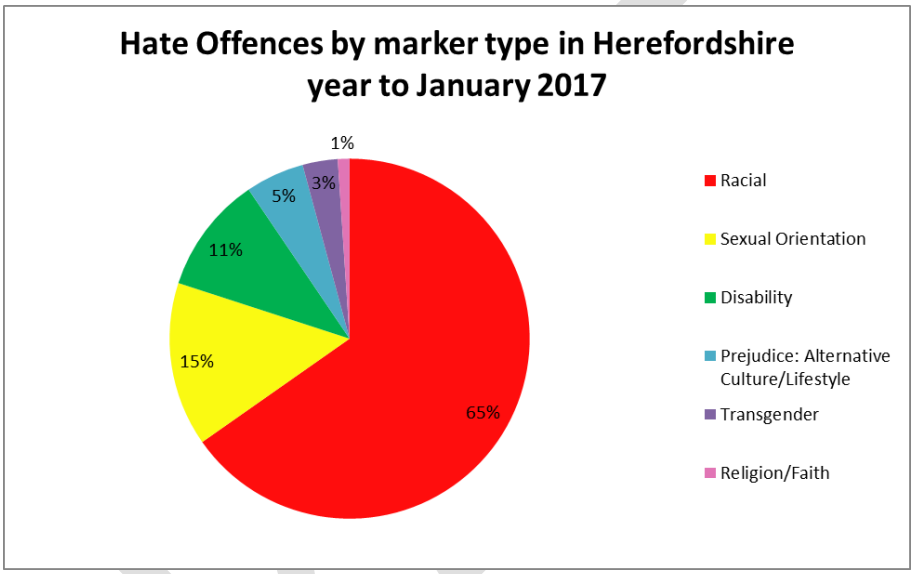
Antisocial behaviour (ASB) offences

In the period January to December 2016 West Mercia Police recorded 6,465 antisocial behaviour (ASB) offences representing no significant change from those recorded in 2015 (6,434 offences). Eighty per cent of these were recorded as 'ASB – nuisance'; 795 were alcohol flagged offences, and 758 recorded had a youth marker. The majority of each of these ASB offences was committed in the 'Hereford City and Rural' area category.

Hate Crimes[6]

Hate crime increased in Herefordshire in 2017 when compared to the year before by 38.8 per cent which is in line with the 37.2 per cent increase observed across West Mercia. The majority of hate crime was racial in nature which, by the year to February 2017 had increased by 24 per cent compared to the previous 12 months. Figure 7 illustrates the different stimulations for hate crime in the county as of January 2017. Across West Mercia in 2017 75 per cent of hate crime is racial and has increased at a faster rate than Herefordshire since the previous year (75 per cent).

Figure 9: Hate offences my marker type locally in the year to January 2017.



Source: West Mercia Police

The majority of victims (63 per cent) of Hate Crime were 'White-British' (of the 96 reports that recorded the race of the victim)' and 14 per cent were 'White-any other background'. However, as the data does not distinguish offences by marker type described above, as a county that is predominately 'White-British' (81 per cent), the relatively high victimisation of 'White-British' people compared to other ethnicities is not statistically significant.

Road Safety

In 2015 there were 99 killed or seriously injured (KSI) on Herefordshire roads. This corresponds to a rate of 526 per million population which is ranked 16th highest out of 150 upper tier local authorities across England.

[6] Hate crime date is supplied by West Mercia Police and unless otherwise stated, covers 12 months of reporting up to 2nd February 2017.

STARTING WELL: MOTHERS, BABIES AND CHILDREN

Health and wellbeing has to start before birth, and establishing a good foundation early on in life can have a lasting impact throughout life. This section looks at some of the major challenges which affect maternal and infant health, or help to shape behaviours that can have a greater impact as young people reach adulthood. In areas, such as breastfeeding and immunisations, there have been steady improvement and excellent progress in Herefordshire.

Maternity

In relation to maternal age the highest proportion of children born in Herefordshire in 2014 were born to mothers aged between 25 and 34, with 58 per cent of all births being within this age group; similar patterns were observed both regionally and nationally. The general fertility rate in Herefordshire in 2014 was lower than those recorded regionally and across England and Wales. In 2015, more mothers gave birth to full term babies who were underweight, the proportion was higher than the national figure although lower than that for the West Midlands; however, these differences were not statistically significant.

Mothers Smoking

Smoking is a major cause of premature deaths of mothers and also a leading factor in health inequalities for babies, such as increased risk of cot death and respiratory problems. Preterm and low birth weight increases the risk of various types of disability. In 2015/16 the proportion of mothers in Herefordshire who were smokers when giving birth was 8.9 per cent which is approximately half of the figure recorded in 2006/07. In both 2014/15 and 2015/2016 the Herefordshire prevalence of women smoking at time of delivery was below the national ambition of 11per cent as set by the government's Tobacco Control Plan, while across England as a whole the figure only dropped below the national ambition figure in 2015/16.

Infant and Perinatal Mortality

For the period 2012-2014 the perinatal mortality (stillbirths and deaths under 7 days old) rate in Herefordshire of 8.6 per 1,000 total births was significantly higher than both the national (6.8 per 1000) and regional (7.9 per 1,000) rates. For the same period the Herefordshire infant mortality rate was similar to the regional rate, although lower than that recorded nationally.

Breastfeeding

The breastfeeding rate in Herefordshire has shown a continual increase since 2010/11 and compares very well with the national average. In 2015/16 the proportion of mothers in Herefordshire who breastfed their babies for at least six to eight weeks after birth was 52.3 per cent, a figure significantly higher than that reported for England (43.2 per cent). The health and wellbeing benefits of exclusively breastfeeding infants from birth up to the age of six months are well known, and mothers who are

unable to breastfeed for health or other reason are encouraged to provide a good milk supplement for their infants.

Health protection: Immunisation & vaccination

Immunisation protects children and young people from vaccine preventable infections and communicable diseases. Herefordshire is doing very well in terms of local uptake. In 2015/16 local Dtap/IPV/Hib[7] immunisation rates exceeded the herd immunity uptake target of 95 per cent and were higher than national and regional figures. Similarly, the local uptake for *Haemophilus Influenza type B/Meningitis (Hib/MenC)* and *Mumps, Measles and Rubella (MMR)* first and second doses have increased since 2010/11 and in 2015/16 all exceeded the target of 95 per cent for the first time and were higher than both the national and regional figures.

In September 2014 the routine Human Papilloma Vaccine (HPV) programme was changed from a three to two-dose schedule. Between 2014/15 and 2015/16 the coverage of the initial dose of the HPV vaccine in Herefordshire increased from 81.4 to 83.6 to per cent, while for England the coverage decreased over this time, although the national figure in both years was higher than that for Herefordshire. In 2014/15 the coverage for two doses in Herefordshire was 81.4 per cent which was lower than the national rate.

Local immunisation rates and comparisons with other areas are included in the Department of Health's Public Health Outcomes Framework.

Dental Health

In 2014/15 the proportion of Herefordshire's 5 year olds free from dental decay (59 per cent) was lower than the figures for both England and the West Midlands while the mean number of decayed, missing or filled teeth in 5 year olds in Herefordshire was 1.43, a figure twice as high as in the West Midlands and 30 per cent higher than that for England as a whole. In 2015/16, 94 children and adolescents aged 0 – 19 in Herefordshire underwent hospital dental extractions which is 0.23 per cent of this population compared to 0.25 per cent in the West Midlands and 0.46 per cent nationally.

Childhood obesity

Obesity is commonly measured using weight and height to give a Body Mass Index (BMI) metric. In England, child BMI is measured at Reception Year (age 4-5 years) and Year 6 (aged 10-11 years) through the mandatory National Child Measurement Programme (NCMP). For the majority of children excess weight gain is the result of eating more calories than needed and/or undertaking too little physical activity to match calorie intake, or a combination of both.

[7] Immunisation for Diphtheria, Tetanus and Acellular Pertussis (Dtap); Polio (IPV); and Haemophilus Influenza type B (Hib)

In 2015/16 data from the National Child Measurement Programme data indicated that 9.8 per cent of reception year children in Herefordshire were obese, while the combined proportion of obese and overweight was 22.2 per cent. For year 6 children the prevalence of obesity was 19.8 per cent, while the combined figure for obese and overweight children was 33.8 per cent. For both age groups there were no significant differences between the local and national figures. In Herefordshire, since 2011/12 the prevalence of obesity has fallen in deprived areas of the county with moderate increases evident in children from less deprived areas. Poor diets (foods high in fat, sugars and salt) and lack of exercise can lead to obesity which in turn is a risk factor for non-communicable diseases such as cardiovascular disease and some forms of cancer.

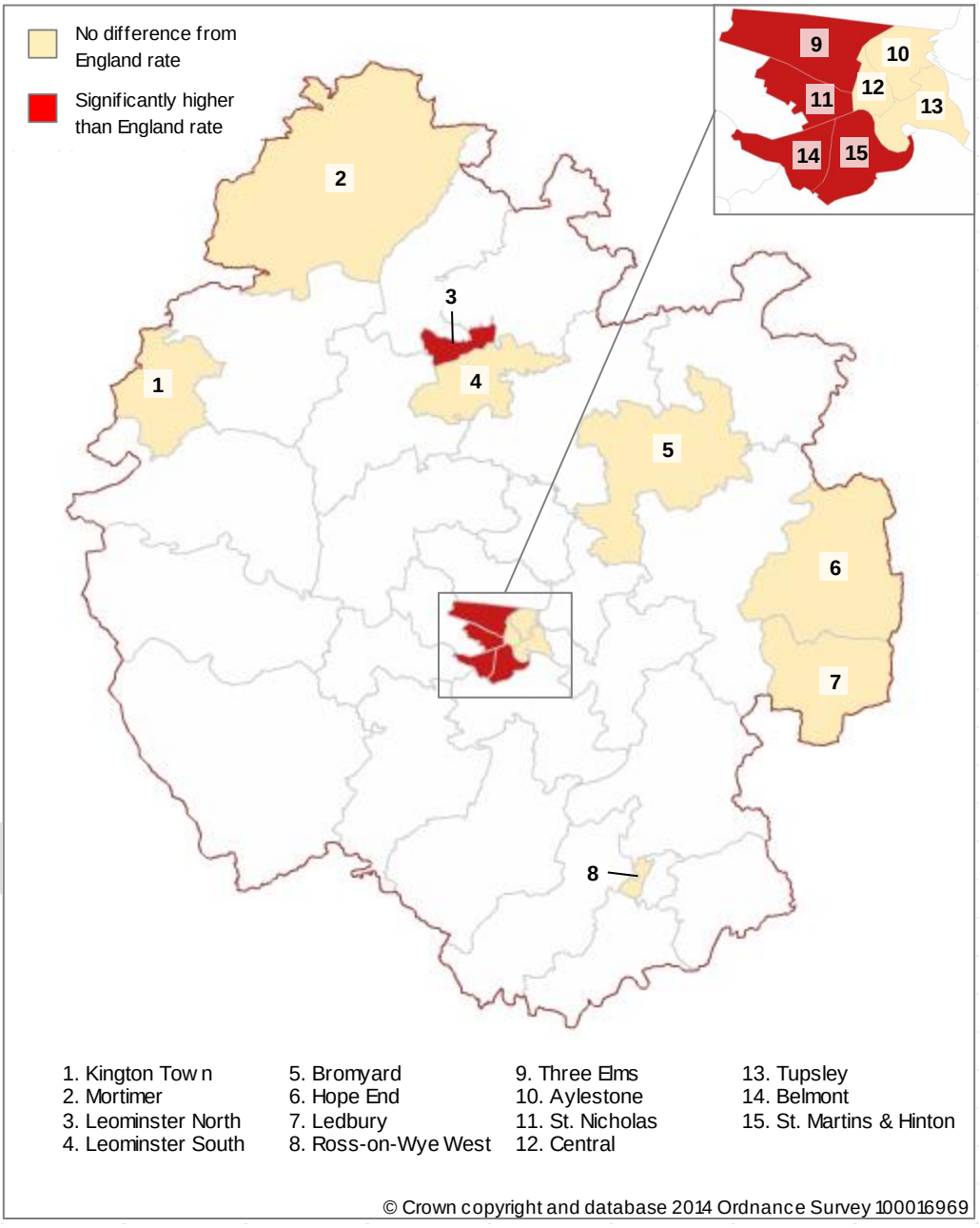
Key Consideration: In Herefordshire as a year group passes from reception to year 6 the proportion of obese children increases by 90 per cent, a pattern similar to those recorded nationally and regionally. Children most at risk of becoming obese when older were those where one or both parents are overweight or obese**,** suggesting that tackling adult obesity has to run in tandem with addressing childhood obesity.

Teenage pregnancy

Fewer teenagers are getting pregnant or having babies in Herefordshire. Teenage pregnancy is defined as under-18 conceptions including those leading to live births and terminations. The number of under18 conceptions in Herefordshire has reduced consistently since 2007-09, with a rate of 23.1 conceptions per 1000 in 2012-14 for girls aged 15 to 17, broadly similar to the national rate (24.9 per 1000 in England and Wales). Herefordshire under 16 conception rates (13-15 years) have followed the national and regional declining trend from 2009 to 2014. Under 18 conception rates are generally higher in more deprived areas of Herefordshire, particularly north Leominster and South Wye. See Figure 7 for areas in the county that have a significantly higher rate than England.

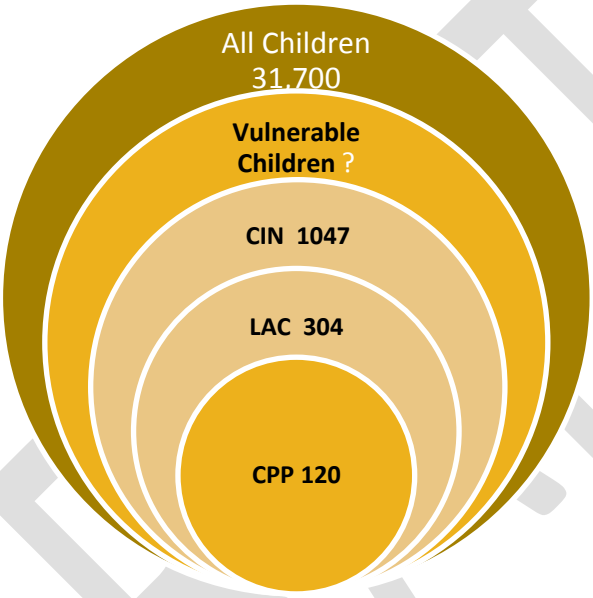
The under 18 birth rate in Herefordshire has also decreased since 2009, and both the number and rate of under 18 terminations in Herefordshire have declined since 2007-09, with the abortion rate in 2012-14 being similar to national and other comparator figures. For example, for girls aged 13 to 15, the abortion rate has fallen by 45 per cent since 2008-10. In 2015/16 there were 17 under 18 births, of which six were to mothers from the most deprived quartile in the county and one to a mother from the least deprived quartile. In 2015 almost half of all terminations in Herefordshire were to women in their 20s.

Figure 10: Teenage conception rates in in Herefordshire wards compared to national rate, 2012-14.



STARTING WELL: EARLY HELP AND PREVENTION

There **are 31,700 under-16s in the county** – this remains a similar proportion (17 per cent) as nationally (19 per cent). Numbers of children had been declining in Herefordshire throughout the last decade, levelling out over the last five years. However, the number of births and children under five has been rising for the best part of the last decade **(9,900 under-fives at mid-2015 and 1,700 births in the year to mid-2015).** The next 10 years are expected to yield a gradual increase in the numbers of children.



Source: Children's Wellbeing, HC (2016/17)[8]

Families First

The Families First Programme in Herefordshire, first established in 2014/15, is a local approach to the national Troubled Families Programme. Herefordshire Council has recently been granted a five year extension until 2020, enabling an additional 400,000 people to be supported during that time. The Programme is a key priority area of the Health and Wellbeing Board and of the Children and Young People's Partnership. It also links with all four priority areas highlighted in the Herefordshire

[8] **Key**: CIN children in need; CPP children with protection plans; LAC Looked After Children. No standard definition of 'vulnerable children' exists, but the population would include those exposed to abused, neglected, sexually abused and exploited.

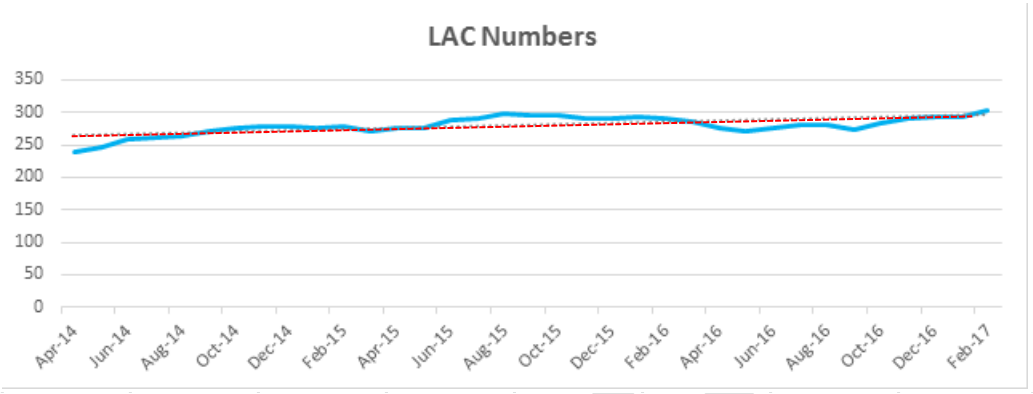
Community Safety Strategic Plan 2014-17, Herefordshire's Children's and Young people's 2014-2018 plan and Herefordshire Council's Early Help Strategy.

At December 2016, 627 families have been identified and 460 families engaged with. These families have been assessed and have a key worker and a support plan. By December 2016, 58 families had made sustainable changes and the council made a successful Payment by Results claim, with a further 30 families being reviewed by internal audit procedures for further claims. Currently 113 families, including 272 children, are being engaged and supported towards meeting their outcomes and achieving sustainable positive change in their lives. A key aspect of developing the Families First programme for identified families is to provide an intensive, flexible response that allows for support outside traditional working hours. This approach, together with a family key worker, could potentially lead to more resilient families leaving intensive support sooner, but still be able to access other forms of support. The council has plans to revise and improve the workings of the current multi-agency meetings (or MAGs) as part of the early help strategy.

Looked after children (LAC)

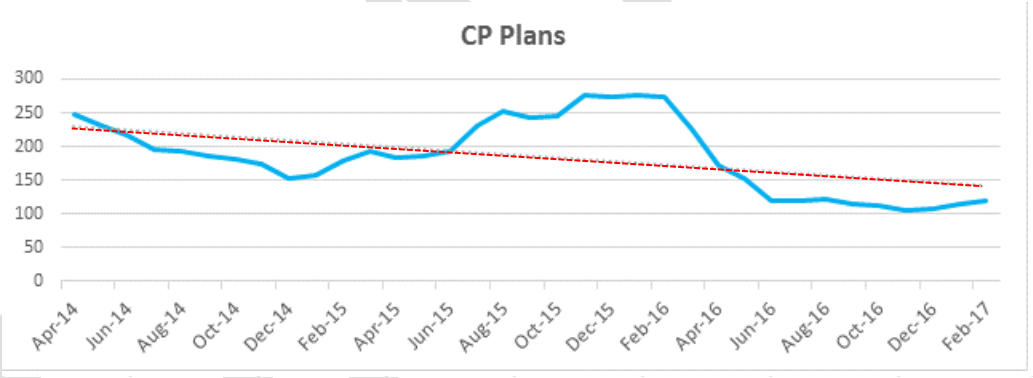
At the end of February 2017 there were 304 looked after children (LAC) and young people in Herefordshire, reflecting an upward trend over the past three years. The main reason why children are taken into care is abuse and neglect. Local performance analysis indicates that the reason for a high LAC population is partly due to a 'risk averse' response, which means that once a child comes under local authority care, it is often difficult to reunite them with their families. However, appropriate application of 'need' thresholds has led to a sustained reduction in children subject to child protection plans and a reduction in the numbers of children being admitted to care. Herefordshire currently supports 120 children who are subject to a child protection plan and there has been an overall downward trend in numbers of children with protection plans over the past twelve months. Therefore, it is expected that the LAC numbers will gradually decrease over time as the legacy will take some years to work through as children grow up. See Figures 11 and 12.

Figure 11: Number of children who are looked after. (Dotted red line reflects trend)



Source: Children's Wellbeing, Herefordshire Council

Figure 12: Number of children on child protection plans. (Dotted red line reflects trend).



Source: Children's Wellbeing, Herefordshire Council

LEARNING WELL: CHILDREN IN EDUCATION

The **total number of pupils** on roll has risen by 326 from 22,770 in spring 2013 to 23,096 in autumn 2016, representing a 1.43% increase in total numbers over the three years.

In autumn 2016 school census recorded that **51.4 per cent of the total number of pupils were boys.** The gender gap has been closing in terms of pupil numbers since spring 2015.

In 2016 the **highest number of pupils were in Reception year, Year 1 and Year 2**, whilst the **fewest were in Year 10, 11, 9**

Most children in Herefordshire were able to attend the school of their choice at the start of the 2016/17 academic year (95 per cent) and 98.6 per cent receiving one of their three expressed preference schools. This is considerably higher than the England averages of 88.4 per cent (first preference) and 96.3 per cent (one of top three preferences) for the same period.

Ethnic Background

The number of pupils recorded as White British has fallen by 251 over the period spring 2012 to spring 2016, or 91.8 per cent to 89.1 per cent.

The number and percentage of pupils recorded as belonging to Black and Minority Ethnic groups (BME) has shown an annual increase from 1,756 (7.7%) in Spring 2012 to 2,461 (10.6%) in Spring 2016.

Those of White Eastern European ethnic origin are the largest single BME group

First Language

The five largest language groups other than English in the autumn 2016 school census were:

- Polish – 771 pupils
- Lithuanian – 155 pupils
- Other than English – 127 pupils
- Romanian – 94 pupils
- Portuguese – 77 pupils

In spring 2013, a total of 58 different languages other than English were recorded in the school census. By autumn 2016, 65 different languages other than English were spoken in Herefordshire schools.

Good Level of Development

In 2016, **Herefordshire out-performed the national average** (69.3%) with 71.7% of pupils locally achieving a Good Level of Development (GLD) standard. Herefordshire was in the top quartile of local authorities in England in 2016.

Year 1 PHONICS

2016 was the **first year that local results were in line with the national average**. Herefordshire Year 1 pupils performed similarly to England with 81% meeting the threshold mark, representing a local rise of 13 percentage points from 69% in 2013.

KEY STAGE 1

In 2016, at the end of key stage 1 68% of pupils reached the Expected Standard in writing, 74% in mathematics and 75% in reading. Across state-funded schools in England 65% in writing, 73% of pupils reached the expected standard in mathematics and 74% in reading.

KEY STAGE 2

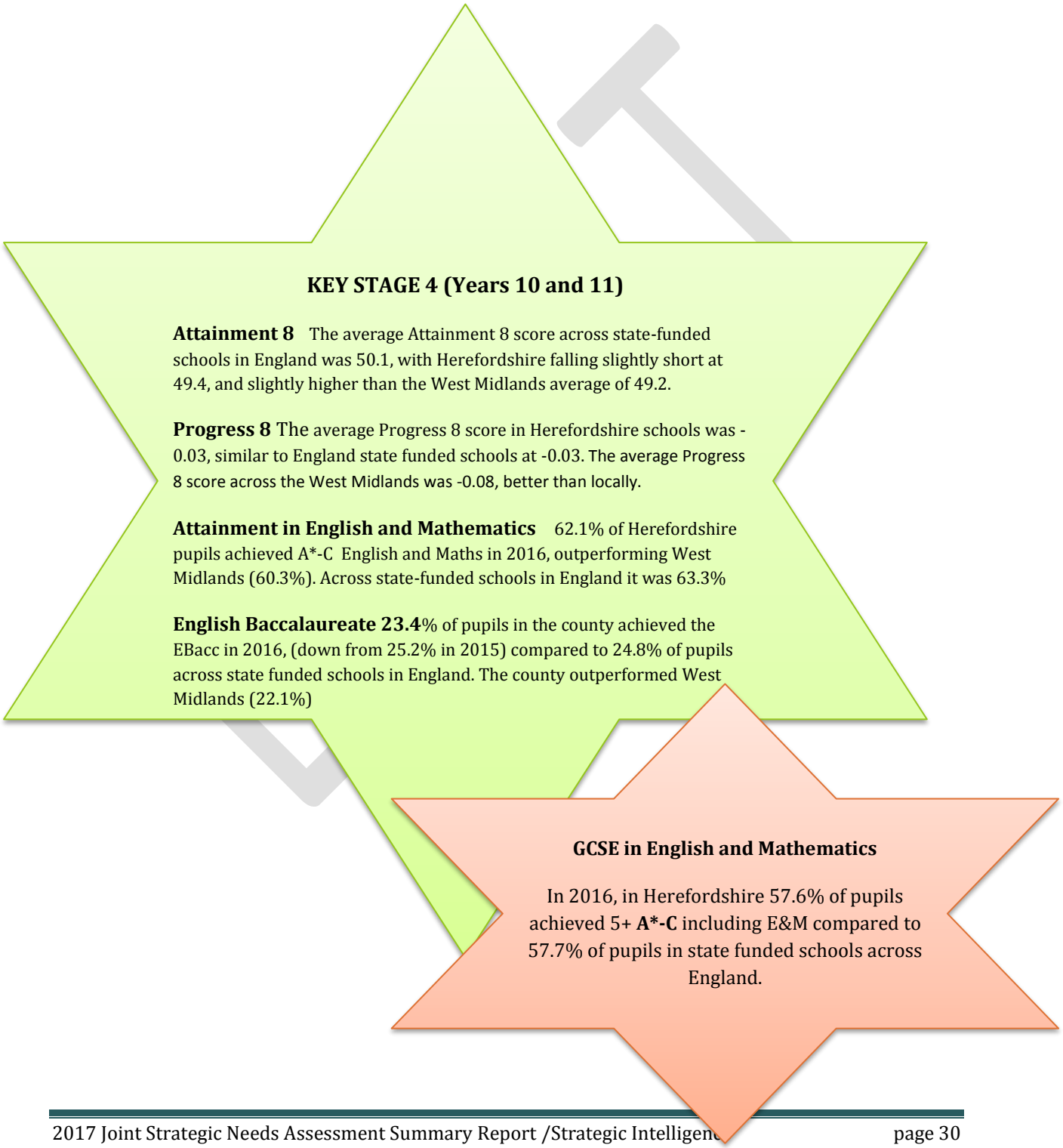
In Herefordshire, in 2016, 52% of pupils reached the Expected Standard in reading, writing and maths with 5% of pupils reaching the higher standard. Across England, 53% of pupils reached the expected standard and 5% achieved a high standard in reading, writing and mathematics. Local performance exceeded the regional average of 51%.

Special Educational Needs (SEN)

Between spring 2015 and spring 2016 the **total number of pupils with Statements of SEN or EHCP** increased from 571 to 591.

New accountability measures for secondary school education in 2016

A new secondary school education accountability system was implemented in 2016, with headline accountability measures for schools as: Attainment 8, Progress 8, Attainment in English and Mathematics (A* to C) and achievement of the English Baccalaureate (EBacc). In Herefordshire 43.1 per cent of pupils were entered for the EBacc, up from 41.5% in 2015.



DOING WELL: YOUNG PEOPLE IN EDUCATION AND TRAINING

Young People in Education and Training

Under the Raising of the Participation Age agenda between 2013 and 2015 the Government has increased the age that all young people will continue in education or training from 17 years to 18. Data published for December 2016 shows that fewer 16 and 17 year olds in Herefordshire were in full time education and training (89.6 per cent) compared to the England average of 91.3 per cent. Herefordshire had a smaller percentage of the 16/17 year old cohort engaged in Apprenticeships (4.2%) than the England average (5.4%), a smaller percentage of the cohort in Training (0.8% compared to England average 1.3%), Work Based Learning (0.6% compared to England average 0.8%) and Part time Education (0.1% compared to England average of 0.3%).

NEETs – those not in employment, education or training

A 16 to 18 year old who is not in education, employment and training is referred to as NEET. Amongst its statistical neighbours, Herefordshire reported the fourth highest percentage of NEET young people compared to its statistical neighbours, showing improvement on 2014 when the county presented the highest percentage of NEET.

Provisional data for **2016** indicates that there were **an estimated 116 NEET young people in Herefordshire** across years 12 and 13, **equating to 3% of all 16-18yr olds** known to the local authority. This represents a reduction from 5.7% in 2014, and 6.4% in 2013. Of the 116 NEET young people:

- 53 (45.7 per cent) were male and 63 (54.3 per cent) female.
- 22 of the NEET cohort (19.0 per cent) were eligible to free school meals when in school.
- Ten girls were unavailable for work due to pregnancy.
- The majority were of 'White British' ethnic background.

INEQUALITIES IN EDUCATION

Child Poverty

The number of children under 16 estimated to be living in poverty[9] in Herefordshire increased in 2014 after four successive years of declining numbers. The increase in numbers from 3,990 to 4,390 reflected a percentage increase from 13.2 per cent to 14.7 per cent. Despite the local increase, rates in Herefordshire continue to be significantly lower than across both the West Midlands region and England.

In 2014 the three lower super output areas[10] (LSOAs) with the highest percentage of child poverty were in the areas of Redhill-Belmont Road, Newton Farm-Brampton Road in Hereford and Ridgemoor in Leominster. In 2016, children in all three LSOAs failed to achieve the local authority (LA) average for a Good Level of Development at the end of the Reception year. None of the areas reached the LA average in reading or maths at Key Stage 1 and none reached the LA average for the expected standard in reading, writing and maths at Key Stage 2.

Free School Meals

Free School Meals are claimed for children by parents who receive a qualifying state benefit. Since the Spring School Census of 2013 there are 548 fewer pupils eligible for claiming free school meals. The gap between pupils who are eligible to free school meals and their peers who are not, has narrowed in Herefordshire. However, the gap has been consistently wider than the national gap for FSM pupils and non-FSM pupils, in all areas of educational attainment except Key Stage 4 (Attainment 8) which encouragingly was higher than nationally, reflecting gradual improvement over the years.

The Department of Education defines a **disadvantaged pupil** as those eligible for free school meals at any time during the last 6 years or those children who are looked after by the local authority for at *least one day* or are adopted from care (including those who are adopted, have a residence order or other type of order). The performance of the disadvantaged cohort reflects the performance of the FSM cohort reported above as the FSM pupils make up the majority of the 'disadvantaged pupil' cohort.

[9] The Children in Low-Income Families Local Measure is the proportion of children living in families either in receipt of out-of-work benefits *or* in receipt of tax credits with a reported income which is less than 60 per cent of national median income; (previously known as the Local Child Poverty Measure or National Indicator 116), produced by HM Revenue and Customs.

[10] Lower Super Output Areas (LSOAs) are fixed statistical geographies of about 1,500 people designed by the Office for National Statistics (ONS), of which there are 116 in Herefordshire.

Autism

The Royal College of General Practitioners made autism a clinical priority 2014-17. It is estimated that 1 per cent of the population could be autistic, meaning that potentially 1800 people in Herefordshire could be autistic. While the actual number of people suffering from autism in the county is not known better diagnosis by GPs could help rectify this and research has shown that individuals on the autism spectrum benefit from diagnosis. In a survey conducted by The Autism Partnership Board and Healthwatch Herefordshire 47 per cent of subjects were 16 years and younger. The survey indicated that 84 per cent of those on the autistic spectrum in Herefordshire are known to their GP, while of those who have not received a diagnosis from their GP 55 per cent would like one.

English as an Additional Language (EAL)

The performance of pupils whose first language is not English will be affected by the length of time that they have resided and been educated in England. Those with several years of state education are likely to perform better than newly arrived pupils with fewer English speaking skills. Overall, there still exists a larger inequality gap between the performance of EAL pupils in Herefordshire compared to nationally, but there is a mixed picture of performance.

The gap between the percentage of EAL and non EAL pupils achieving a good level of development in the early years foundation stage profile in Herefordshire fell significantly in 2016, due largely to a dramatic improvement in the percentage of EAL pupils reaching a Good Level of Development. Encouragingly for the first time this EAL cohort in Herefordshire performed in line with their peers nationally. 2016 saw EAL pupils in Herefordshire out-performing non EAL pupils in the Year 1 Phonics Screening Check, and it was also the first year that EAL locally out-performed EAL pupils nationally in the test. Only 50 per cent of EAL pupils across Herefordshire achieved A*-C in GCSE English and Mathematics which was significantly below the 62.8 per cent of EAL pupils nationally who achieved the measure.

LIVING WELL: ADULTS' HEALTHY LIFESTYLES

The following section covers a range of issues relevant to different ages in adulthood. There is specific focus on risk factors most strongly associated with poor outcomes and long term conditions. The key message is that these risk factors are preventable by choosing healthier lifestyles.

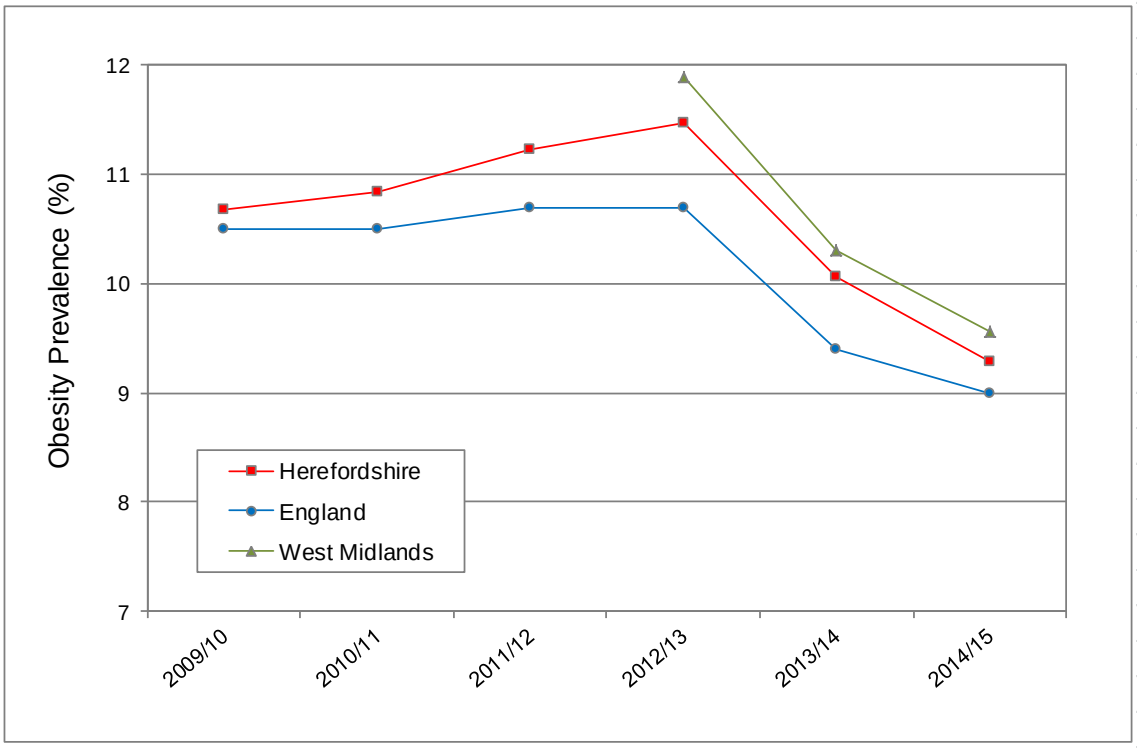
Obesity

In 2013-15 63.9 per cent of adults in Herefordshire were estimated to be either overweight or obese compared to the national figure of 64.8 per cent. However, comparison with GP records indicates that it is highly probable that obesity prevalence is under-recorded.

In 2015/16 according to QoF approximately 15,300 adults registered with a Herefordshire general practitioner (GP) practice were recorded as obese, which represents 10.2 per cent of all patients aged 18 years and over. Across Herefordshire GP practices the prevalence of obesity ranged between 6.34 and 15.1 per cent, while the highest locality prevalence (10.7 per cent) was recorded in City and the lowest (9.1 per cent) in East.

Prior to 2015/16 obesity was reported in those 16 years and over. Between 2009/10 and 2014/15 obesity prevalence in this age group Herefordshire was consistently higher than the national figure and comparator group, although both measures followed similar temporal trends with increases evident up to 2012/13 followed by falls over the subsequent years (Figure 13). Local evidence suggests strong links between likelihood of becoming morbidly obese and social deprivation. Health outcomes for adults who are overweight and obese is poor and results in a range of adverse health conditions such as hypertension, heart disease, stroke, Type II Diabetes, sleep disorders and depression.

Figure 13: Prevalence of adult (16+) obesity in Herefordshire, West Midlands and England, 2009/10 – 2014/15.



Source: PHE: Quality of Outcomes Framework

Physical Activity

In Herefordshire, the baseline public health promotion strategy has been towards population activities to increase exercise and to improve healthy eating. Across the county, there is a relationship between obesity and levels of activity with obesity increasing with reduced activity, as well as a link between obesity and low consumption of fruits and vegetables.

Sport England commissions the Active Peoples Survey (APS) which provides a comprehensive measure of participation in sport and recreation in England. The main measure is based on the percentage of adults playing at least 30 minutes of sport at a moderate intensity on at least four days in the last 28 days (equivalent to 30 minutes on one or more day a week) with the resulting categories: active, insufficiently active and inactive. Between 2012 and 2014 the level of activity increased across Herefordshire from 56.9 per cent to 61.3 per cent, while the level of inactivity fell from 29.2 per cent to 22.7 per cent, although the level of insufficiently active increased from 13.9 per cent to 16.0 per cent. When compared to comparator counties and unitary authorities the level of inactivity in Herefordshire is less than the average for the group, while activity levels are higher than the group average.

It is never too late to change behaviours since dietary improvements made in older age significantly reduce the risk of chronic diseases and life limiting illnesses. Consequently, delivering healthier food options for older people in residential settings is a key consideration.

Alcohol Misuse

In 2015/16 there were 602 hospital admissions for alcohol-specific conditions (those caused exclusively by the consumption of alcohol), which equates to a rate of 314 per 100,000 population and significantly lower than the rate for England of 583 per 100,000. The local admission rate for adults has remained relatively consistent between 2008/09 and 2015/16. The admission rate for those aged under 18 has shown a decrease since 2006/07, although the rate has remained above both the national and regional rates, although the gap has reduced over this period. In the period 2013/14 to 2015/16 the rate was 50.8 per 100,000 compared to 37.4 per 100,000 across England (Figure 14).

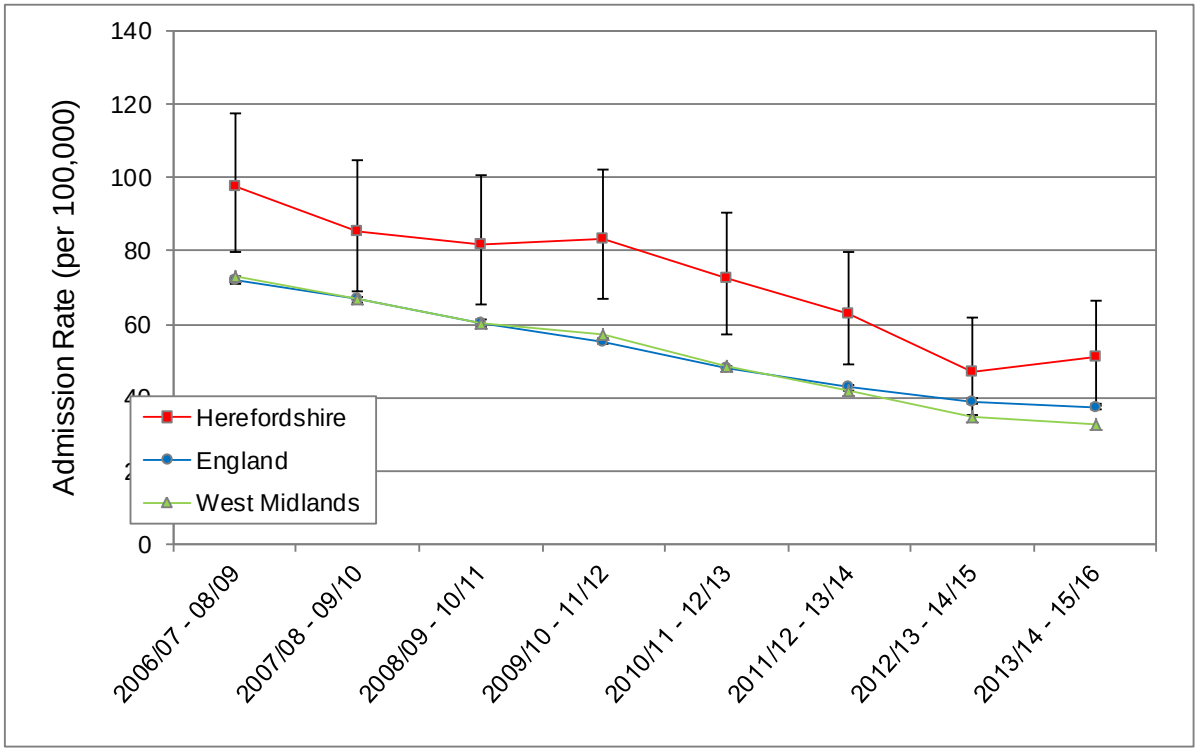
The latest set of Local Alcohol Profiles for England (LAPE) estimate that 26 per cent of the Herefordshire drinking population indulge in increasing or higher risk drinking, and that 21 per cent of all adults binge drink[11] (2011-14 estimates). Data suggests that excessive drinking is worse amongst people aged 40 years and over. In 2014/15, 45 per cent of alcohol related hospital admissions in Herefordshire involved individuals aged 40 to 64 years, with 37.5 per cent who were aged 65+ years, while 17.5 per cent were aged less than 40 years. 55 per cent of all admissions were males. However, in the period 2013-15 there were 48 alcohol specific deaths in Herefordshire, at a rate lower than the national average (8.1 per 100,000 compared to 11.5 per 100,000 respectively).

The 'misuse' of alcoholic beverages impacts on a number of areas, for example, it is linked to a large proportion of violent crime, particularly related to the night time economy, and it is also implicated in the escalation of domestic abuse.

Individuals from the most deprived areas of the county being over three times as likely to be admitted to hospital due directly to alcohol consumption as someone living in the least deprived areas

[11] Estimate of the percentage of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, 8 or more units for men and 6 or more for women).

Figure 14: Alcohol related directly age standardised hospital admissions rate for individuals aged under 18 for Herefordshire, England and the West Midlands, 2008/09 to 2014/15.

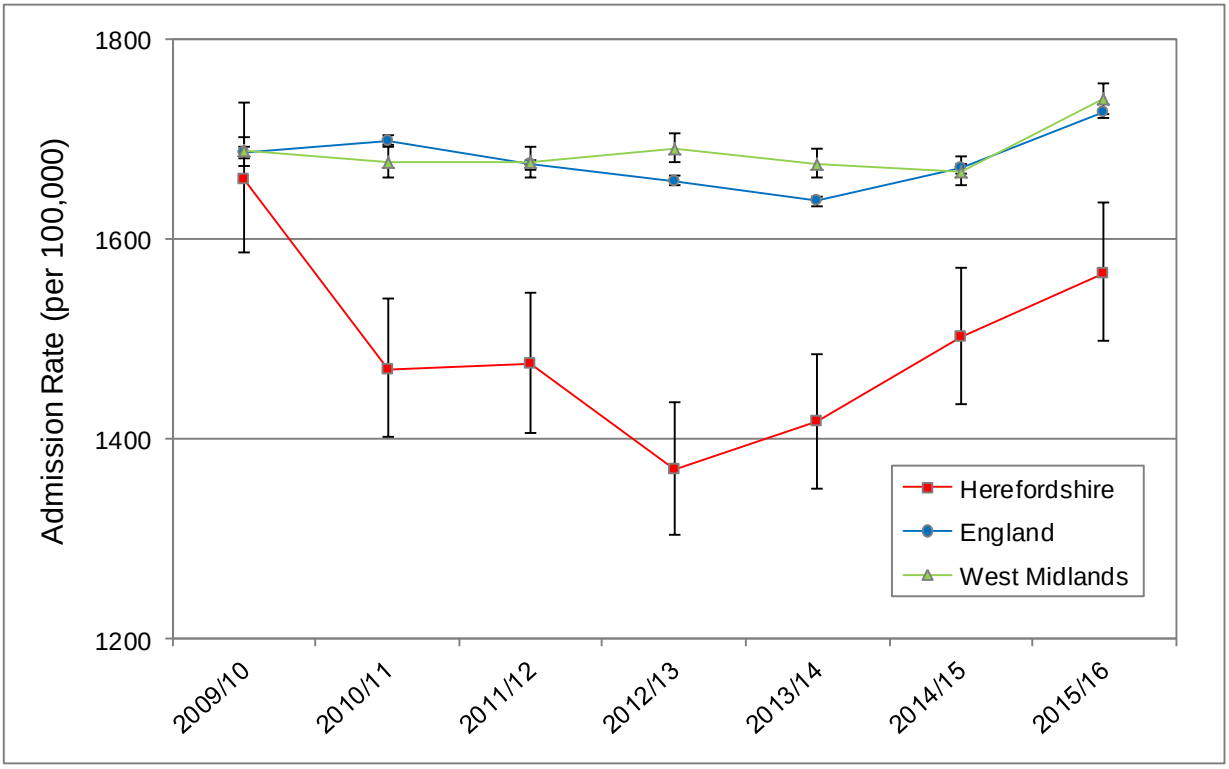


Source: PHE – Local Alcohol Profiles for England

Smoking

Smoking tobacco is a known (and modifiable) risk factor for respiratory diseases. In 2015, the prevalence of adult smokers in Herefordshire (17.5 per cent) was higher than England as a whole (16.9 per cent). Locally, smoking prevalence is greater in areas of high deprivation. In 2014/15 the smoking related hospital admission rate in Herefordshire of 1,500 per 100,000 population was lower than the national figure of 1,670, a pattern evident since 2010/11, although the local rate has increased steadily since 2013/14 (Figure 15). To stop smoking is a key indicator of people's desire to making healthier lifestyle choices; however quit rates for smoking in Herefordshire are poor. Between 2013/14 and 2015/16 the rate at which individuals successfully quit smoking fell by over 70 per cent from 1,565 to 442 per 100,000.

Figure 15: Directly standardised smoking attributable hospital admission rates for Herefordshire, England and the West Midlands, 2009/10 to 2015/16.



Source: PHE – Local Tobacco Control Profiles for England

Drug Misuse

In 2011/12 there were estimated to be 719 opiate and/or crack cocaine users in Herefordshire which represents a prevalence of 6.3 per 1,000, which is lower than the national figure. Of these users 391 are intravenous users representing a prevalence of 3.4 per 1,000, which is higher than the national average and ranked 106th out of 151 counties and unitary authorities.

Sexual health

Sexual health is a key public health issue and the Department of Health (DoE) has outlined its ambition for good sexual health in "A Framework for Sexual Health Improvement in England"[12] which describes key principles of best practice in sexual health commissioning with the aim of improving the sexual health of the whole population. In 2015 there were 925 new cases of sexually transmitted infections (STIs) diagnosed in Herefordshire which ranked 128 out of 150 local authorities.

[12] A Framework for Sexual Health Improvement in England, Department of Health 2013. Available at: https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

The detection rates for a range of sexually transmitted diseases in Herefordshire show some variability, although all but genital herpes have shown rates significantly lower than that for England. In 2015 the genital herpes diagnostic rate was ranked 96 out of 150 local authorities, broadly similar to the national figure.

LIVING LONGER

Life Expectancy and Health Life Expectancy

Life Expectancy

For those born in Herefordshire in **2013-15** the average **life expectancy is 80.4 years for males**, while **for females it is 83.9 years** with both figures rising steadily since 1991-93 and are **higher than the national figures**.

Health Life Expectancy

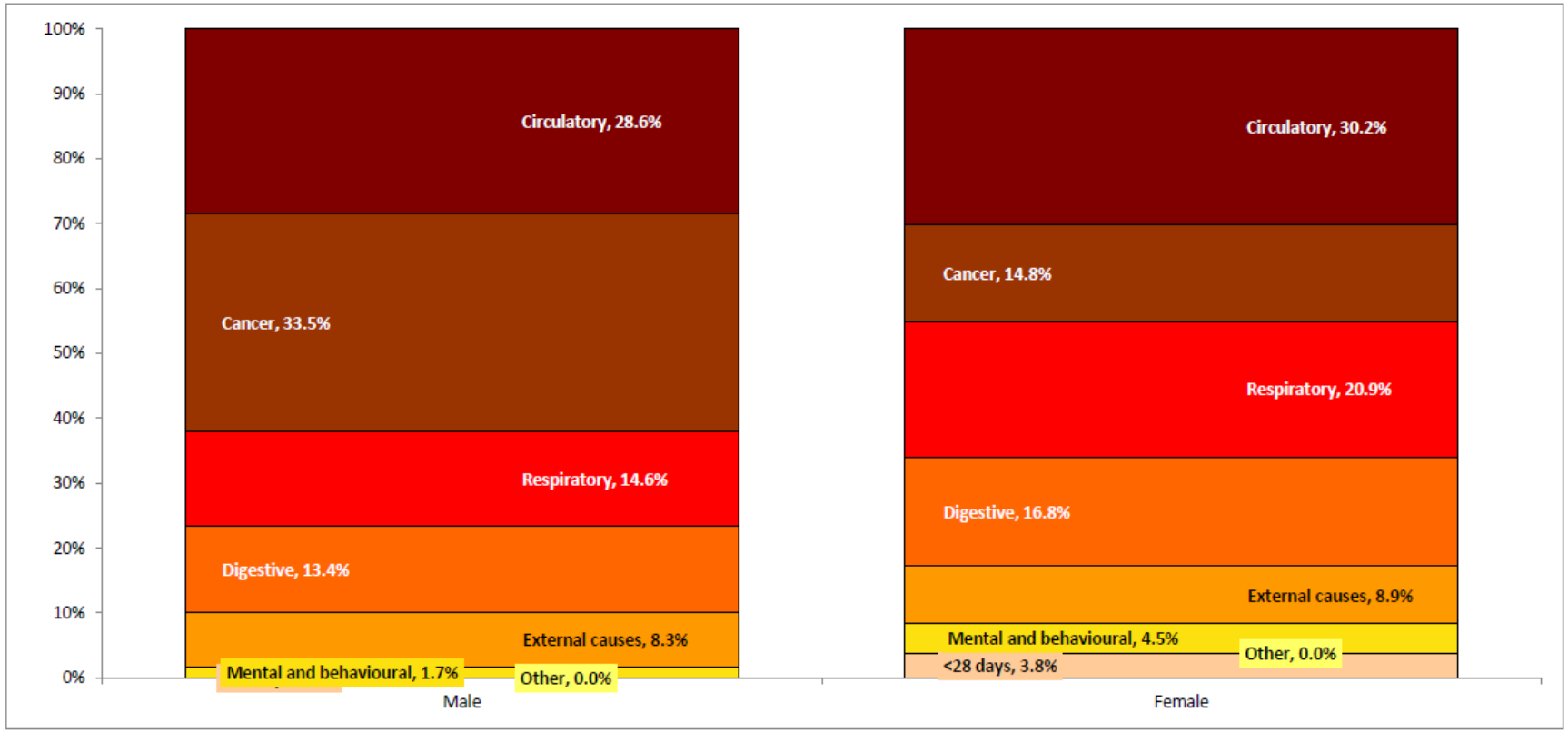
In **2013-15** the **healthy life expectancy** in Herefordshire was **67.1 years for males and 68.2 years for females** which are both **higher than the national figures**.

There is clear correlation between life expectancy and the level of deprivation in both males and females with data from Public health England indicating that individuals born in the most deprived areas of Herefordshire have a shorter (4-5 years) life expectancy than those living in the least deprived areas.

The broad causes of death underlying the life expectancy gap between the least deprived and the most deprived quintiles in Herefordshire are circulatory diseases, cancers and respiratory diseases. Between them these causes represent 77 per cent of male deaths and 66 per cent of female deaths contributing to the life expectancy gap in the county (Figure 16).

APPENDIX 1

Figure 16. Scarf chart showing the breakdown of the life expectancy gap between the most deprived and least deprived quintiles in Herefordshire by broad cause of death, 2012-2014. (Source: PHE – The Segment Tool)



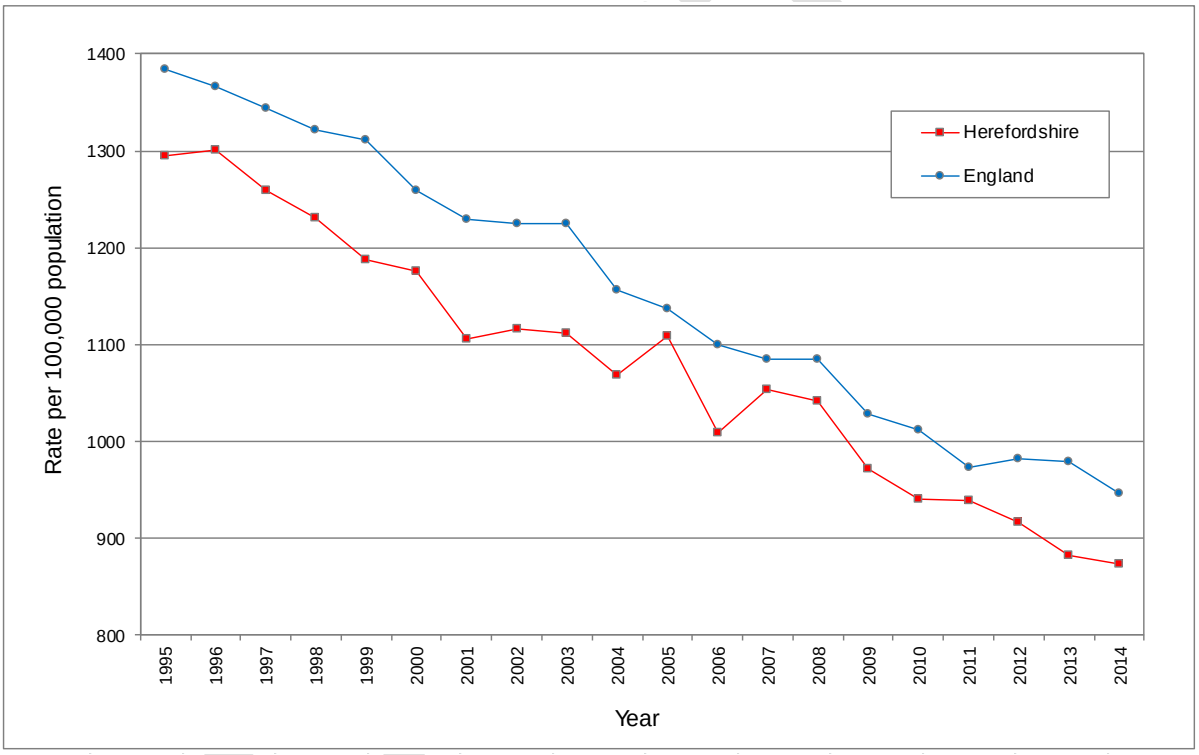
Footnote: Circulatory diseases includes coronary heart disease and stroke. Respiratory diseases includes flu, pneumonia and chronic obstructive airways disease. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis. External causes include deaths from injury, poisoning and suicide. Mental and behavioural includes dementia and Alzheimer's disease.

Analysis by Public Health England Epidemiology and Surveillance team based on ONS death registration data, and mid year population estimates, and DCLG Index of Multiple Deprivation, 2015

Mortality (deaths)

Since 1995 the number of deaths recorded annually in Herefordshire has remained relatively constant ranging between 1,860 and 2,100 per year in 2005 and 2015 respectively. As the county population of Herefordshire has increased appreciably between 1995 and 2014 the county mortality rate has fallen steadily over this period from 1,300 to 870 per 100,000 in 2014 and the local rate has been consistently lower than that recorded nationally (Figure 16). The most common underlying causes of death in Herefordshire were diseases of the circulatory system. Ten per cent were due to respiratory diseases.

Figure 16: All cause directly age-standardised mortality rates for Herefordshire, comparator group and England, 1995 - 2014.



Source: NHS Digital Indicator Portal

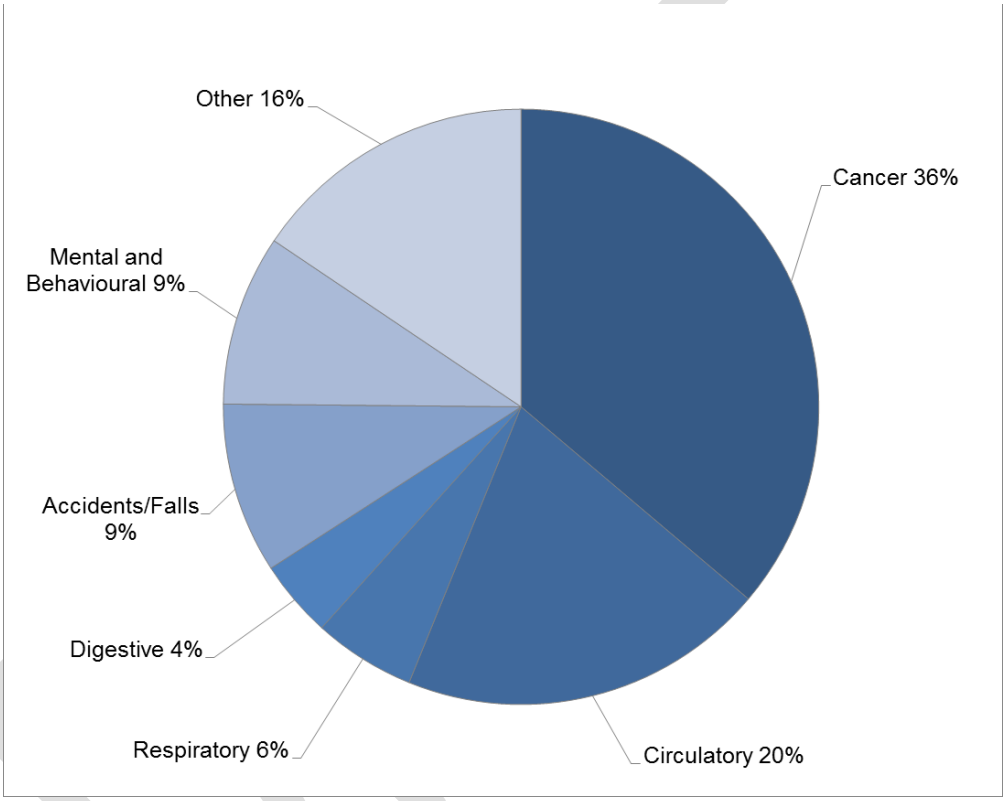
Premature mortality (deaths under the age of 75 years)

During 2013-2015 premature mortality in Herefordshire accounted for approximately 540 deaths per year or 27 per cent of all deaths. Cancers accounted for around 41 per cent of premature deaths in the county, coronary heart disease 14 per cent and respiratory disease 10 per cent.

Years of Potential Life Lost (YPLL)

In 2012-14 the number of Years of Potential Life Lost[13] due to premature mortality in Herefordshire was 19,691, which corresponded to 12.4 years per premature death and a directly standardised rate of 385 per 10,000 population, a rate that is significantly lower than those reported both nationally and regionally. Cancers accounted for 36 per cent of YPLL in Herefordshire, coronary heart disease 12 per cent and respiratory disease 6 per cent (Figure 17).

Figure 17: Proportion of total years of life lost (YLL) associated with underlying causes in Herefordshire, 2012 – 14.



Source: NHS Digital Indicator Portal

Suicides

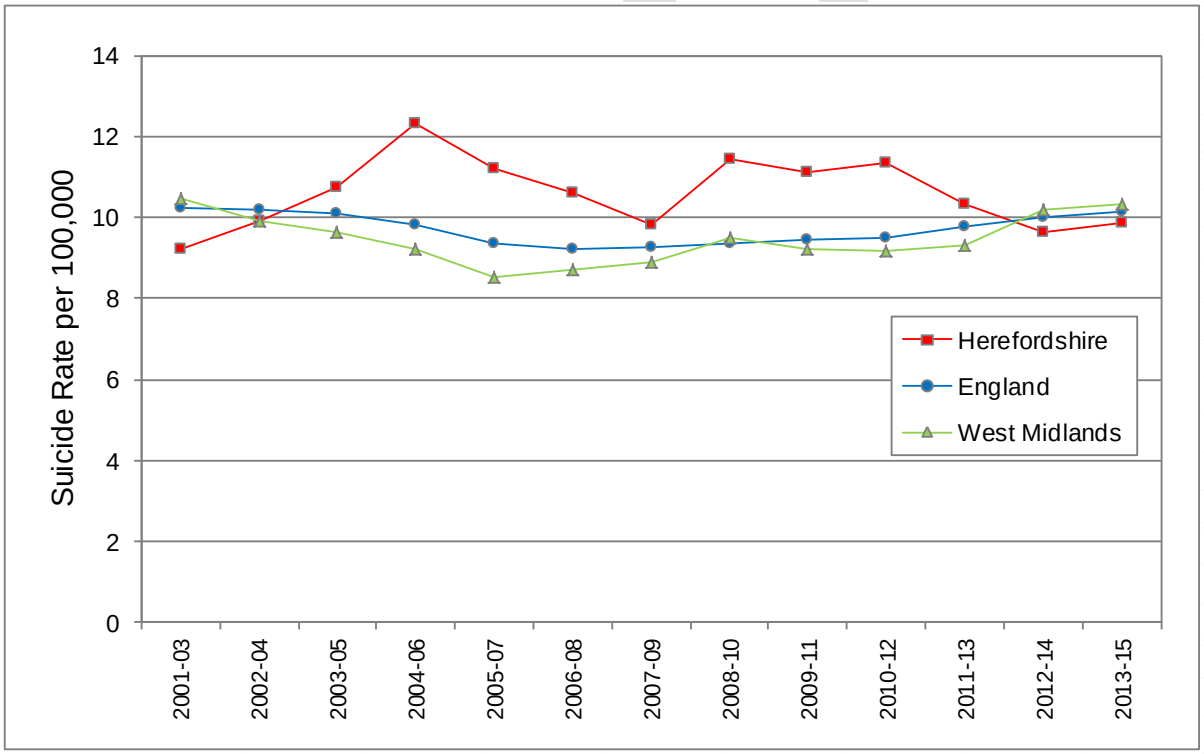
Since 2001-03 and 2013-15 the suicide rate in Herefordshire has fluctuated and has been little different from both national and regional rates which have both shown some variability (Figure 18). Between 2013 and 2015 there were 50 individual suicides in Herefordshire which corresponds to a suicide rate was 9.9 per 100,000 population. The suicide rate in the 35-64 age group in Herefordshire

[13] Years of potential life lost (YPLL) is a measure of premature mortality. Its primary purpose is to compare the relative importance of different causes of premature death within a particular population and it can therefore be used by health planners to define priorities for the prevention of such deaths.

is higher than those observed in older and younger age groups; this pattern is also observed nationally and regionally. Herefordshire male suicide rate is higher than that for females.

Residents of the most deprived areas of Herefordshire are approximately a third more likely to die as a result of suicide than those in less deprived areas of the county.

Figure 18: Directly age-standardised suicide rates for Herefordshire, England and West Midlands populations, 2001-03 – to 2013-15.



Source: PHE – Suicide Prevention Profile

BEING WELL: LONG TERM CONDITIONS

A long term condition (LTC) is defined as a condition that cannot, at present be cured but can be controlled by medication and/or other therapies. Examples of LTC are diabetes, heart disease and chronic obstructive pulmonary disease some of which are discussed in more detail below. Nationally people with LTC account for 50% of all GP appointments, 64% of all outpatient appointments and over 70% of all inpatient bed days.

In 2015/16 the proportion of registered patients across Herefordshire GP practices with LTC varied between 43.8 and 64.0 per cent with a countywide average of 55.4 per cent compared to a national average of 53.2 per cent (see Table 1). When considering the CCG localities the highest prevalence (57.9 per cent) was recorded in East and the lowest (51.7 per cent) in South and West.

Table 1: Prevalence of long term conditions in Herefordshire and England, 2015/16.

Long Term Medical Condition (LTC)	Herefordshire	England
Cancer	3.2	2.4
Coronary Heart Disease	3.5	3.2
Stroke	2.2	1.7
Hypertension	16	13.8
Diabetes	6.4	6.4
Chronic Kidney Disease (CKD)	4.8	4.1
Asthma	6.2	5.9
COPD	2.1	1.9
Depression	7.4	8.3
Learning Disabilities	0.52	0.5
Dementia	0.87	0.8
Osteoporosis	0.34	0.3
Rheumatoid Arthritis	0.99	0.7
Over all LTC Prevalence	**55.4**	**53.2**

Source: QOF

There is no correlation between the proportions of registered patients at each practice with LTC and other factors such as age and deprivation. This pattern does not appear to follow the national pattern

of LTC being more prevalent in older people (58% of people over 60 compared to 14% under 40) and in more deprived groups (people in the poorest social class have a 60% higher prevalence than those in the richest social class).

The NHS have produced the Right Care database which provides information summarising a number of LTC disease areas and elements of care. The Herefordshire pack is available here: https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2016/08/cfv-herefordshire-ltc.pdf

Cardiovascular disease

Cardiovascular disease (CVD) is a general term that describes a disease of the heart or blood vessels (circulatory system) and includes coronary heart disease (CHD) and stroke (where blood supply to part of the brain is cut off). Since 2009/10 the stroke prevalence in Herefordshire has not changed appreciably, ranging between 2.2 and 2.3 per cent, although the local figure has been consistently higher than that reported for England as a whole. In 2015/16 stroke prevalence in Herefordshire GP practices ranged between 2.34 and 4.18 per cent. On a locality basis the highest stroke prevalence (2.55 per cent) was recorded in North and West and the lowest (2.03 per cent) in City.

Similarly, local CHD prevalence has shown little temporal change and in 2015/16 was 3.5 per cent, a figure significantly higher than that recorded for England (3.2 per cent). In 2015/16 CHD prevalence in Herefordshire GP practices ranged between 1.52 and 3.11 per cent. On a locality basis the highest CHD prevalence (4.00 per cent) was recorded in North and West and the lowest (3.24 per cent) in City.

People living in more deprived areas are at greater risk of CVD than the general population. In 2015/16 hypertension (high blood pressure) prevalence in Herefordshire was 16.0 per cent compared to 13.8 per cent across England as a whole, while prevalence in Herefordshire GP practices ranged between 13.5 and 18.8 per cent. On a locality basis the highest hypertension prevalence (16.6 per cent) was recorded in North and West and the lowest (15.4 per cent) in City. Hypertension is the single biggest risk factor for stroke and also plays a significant role in heart attacks. Risk factors for hypertension include being overweight or obese, lack of physical activity, and being diabetic.

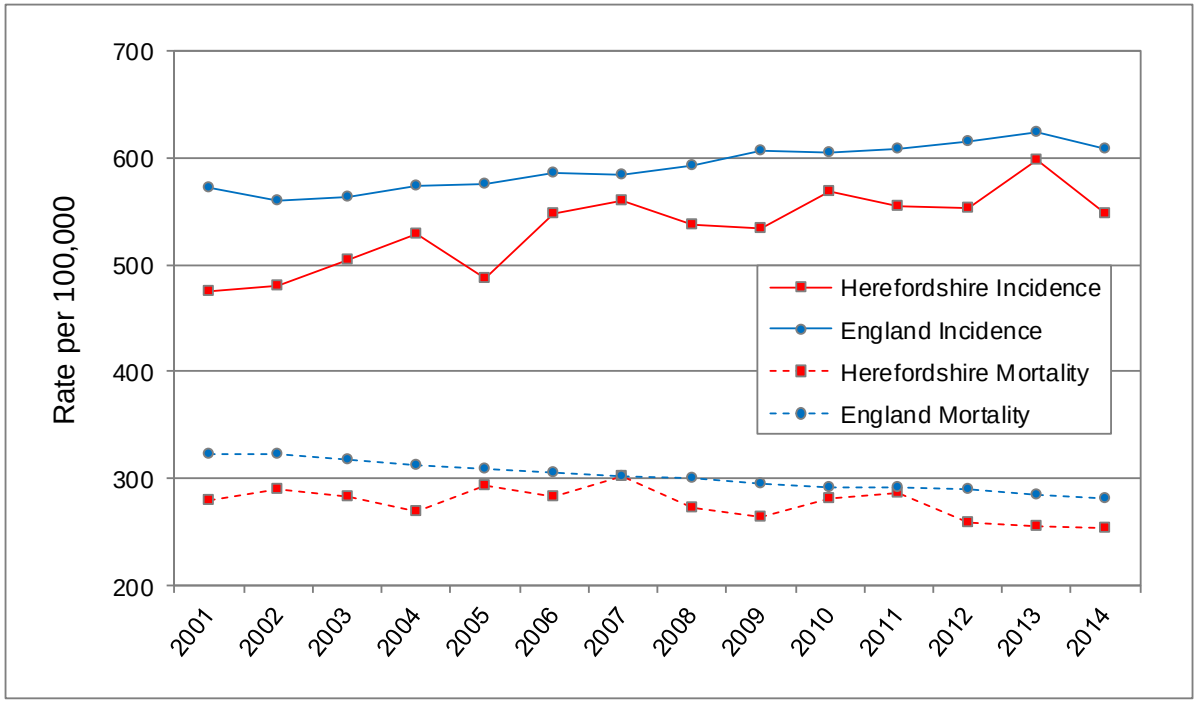
Cancer

Between 2001 and 2014 the number of new cancer cases diagnosed annually in Herefordshire has increased steadily from 802 to 1,136, reflecting a high incidence rate which is significantly higher than the national figure. Similarly, prevalence has increased locally and in 2015/16 was 3.2 per cent, a figure significantly higher than that reported nationally (2.4 per cent). In 2015/16 cancer prevalence in Herefordshire GP practices ranged between 1.87 and 4.32 per cent, while for localities the highest prevalence (3.67 per cent) was recorded in North and West and the lowest (2.72 per cent) in City.

In 2014 there were 537 cancer specific deaths in Herefordshire. Between 1995 and 2014 the cancer mortality rate in Herefordshire fell from 304 per to 245 per 100,000 population and the local rate was consistently lower than both the national and regional rates (Figure 17). The most common causes of cancer-related deaths in Herefordshire were lung, urological and upper and lower gastro-intestinal[14] cancers.

More detailed analysis can be found in the latest (2016) Overview of cancer in Herefordshire.

Figure 17: All age directly age-standardised cancer incidence and mortality rates for Herefordshire and England and West Midlands, 2001 – 2014.



PHE – CancerStats

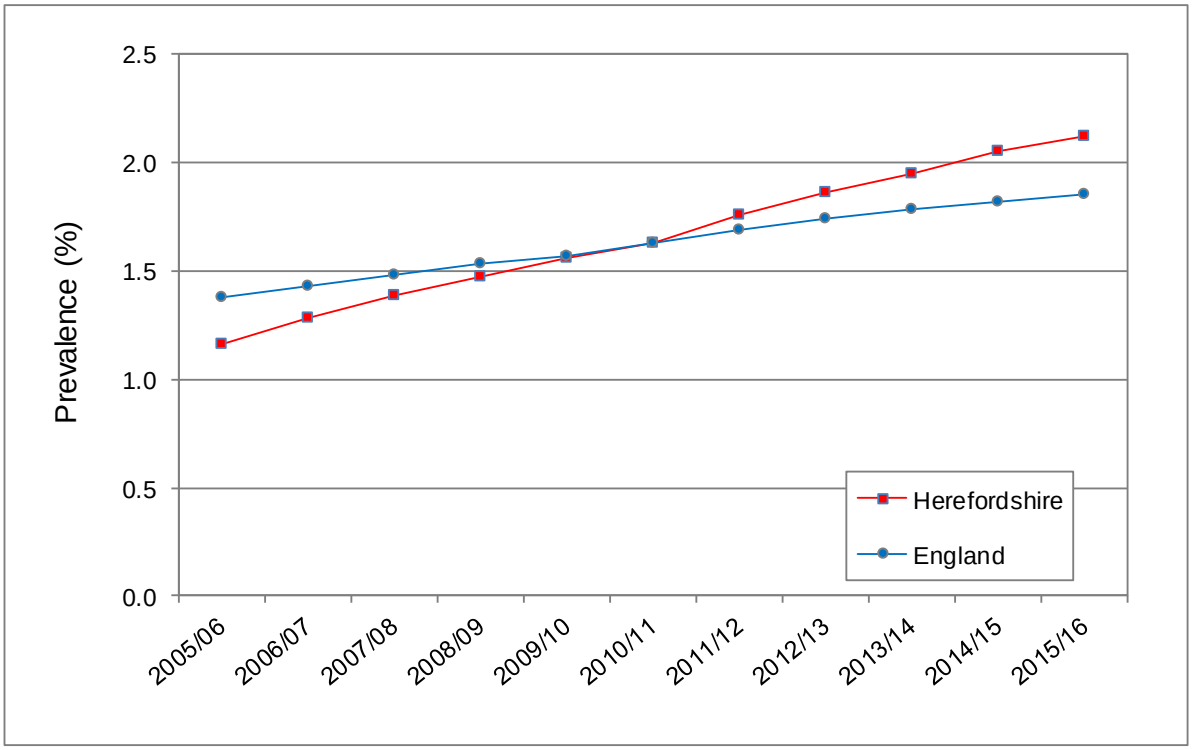
Respiratory diseases

People suffering with chronic obstructive pulmonary disease (COPD) in Herefordshire have increased steadily since 2005/06 (Figure 18). Since 2011/12 the local prevalence has been higher than the national figure whereas prior to 2009/10 the opposite pattern was observed. In 2015/16 the Herefordshire COPD prevalence was 2.12 per cent compared to 1.85 per cent across England as a whole. For Herefordshire GP practices COPD prevalence varied between 1.07 and 3.43 per cent,

[14] Urological cancers include bladder, kidney, prostate and testicular; gastro-intestinal cancers include those of the stomach, oesophagus, intestine and pancreas.

while for localities the highest prevalence (2.28 per cent) was recorded in City and the lowest (1.85 per cent) in South and West.

Figure 18: Prevalence of chronic obstructive pulmonary disease (COPD) in Herefordshire and England, 2005/06 to 2015/16.



PHE – Inhale

The local prevalence of asthma has shown little change since 2005/06 and has been consistently higher than the national figure; in 2015/16 the local asthma prevalence was 6.2 per cent compared to the England figure of 5.9 per cent, ranging between 4.53 and 7.58 per cent across GP practices in the county. For localities the highest prevalence (6.59 per cent) was recorded in North and West and the lowest (5.74 per cent) in City. Respiratory diseases remain the most prominent underlying cause of excess winter deaths. Respiratory as a cause of death as a category in the Excess Winter Mortality index scored 41 per cent in 2015/16. This means that there were 41 per cent more deaths from respiratory deaths in the winter months than there were in the non-winter months, equating to 8,600 deaths, and accounting for 35 per cent of all excess winter deaths.

Mental Health

In 2015/16 there were an estimated 1,500 individuals in Herefordshire suffering from severe mental health disorders (schizophrenia, bipolar affective disorder and other psychoses) which represents a local prevalence of 0.81 per cent, which is lower than the national figure of 0.90 per cent. Across Herefordshire GP practices the prevalence ranges between 0.33 and 1.41 per cent, while the highest locality figure (0.97 per cent) was recorded in City and the lowest (0.65 per cent in East.

Across GP practices the recorded prevalence of stroke, CHD, hypertension and cancer show some correlation to the proportion of patients aged 65, while prevalence of LTC and COPD show some correlation with smoking prevalence. The prevalence of obesity in practices show some relationship to COPD, Asthma and mental health, while levels of obesity are higher in more deprived practices and where smoking is more prevalent. The prevalence of CHD, COPD and asthma also show some relationship to deprivation as measured by IMD2015, while smoking is more prevalent in practices with higher levels of deprivation.

The key message to local commissioning groups is that individual treatment and pathways developed by traditional health and social care services have to adapt to increasing complexity of need. There is rising demand for management of multi-morbidity and co-morbidity of physical and mental disorders rather than of single diseases. Preventative strategies are currently being developed to manage demand, reduce costs, and respond to changing disease patterns.

Screening and Vaccination

Screening programmes: For Q2 2016-17 Herefordshire achieved national standards for both antenatal & newborn screening and non-cancer as well as cancer screening programmes except cervical screening (76.6 per cent against national standard of >80 per cent). However, this decline has been in line with the national trend. PHE and NHSE have been working with primary care to improve uptake.

Flu vaccination uptake in Herefordshire had been low in 2014-15 and 2015-16 across all groups eligible for free flu vaccine and was below the national and regional averages. In 2016-17 flu vaccine uptake data showed increase in uptake in Herefordshire in all eligible cohorts (including healthcare workers) except pregnant women. The uptake in individuals aged 65 years and over (70.2 per cent) was comparable to national (70.4 per cent) and regional averages (70.0 per cent), whereas the uptake in other cohorts was higher than the national and regional averages. However, in pregnant women the uptake (39.2 per cent) was lower than national (44.8 per cent) and regional (43.9 per cent) averages. In school aged children it exceeded the national target of 60 per cent.

AGING WELL: PEOPLE AGED 65 YEARS AND OVER

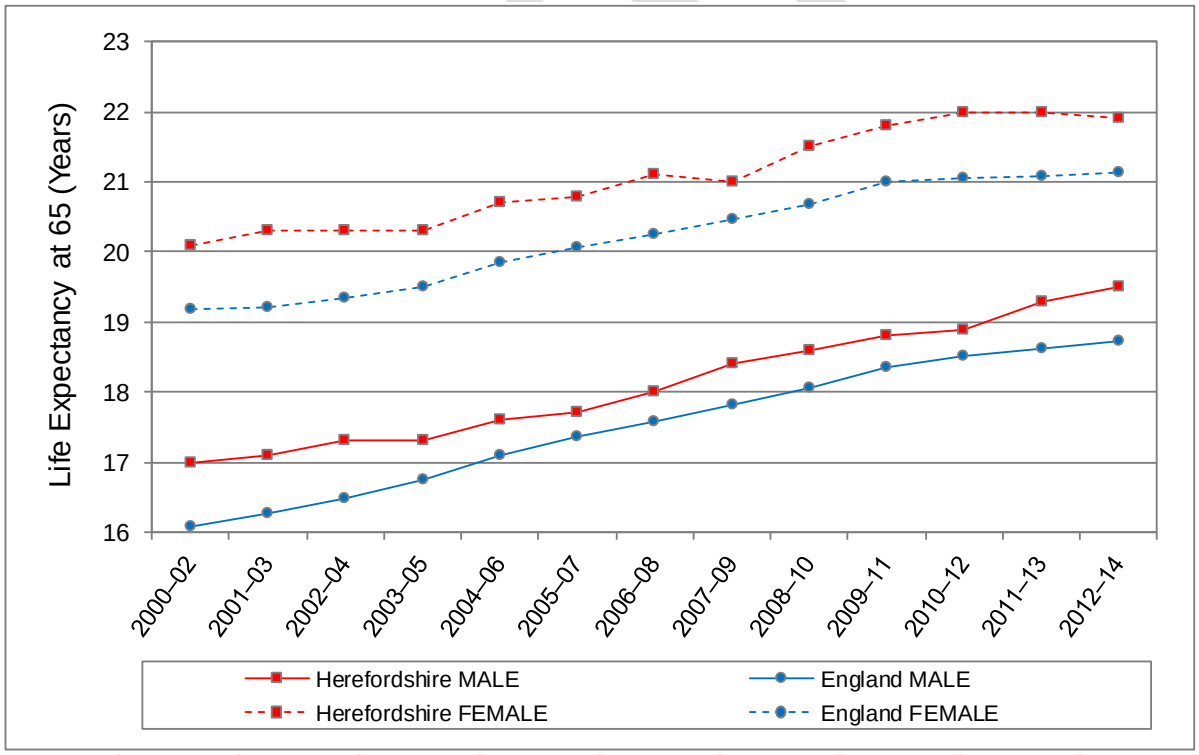
The following section focuses on areas of particular concern to older people. Given the aging demographic profile in Herefordshire, the focus on prevention is on healthy active aging (supporting independence), feeling connected to communities and feeling safe at home. Social isolation and loneliness can further exasperate complex health problems. Those aged 65-84 are more likely to live in rural villages and dispersed areas than the population as a whole

Life Expectancy at 65 years

People turning 65 in the county can expect to live longer, but they might not be in good health depending on their lifestyle choices, and fragility brought about by chronic illness and disability.

In 2012-14 the Herefordshire **life expectancy at 65** was **19.5 years for males and 22.0 years for females,** with both figures rising steadily since 2000-02 and are higher than those recorded nationally (Figure 19). For the same period the Herefordshire male life expectancy at 65 was ranked as 24th out of 150 upper tier local authorities, while female life expectancy at 65 was ranked 30th.

Figure 19: Male and female life expectancy at 65 in Herefordshire, England and comparator group, 2000-02 to 2012-14.



Source: ONS

In 2012-15 the Herefordshire **healthy life expectancy at 65** was **12.0 years for males and 13.2 years for females**, with both being higher than those recorded nationally. In 2012-15 the Herefordshire male healthy life expectancy at 65 was ranked as 32nd out of 150 upper tier local authorities, while female healthy life expectancy at 65 was ranked 29th.

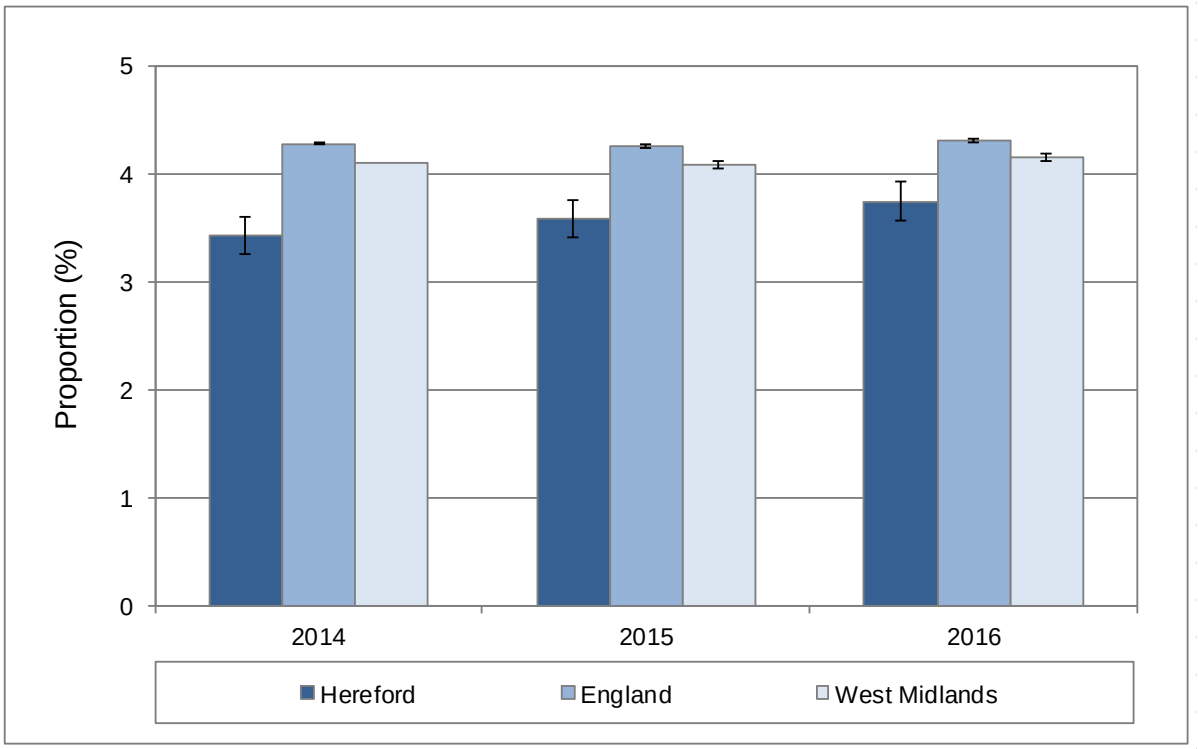
Falls

The risk of accidental falls increases with age, and is mostly strongly linked with people with medical conditions, living alone and socially isolated, and living in deprived communities. Falls are the largest cause of emergency hospital admissions for older people (over 65 years) and significantly impact on long-term outcomes; for example, falls can be a major precipitant of people moving from their own home to long-term nursing or residential care. In 2015/16 there were 1,340 fall related hospital admissions in Herefordshire of which over 70 per cent were for those aged 65 and over. In 2015, injuries and falls accounted for 9% of premature deaths. In the 65 and over age group almost two thirds of fall related hospital admissions are for females. Across the county the rate of fall related admissions are highest in the most deprived areas.

Dementia

Dementia is an umbrella term for a number of progressive diseases affecting the structure and chemistry of the brain which become increasingly damaged with time. Alzheimer's disease accounts for over 60 per cent of all dementias in England. Age is the biggest risk factor for dementia. As of September 2016 in Herefordshire there were 1,760 diagnosed cases of dementia in those aged 65 and over which represents 97 per cent of all dementia cases in the county. Despite this high figure, the local prevalence of dementia in individuals aged 65 and over (3.7 per cent) significantly lower than in West Midlands and England as a whole and has been over the last three years (Figure 20). However, it is likely that there is significant under-recording of dementia prevalence across the county, as is the case nationally.

Figure 20: Proportion of over 65s suffering from dementia in Herefordshire, England and the West Midlands, 2014 to 2016.



Source: Public Health England – Dementia Profile

Excess Winter Deaths

In common with other countries, more people die in the winter than in the summer in the UK – this pattern is known as excess winter deaths are typically observed between December and March in England. Between 1991/92 and 2014/15 the number of excess winter deaths showed considerable variation from a low of 20 deaths in 2013/14 to a high of 220 deaths recorded in 2014/15. Over half of all excess winter deaths in Herefordshire are in those aged 85 and over with the most common underlying cause being respiratory disease.

Social Isolation

The Campaign to End Loneliness (2016) listed a number of social isolation triggers which is useful to assess vulnerabilities in older people. Age UK have produced loneliness heat maps which look at these triggers and related factors in local areas:

http://ageuk.org.uk/professional-resources-home/research/loneliness-maps/

EVALUATION AND REVIEWS

In the year to March 2017, several 'deep dive' projects were undertaken to provide a fuller understanding around a particular topic. This section provides information on four deep dive investigations, to inform commissioners on the nature and extent of the needs of a particular population cohort, and how it might impact on service demand and provision.

Review of Military and Ex-military personnel in Herefordshire 2016

Herefordshire is the location of Hereford Garrison, home of 22 Special Air Service, of the British Army's Special Forces. As well as serving and ex-members of the Regular Army connected to the garrison, Hereford is the home of 10 Platoon, E Company of the 6th Battalion The Rifles (6 RIFLES). Herefordshire Council has a corporate covenant which demonstrates support for the armed forces community by ensuring that council business does not disadvantage members of the armed forces community compared to any other citizen. This includes employment support for veterans, reservists, service spouses and partners as well as support for cadet units, Armed Forces Day and discounts for the armed forces community.

In 2016, a short piece of research commenced to ascertain the level of need in the ex-military population in Hereford. Preliminary findings are reported here.

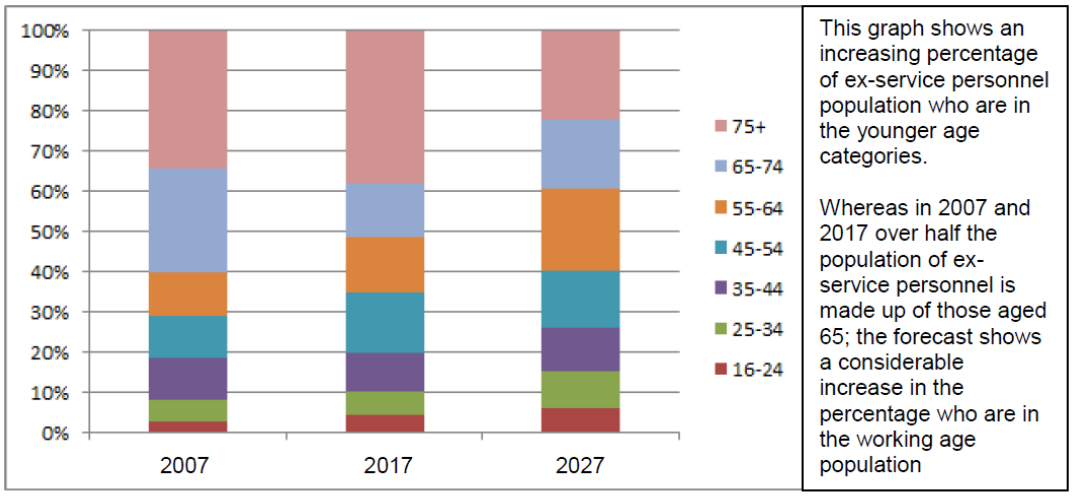
Key findings were:

- The 2011 Census recorded around 1,000 people as being employed by the armed forces in Herefordshire, but not necessarily *resident* in the county; and just under **1,200** people employed by the armed forces and resident in the county, but not necessarily *working* in Herefordshire. The 1,200 Herefordshire residents represent 0.8 per cent of the total number of residents of England and Wales employed in the armed forces (around 153,200). The majority are male, of White British ethnicity, with 79 per cent aged 25-29 years. The 1,200 members living in the county had 1,450 family members (spouse, partner, child or step-child) living with them. Of these, 50 per cent were aged 16 years or under.

- MOD data indicates that there were 1,600 members of the regular armed forces stationed in Herefordshire in October 2015. Of these, 94 per cent were army personnel. The ratio of officers to other ranks has been consistent at around 1:10.
- Service personnel working in Herefordshire have an older profile than the national picture, with just 10 per cent under the age of 25 compared to 31 per cent across the whole of England and Wales. Most (85 per cent) were aged 25 to 49 (compared to 63 per cent nationally). Given the relatively older structure of Herefordshire's population, it is likely that there are a disproportionate number of veterans who served in World War II or undertook

National Service until it ended in the early 1960s (11,400 men aged 72+ live in the county; 1,400 of whom are aged 87+). In March 2016, there were 2,190 ex-service recipients of an occupational pension in Herefordshire. See Figure 21 for a population forecast for veterans.

Figure 21: Percentage change of veterans and forecasted veteran household projection in England by age from 2007 to 2027.



Health Challenges

A number of challenges for those working or leaving the Armed Forces were identified through a substantial literature review.[15] The evidence points to personnel who leave the Services early on in their army career, being particularly vulnerable, especially from a mental health perspective. Some find difficulty in making the transition from being in the Armed Forces to becoming a citizen or 'civvy', challenging for both ex-military personnel and their families. However, the majority of people leaving the Armed Forces are fit, healthy and remain so, contrary to current perceptions demonstrated, for example, by veterans being more likely to undertake vocational training on leaving the Services.

Medical discharges from HM Armed Forces are predominantly for musculoskeletal disorders and injuries, and the second most common reason for a medical discharge is for mental and behavioural disorder[16]. The impact of musculoskeletal injuries within this population is of concern as a higher proportion of ex-service personnel having these issues as they grow older. Military staff are looked after by the Defence Medical Service, and medical records are transferred to local GP practices that ex-military personnel register with. However, it is not known how many ex-military personnel disclose

[15] Including '*The needs of the Armed Forces community across Coventry, Solihull and Warwickshire' (2016)*.

[16] Defence Statistics MoD (2015) Annual medical discharges from the UK Regular Armed Forces 2009/10 to 2013/14.

their military history to GPs, or if GPs ask the question. The number of children and young people taking care of parents who have been medically discharged is unknown, and local figures for young military carers are not available. The research also highlighted key challenges for ex-military personnel such as housing and poverty. For example, in 2016-17, 901 pupils from military families in Herefordshire's maintained schools attracted the Service Pupil Premium.

Review of Child Sexual Exploitation in Herefordshire 2016

Research on child sexual exploitation was commissioned by the Herefordshire Community Safety Partnership and the Herefordshire Safeguarding Children's Board. Child Sexual Exploitation (CSE) in Herefordshire is a serious concern given that the county ranks 18 out of the 315 Community Safety Partnerships (CSPs) in England and Wales for CSE, (when ranked in order of most to least prevalent).

Child exploitation of children and young people under the age of 18 involves exploitative relationships, violence, coercion, and intimidation, and those from disadvantaged backgrounds are most at risk. Across Herefordshire, 2.8 per thousand children are marked as being a victim of a sexual related crime potentially involving CSE, and Herefordshire has a higher prevalence rate in terms of all sexual offences involving children compared with England & Wales as a whole (9.7 per thousand children compared with 6.5 per thousand respectively). Most concerning is that the proportion of children aged 13-15 involved in sexual activity in Herefordshire (15.5 per thousand) is more than double that of England and Wales (6.0 per thousand). It is also known that locations experiencing the greatest concentrations of offences are more likely to be situated within the most deprived areas of the county, generally within urban or semi-urban areas.

The key issue for social workers and commissioners is the finding that out of the 78 assessments carried out during the period October 2015 and June 2016, 81 per cent (63) had not been assigned a clear cut level of risk, and this is thought to be a risk averse response to the complexities of identifying CSE. Children and young people have a range of vulnerabilities which may be associated with physical and mental health problems, some contributing to abuse, and others arising from it. A key message from best practice in other authorities is that preventative work should start at a much younger age than previously thought as perpetrators are grooming children at younger ages for exploitation when they are older, so early education of CSE dangers and more effective engagement with schools are required. Children at risk in Herefordshire were spread over 27 different local schools and training establishments in the county.

Evaluation of Herefordshire's Community Health Services for Children and Young People (CYP) 2016

Commissioned by Herefordshire Clinical Commissioning Group, Public Health/Strategic Intelligence undertook an evaluation of eleven community health services for children and young people provided

in Herefordshire for its 0-16 year child population. The evaluation highlighted several areas for improvement and recommendations were made based on the findings.

The evaluation data suggested a need for services to shift to a model that better manages demand and waiting times so that timely health care needs for children and young people were met sooner. Improvements were needed for referral processes, sharing of patient notes, and greater clarity on care pathways so that both individual patient and service outcomes are achieved. Cross-sector professional differences in delivering integrated care and high staff turnover were perceived barriers to providing better care. A key challenge for all services was increasing pressure to meet the community health needs of CYP with multiple or complex health conditions as more children are living longer but with complex needs developed in infancy. Clinicians and staff had a high level of commitment to improving community health, and recognised the benefits of greater engagement with patients and families as less was known on how users experienced the services on offer.

Preventative care and early intervention was promoted where possible by the Services, and self-care and self-management of health conditions, where appropriate, was facilitated and actively supported. In the longer term, clinicians and managers were agreed that sustainable solutions needed to found to ensure a fit for purpose community health service for the local population.

Evaluation of the Local Response to Domestic Violence and Abuse 2017

Domestic abuse is the abuse of one partner within an intimate or family relationship. It is a repeated and habitual use of intimidation and coercion to control a partner. The abuse can be one or a combination of physical, emotional, psychological, financial or sexual. Domestic violence and abuse in Herefordshire is one of the Community Safety Partnership's five main priorities, and in 2016, the Partnership commissioned the council's Strategic Intelligence to undertake an evaluation of the local response to domestic violence and abuse in Herefordshire, The evaluation did not assess 'needs' as this was undertaken in the Domestic Violence and Abuse Needs Assessment 2013 (DVNA 2013) which resulted in an action plan based on the DVNA recommendations. An update on the success of those recommendations also formed part of the evaluation. The evaluation focused on the strengths, weaknesses, threats and opportunities of the current local response to DVA for victims (female and male) and perpetrators of DVA, as well as the strength of the partnership as a whole in responding appropriately to DVA within the county.

The evaluation found that the local response to domestic violence and abuse was effective in delivering some but not all health and wellbeing outcomes for women experiencing domestic abuse due to a number of reasons, such as diminishing resources (funding and capacity); lack of information sharing across agencies; and lack of a cohesive county wide model for addressing system wide challenges. The local response to DVA for male victims is limited.

CONCLUSIONS – KEY PRIORITIES

Taking an overview of the findings of the JSNA, a number of areas stand out as representing key priorities for consideration by the system as a whole:

- Herefordshire has a lower proportion of younger working age population as compared to the national average. Though there are high expectations that the new Herefordshire University in 2018/19 will enable us to retain and develop the county's own young people, talent and skills, this alone will not be enough to fulfil county's future workforce demand. Therefore, this necessitates strategic planning for a broader workforce development.

- The crude rate of killed or seriously injured (KSI) casualties of all ages (2013-15) on Herefordshire roads (43/100,000 population) is high compared to the regional (33.9/100,000 population) and national (38.5/100,000 population) figures. Though the absolute numbers are small (223 in two years: 2013-15), these are preventable causalities and result in significant cost to health and social care. Therefore, this needs further analysis to determine the underlying factors and to put appropriate prevention measures in place.

- Fuel poverty is a longstanding issue. Latest available data (2014) show that the proportion of households that experience fuel poverty in Herefordshire (15.1%) is higher than the regional (12.1%) and national (10.6%) averages; and in our deprivation decile,[17] we have the worst figure. Fuel poverty is a significant factor contributing to excess winter deaths (225 in total in 2014-15) and alleviating fuel poverty is likely to help saving lives. Therefore, this merits a priority consideration to explore measures to minimise its economic and health impact.

- In 2014-15, in Herefordshire's proportion of 5 year olds with more than one decayed, missing or filled tooth (41.3%) was much higher than the regional (23.4%) and national (24.8%) averages and we have the worst figure in in our deprivation decile. One public health programme to tackle obesity and poor dental health, the "sugar swap" campaign, is ongoing. Among other specific interventions to improve oral health, such as fluoride varnish (patchy provision in Herefordshire) and targeted provision of tooth brushes and paste (to be re-launched this year), fluoridation of water has the highest return on investment (for every £1 spent the return is £12.71 in 5 years and £21.98 in 10 years). This warrants urgent consideration of fluoridation of water in the county.

- In 2016, in Herefordshire 9.8% of reception year children were obese, while the combined proportion of obese and overweight children was 22.2 %; for year 6 children the prevalence of obesity was 19.8%, while the combined figure for obese and overweight children was 33.8%. These figures are higher than the regional and national averages and we have one of the worst figures in our deprivation decile. Furthermore, 2016 figures show an upward trend. Excess weight and obesity in childhood is a significant risk factor for developing morbid obesity in adulthood. This in turn potentially withholds individuals from having a productive and fulfilling life.

[17] As per Index of Multiple Deprivation (IMD) 2015, Herefordshire falls in the 4th less deprived decile nationally – 1st is the least deprived and 10th is the most deprived.

Unhealthy food and physical inactivity are the key factors responsible excess weight, which are modifiable. The public health campaign "Change 4 Life" and the National Child Measurement Programme are ongoing. In addition to strengthening these programmes, further action is needed to avert this upward trend in childhood obesity through working closely with schools, parents, communities and businesses.

- Overall prevalence of long term medical conditions (LTCs) in Herefordshire (56.6%) is higher than the national average (54%). This could be attributed to the aging population. One LTC of particular concern is high blood pressure (hypertension); local figure is 16% as compared to the national average of 13.8%. High blood pressure is the 3rd biggest risk factor for premature death and disability in England after smoking and poor diet. At least half of the all strokes and heart attacks are associated with high blood pressure and it is a major risk factor for chronic kidney disease, heart failure and dementia. People in the most deprived neighbourhoods are 30% more likely than the least deprived neighbourhoods to have high blood pressure. It is estimated that there are 21,000 undiagnosed cases of high blood pressure in Herefordshire.

- Therefore, primary prevention and early detection & treatment are central tenants of our strategy to combat high blood pressure. Primary prevention involves behavioural change to influence modifiable risk factors – excess salt intake is one of most important modifiable risk factor. Early detection and treatment is through either opportunistic or NHS health checks programme. Between April 2014 and March 2017, NHS health checks programme identified 3,689 new cases of high blood pressure. Lowering systolic blood pressure just by 10mmHg on average in people with high blood pressure can potentially save 273 deaths, and 87 strokes, 75 coronary heart disease and 51 heart failure events in one year in Herefordshire. Therefore, there is case for continuing to invest in healthy lifestyle programmes and NHS health checks.

- There is a life expectancy gap of 4.2 years for males and 2.3 years for females between the most deprived and least deprived deciles of the county population. Three health conditions (circulatory diseases, cancers and respiratory diseases) largely account for this life expectancy gap (77% in male and 66% in female). There are number of modifiable lifestyle risk factors associated with these conditions; Smoking is the largest preventable lifestyle risk factor and prevalence of smoking in Herefordshire (17.5%) is significantly higher than the England best (9.5%). Therefore, influencing people to adopt healthy lifestyles is central our health & wellbeing agenda and public health has been running "One You" campaign. However, this agenda needs to be owned by all stakeholders and should be embedded in their core business.

- In 2015-16 there were over 900 fall related hospital admissions in Herefordshire residents aged 65 and over with almost two thirds being for females. Though in 2015-16 the Herefordshire hip fracture rate in this age group (551/100,000population) was lower than the national average (589/100,000 population); but this equates 244 hip fractures in Herefordshire. Each hip fracture could potentially cost over £35k in terms of health and social care costs over a period of two years. We do know falls are largely preventable. Pursuing the Adults & wellbeing directorate prevention agenda a number of measures have been put in place to prevent falls in nursing & residential care homes and in the communities such as postural stability programme. However, the council and NHS commissioners needs to consider further measures to reduce falls such as early identification of high risk individuals in primary care and other settings, and offering them appropriate intervention to mitigate risk of falls (for example environmental modification, physical activity, healthy eating programme to enhance

muscle and bone strength, medicine review).

- 2015-16 Herefordshire data for young people mental health reflect poorly across a range of indicators: % of 15 year old drinking regularly (7.8%) is higher than the regional (5.5%) and national (6.2%) figures. Under 18 alcohol specific hospital admissions (50.8/100,000 population) is higher than the regional (32.6/100,000 population) and national (37.4/100,000 population) rates. Under 17 hospital admission due to mental health conditions (144.2/100,000 population) is worst across West Midlands being higher than the regional (89.8/100,000 population) and national (85.9/100,000 population) rates. Though these rates are based on small numbers but trend analysis shows that Herefordshire rates have consistently been higher than the national rates in the last couple of years with recent upward trend. This indicates severity of the local problem. Coupled with this is the persistent high rate of suicide (all ages) in Herefordshire, which is above the national rate.

- Mental health has been identified as number one priority in the Herefordshire Health & Wellbeing Strategy. The public health team has been following a number of actions in order to implementation this strategy:

    - It has been running "5 ways to wellbeing" campaign to promote mental wellbeing.
    - The team has just launched "Youth Mental Health First Aid Training" for school teachers to be rolled out across Herefordshire by December 2017. It is hoped that every secondary school in Herefordshire will have at least one school teacher trained by that time.
    - Public health and Environmental Health & Trading Standards (EH&TS) have been working together to run a campaign to curb underage alcohol sales.
    - Herefordshire Council and Clinical Commissioning have been working together to develop "Suicide Prevention Strategy".

- Given young people mental health data, review of current provision of community adolescent mental health service (CAMHS) should be considered to inform future commissioning decisions. Also provision of early identification and brief advice (IBA) to individuals with alcohol abuse problem in primary care should be considered.

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Other Information

New University http://nmite.org.uk/

END

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Joint Strategic Needs Assessment Refresh 2017

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Consultant Public Health

Herefordshire Profile – Key Facts

Population (mid-2015) estimate = 188,100 residents

Land area = 2,180 square kilometres (km^2) - 95% of land area is 'rural'

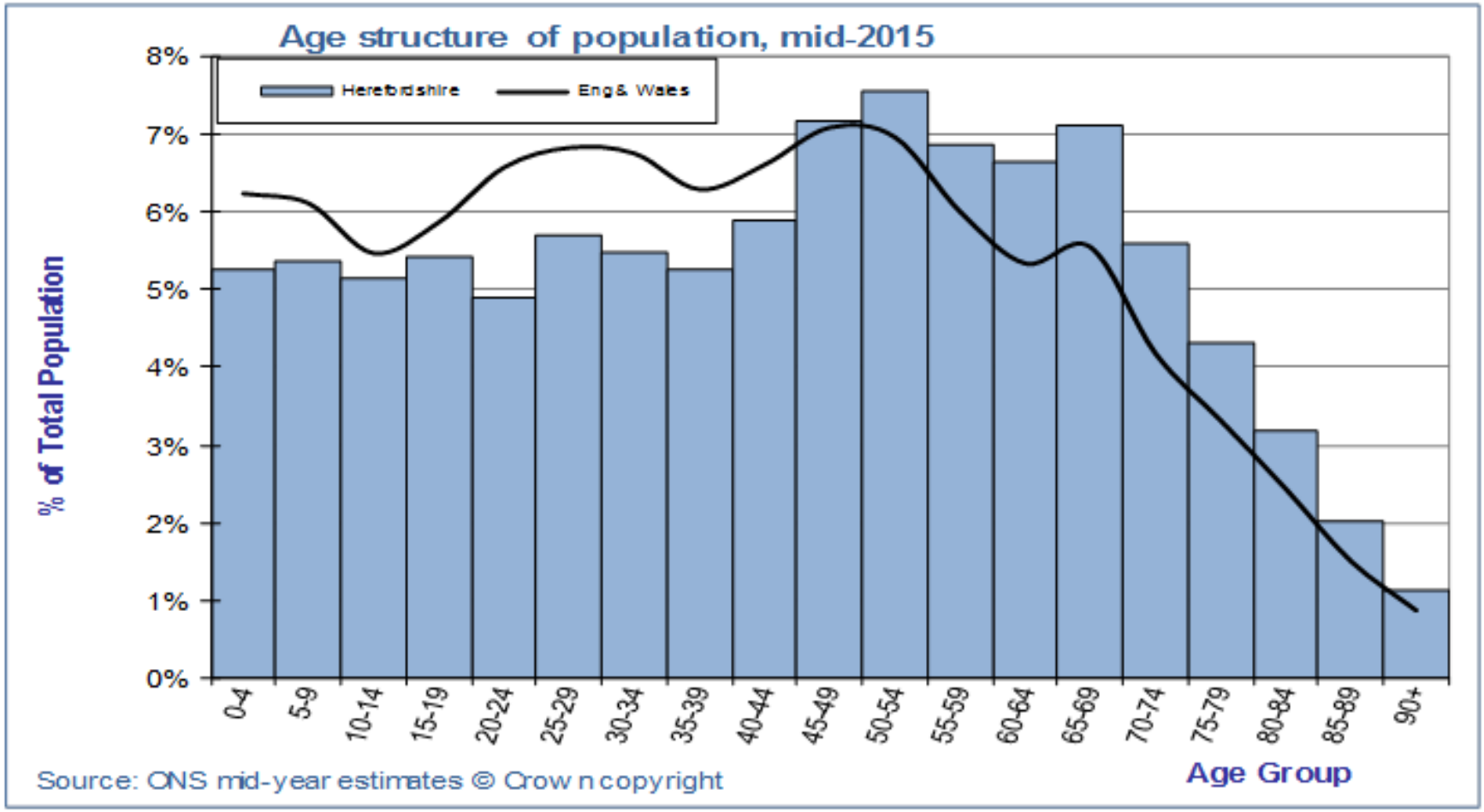
32.1% county residents live in Hereford (60,400)

21.7% live in market towns: Leominster – (11,900), Ross on Wye – (11,100), and Ledbury – (9,900), Bromyard (4,600) and Kington (3,300)

3.8% live in other urban, town and fringe (7,200)

42.4% residents live in the most dispersed rural areas (79,400)

Age Structure of the population



Herefordshire Economy

- In 2016, average weekly wages in Herefordshire was **13 per cent** lower than the West Midlands, and **18 per cent** lower than England's.

- In 2016, women's earnings were **16 per cent** lower than men's, whereas the West Midlands gender earnings gap was **21 per cent** and England's gap was **18 per cent**.

- Long-term unemployment and statutory homelessness figures are lower than the national averages.

C olour key for graphs and figures – compared with benchmark

Better

Similar

Worse

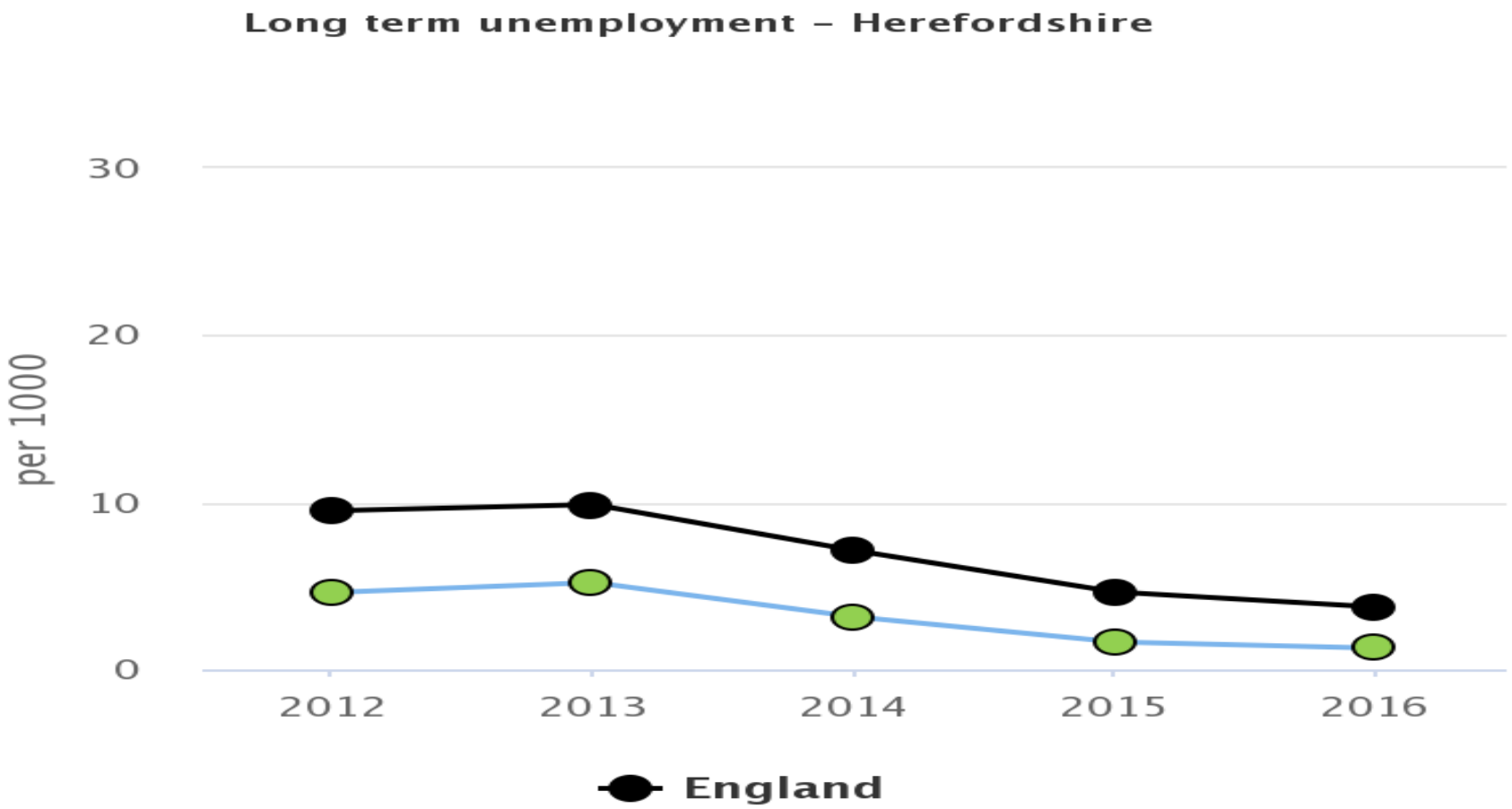
Lower

Similar

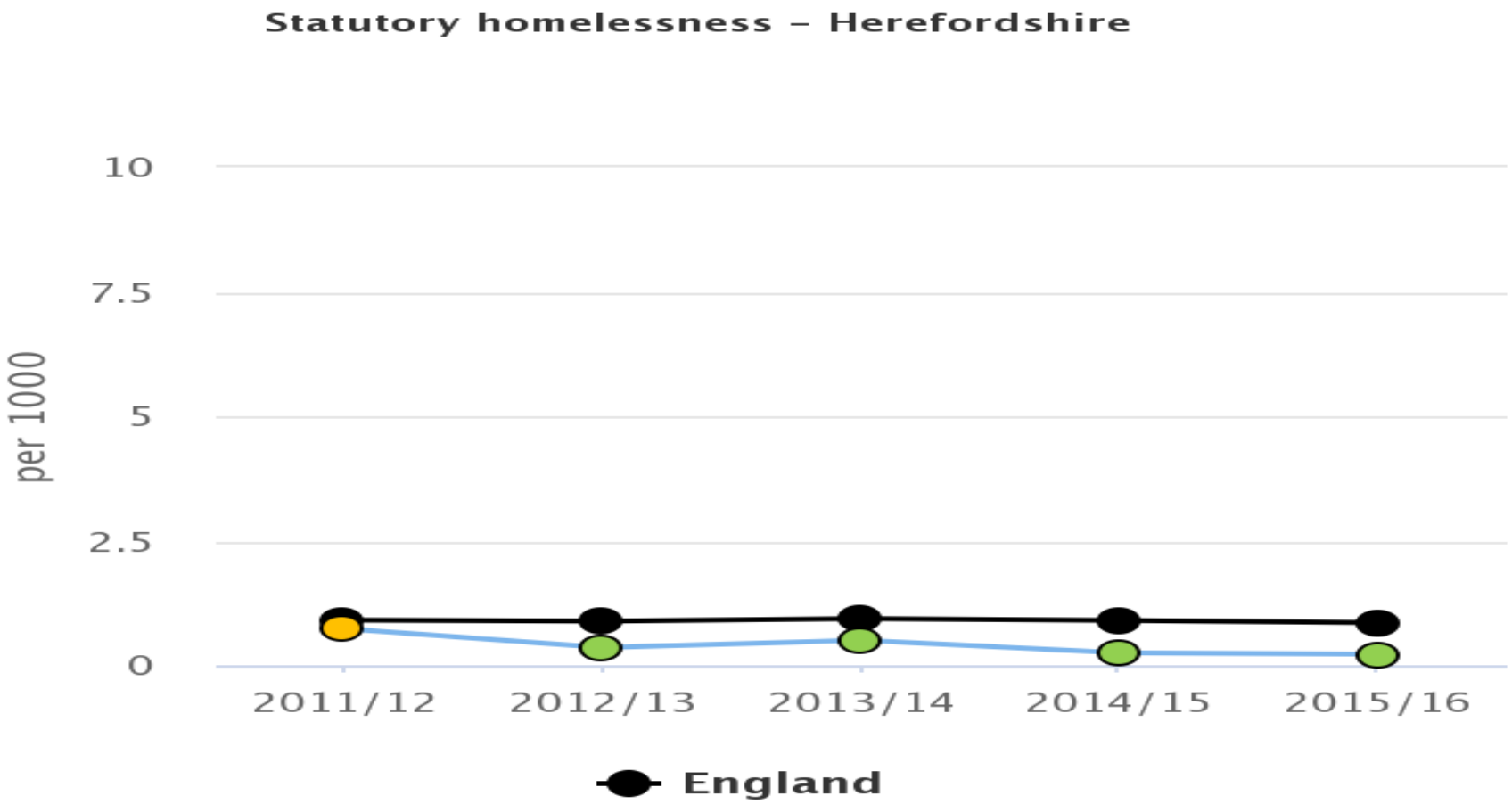
Higher

Not compared

Herefordshire Economy

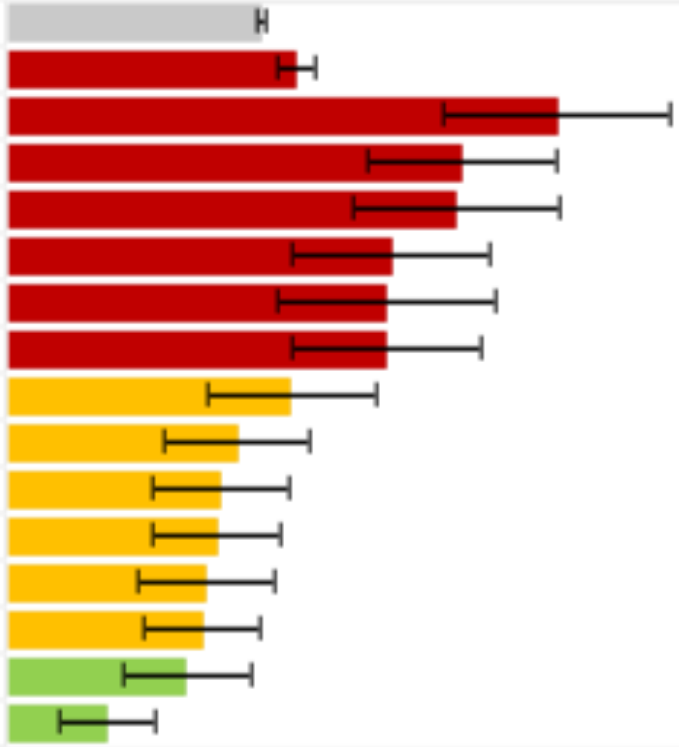


Herefordshire Economy



Herefordshire Economy – Percentage of the population aged 16+ who are unemployed

Area	Value	Lower CI	Upper CI
England	5.1	5.0	5.2
West Midlands region	5.8	5.4	6.2
Wolverhampton	11.0	8.7	13.3
Birmingham	9.1	7.2	11.0
Walsall	9.0	6.9	11.1
Dudley	7.7	5.7	9.7
Stoke-on-Trent	7.6	5.4	9.8
Sandwell	7.6	5.7	9.5
Telford and Wrekin	5.7	4.0	7.4
Coventry	4.6	3.1	6.1
Solihull	4.3	2.9	5.7
Staffordshire	4.2	2.9	5.5
Shropshire	4.0	2.6	5.4
Herefordshire	3.9	2.7	5.1
Worcestershire	3.6	2.3	4.9
Warwickshire	2.0	1.0	3.0



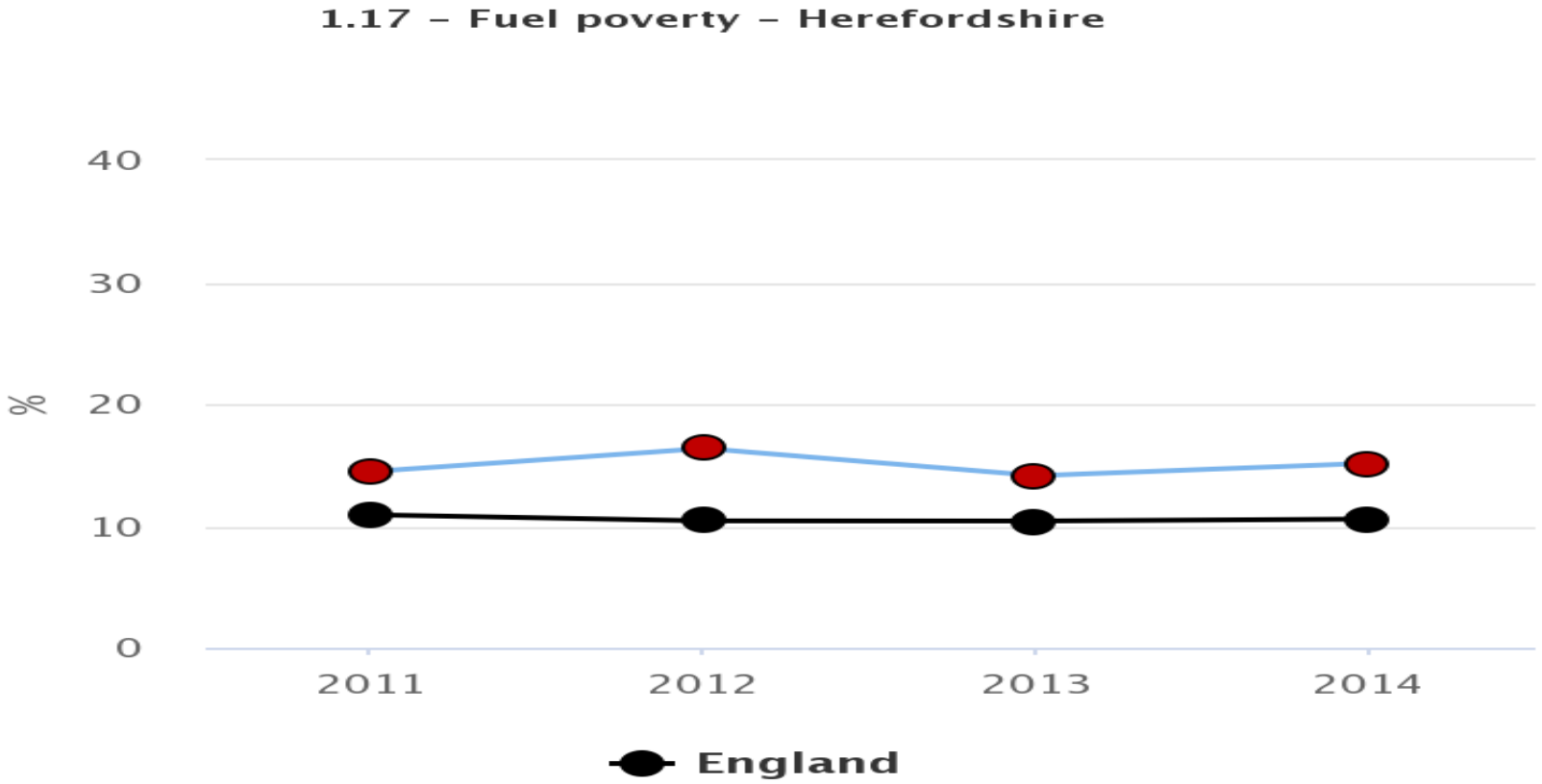
Source: NOMIS: https://www.nomisweb.co.uk/. The APS is a residence based labour market survey encompassing population, economic activity (employment and unemployment), economic inactivity and qualifications. These are broken down where possible by gender, age, ethnicity, industry and occupation. Available at Local Authority level and above.

Herefordshire Economy – People claiming Jobseeker's Allowance (rate /100,000 population aged 16-64)

Area	Value	Lower CI	Upper CI
England	3.7*	3.7	3.8
West Midlands region	6.3*	6.2	6.3
Birmingham	13.8*	13.5	14.1
Wolverhampton	12.4*	11.9	13.0
Sandwell	11.1*	10.6	11.5
Dudley	9.5*	9.1	9.9
Walsall	7.1*	6.7	7.6
Stoke-on-Trent	5.0*	4.6	5.3
Coventry	4.2*	4.0	4.5
Solihull	3.9*	3.5	4.2
Telford and Wrekin	2.8*	2.5	3.1
Worcestershire	2.4*	2.3	2.6
Shropshire	2.0*	1.8	2.2
Warwickshire	1.7*	1.6	1.9
Staffordshire	1.6*	1.5	1.7
Herefordshire	1.3*	1.1	1.5

Source: www.nomisweb.co.uk

Herefordshire Economy - % of households that experience fuel poverty based on the "Low income, high cost" methodology



Herefordshire Economy - % of households that experience fuel poverty based on the "Low income, high cost" methodology

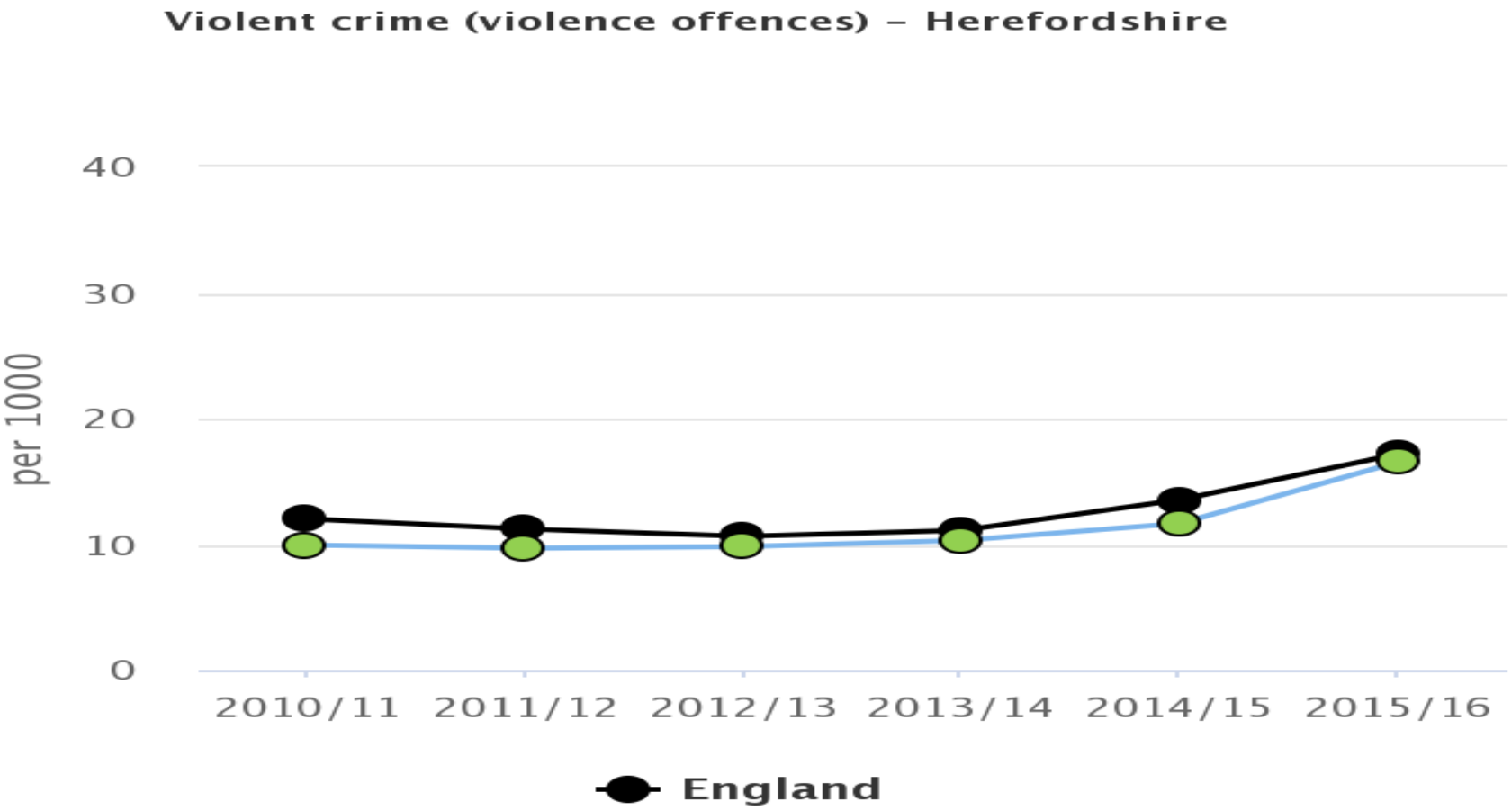
1.17 - Fuel poverty 2014

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	2,379,000	10.6	10.5	10.6
Fourth less deprived decile (IMD2015)	–	290,341	9.5	9.5	9.5
Herefordshire	–	11,978	15.1	14.9	15.4
Reading	–	7,002	10.8	10.5	11.0
Wandsworth	–	13,996	10.7	10.5	10.8
Cheshire West and Chester	–	14,461	10.0	9.9	10.2
Derbyshire	–	33,527	9.8	9.7	9.9
Suffolk	–	31,371	9.8	9.7	9.9
Stockport	–	12,185	9.8	9.7	10.0
Northamptonshire	–	27,958	9.5	9.4	9.6
Nottinghamshire	–	32,029	9.4	9.3	9.4
Bedford	–	6,006	9.2	8.9	9.4
Hillingdon	–	9,202	9.1	9.0	9.3
East Sussex	–	21,631	9.0	8.9	9.1
Kent	–	55,657	8.9	8.8	9.0
Warrington	–	7,246	8.4	8.2	8.6
Milton Keynes	–	6,092	6.0	5.8	6.1

Source: Department of Energy and Climate Change (DECC)

Herefordshire Economy - Crime and Safety



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Herefordshire Economy - Crime and Safety

1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population 2015/16 Crude rate - per 1000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	933,343	17.2	17.1	17.2
Fourth less deprived decile (IMD2015)	–	116,923	16.0	16.0	16.1
Hillingdon	↑	6,177	21.1	20.6	21.6
Reading	↑	3,353	20.9	20.2	21.6
Northamptonshire	↑	13,845	19.4	19.1	19.7
Wandsworth	↑	5,770	18.5	18.0	19.0
Kent	↑	27,768	18.4	18.2	18.6
Bedford	↑	2,962	18.1	17.4	18.7
Herefordshire	↑	3,097	16.5	16.0	17.1
Suffolk	↑	12,163	16.5	16.2	16.8
East Sussex	↑	8,332	15.4	15.1	15.8
Milton Keynes	↑	3,929	15.2	14.7	15.6
Stockport	↑	4,143	14.4	14.0	14.9
Warrington	↑	2,815	13.6	13.1	14.2
Nottinghamshire	↑	10,517	13.1	12.9	13.4
Cheshire West and Chester	↑	4,335	13.0	12.7	13.4
Derbyshire	↑	7,717	9.9	9.7	10.1

Source: Figures calculated by PHE Knowledge and Intelligence Team (North West) using crime data supplied by the Home Office and population data supplied by Office for National Statistics (ONS).

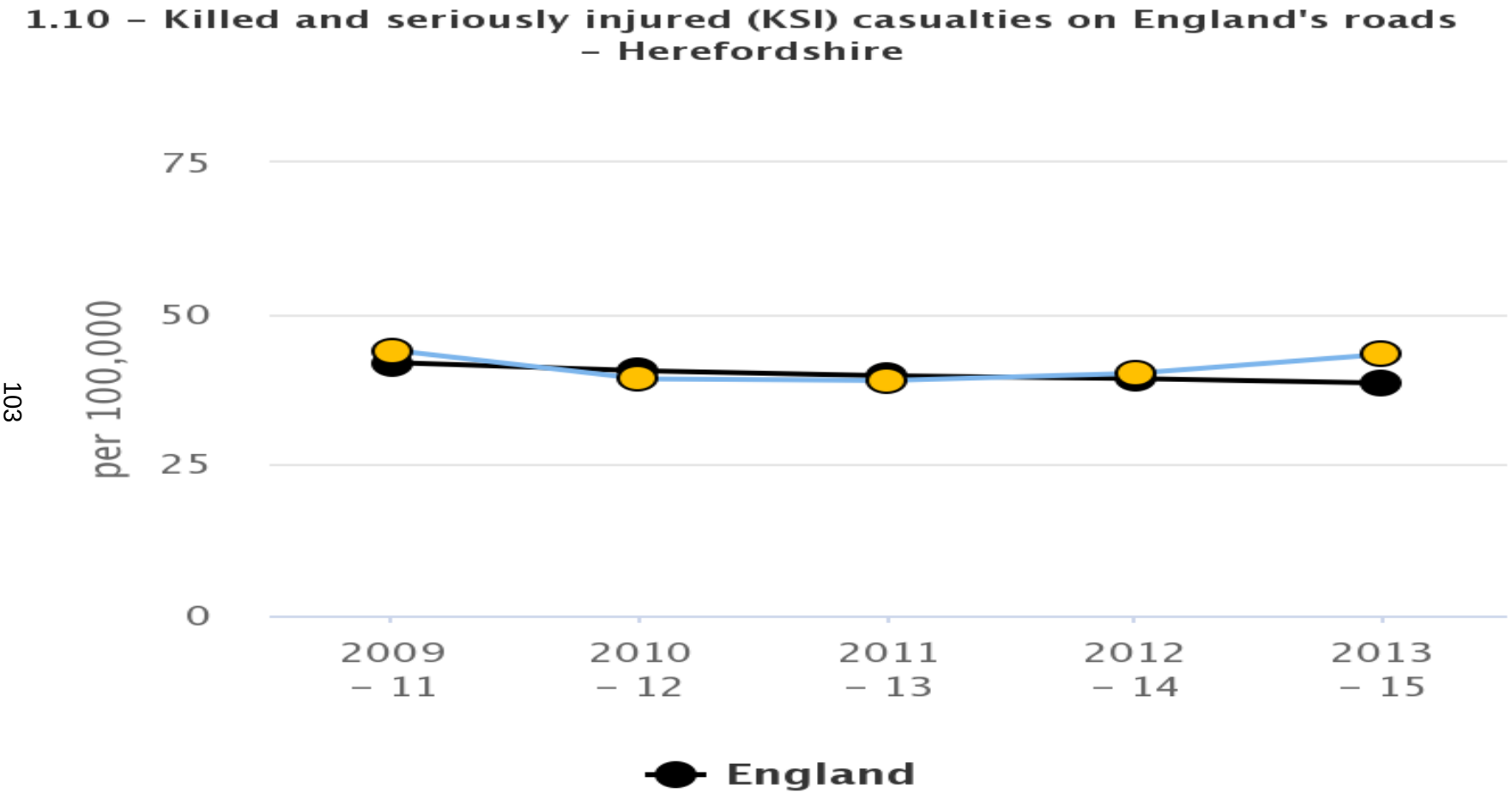
Herefordshire Economy - Crime and Safety

1.13i - Re-offending levels - percentage of offenders who re-offend 2014 Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	115,990	25.4	25.3	25.6
Fourth less deprived decile (IMD2015)	–	13,366	24.3	23.9	24.7
Cheshire West and Chester	→	760	28.1	26.4	29.8
Reading	→	459	27.0	25.0	29.2
Suffolk	→	1,455	26.7	25.5	27.9
Bedford	→	360	26.6	24.3	29.0
Wandsworth	→	543	25.7	23.9	27.6
Nottinghamshire	↓	1,487	24.9	23.8	26.0
Herefordshire	→	349	24.8	22.7	27.2
Warrington	→	405	24.7	22.7	26.9
Stockport	→	439	24.7	22.8	26.8
Derbyshire	→	1,195	24.2	23.0	25.4
Milton Keynes	→	584	24.0	22.4	25.8
Northamptonshire	→	1,440	23.7	22.7	24.8
East Sussex	→	757	23.5	22.0	25.0
Hillingdon	→	590	23.4	21.8	25.1
Kent	↓	2,543	21.7	21.0	22.5

Source: Ministry of Justice

Herefordshire Economy – All ages KSI



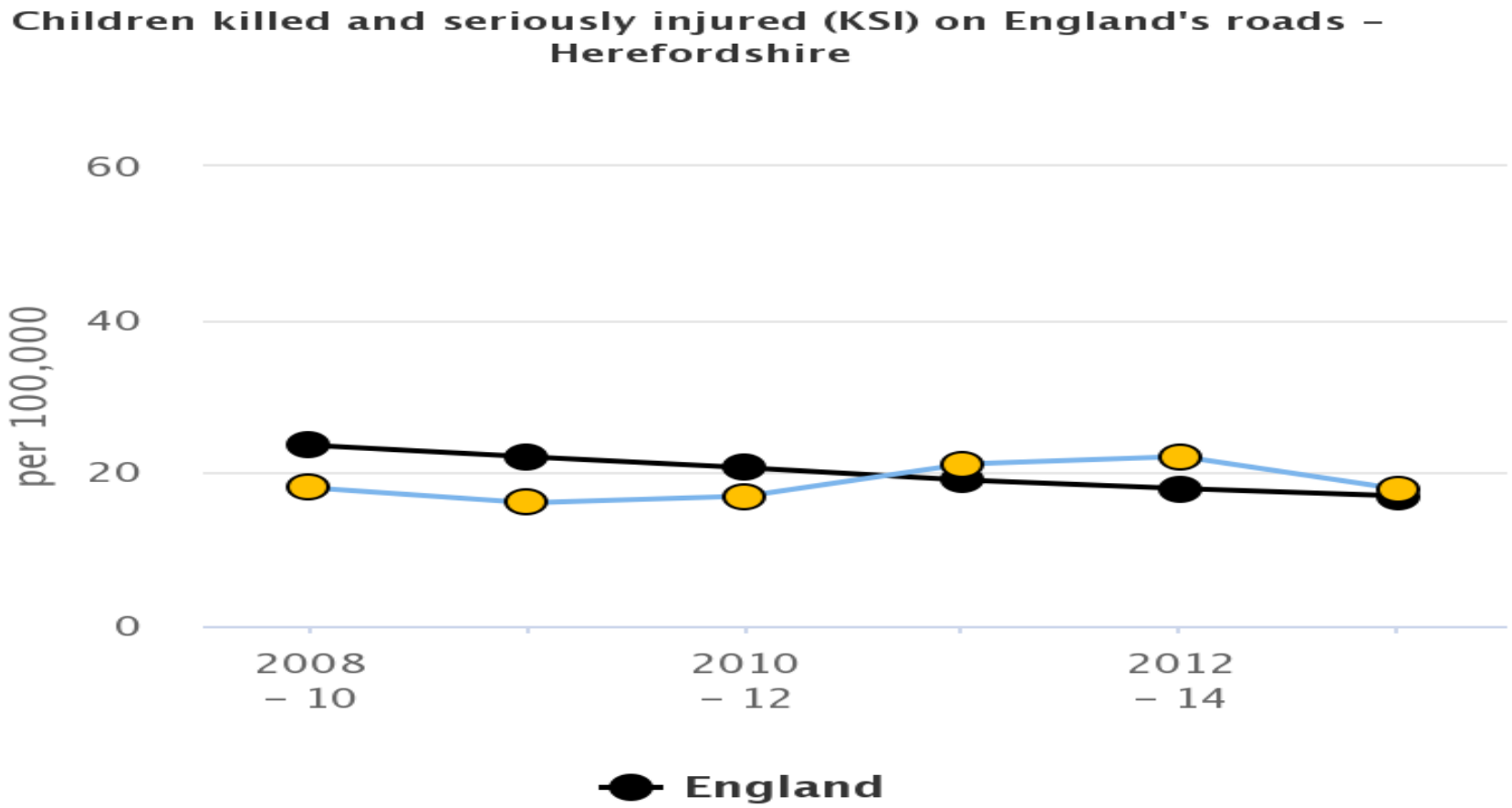
Herefordshire Economy – All ages KSI

1.10 - Killed and seriously injured (KSI) casualties on England's roads 2013 - 15 Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	62,741	38.5	38.2	38.8
West Midlands region	–	5,808	33.9	33.0	34.8
Warwickshire	–	923	55.8	52.2	59.5
Herefordshire	–	243	43.3	38.0	49.1
Shropshire	–	401	43.1	39.0	47.5
Birmingham	–	1,239	37.5	35.4	39.6
Sandwell	–	335	35.3	31.6	39.2
Coventry	–	343	33.9	30.4	37.7
Walsall	–	269	32.7	28.9	36.9
Worcestershire	–	562	32.6	29.9	35.4
Dudley	–	280	29.6	26.2	33.2
Wolverhampton	–	217	28.6	24.9	32.7
Staffordshire	–	606	23.5	21.7	25.4
Telford and Wrekin	–	117	23.0	19.0	27.6
Solihull	–	136	21.6	18.1	25.5
Stoke-on-Trent	–	137	18.2	15.3	21.5

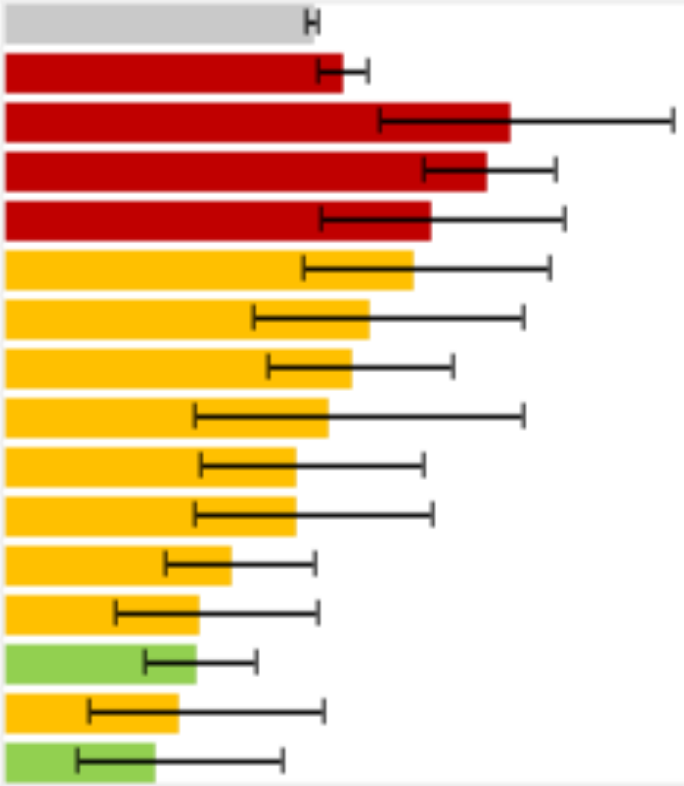
Source: Department for Transport

Herefordshire Economy - Children killed and seriously injured (KSI) on England's roads



Herefordshire Economy - Children killed and seriously injured (KSI) on England's roads

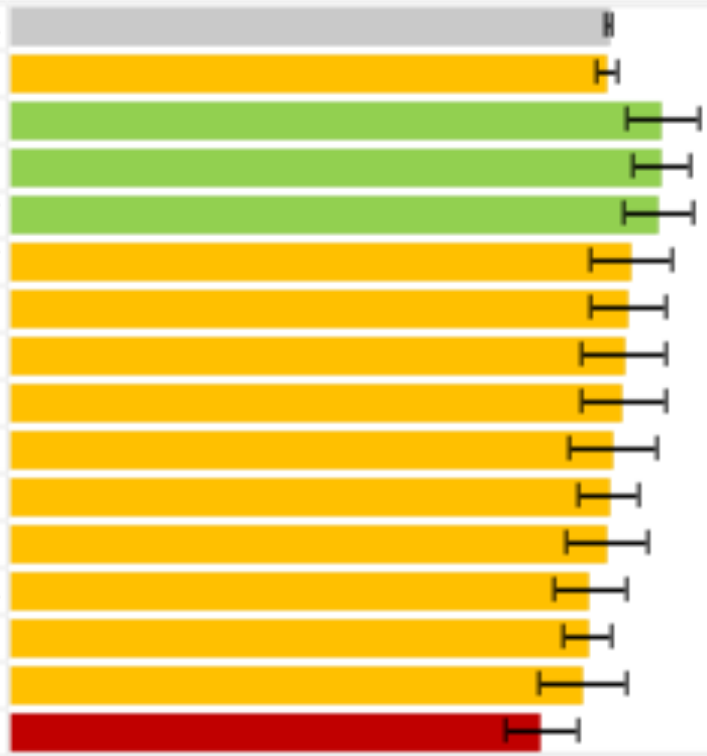
Area	Value	Lower CI	Upper CI
England	17.0	16.5	17.5
West Midlands region	18.6	17.2	20.2
Walsall	27.9	20.5	36.9
Birmingham	26.6	23.0	30.5
Sandwell	23.4	17.3	31.0
Coventry	22.5	16.4	30.2
Wolverhampton	20.2	13.7	28.7
Warwickshire	19.2	14.5	24.8
Herefordshire	17.9	10.4	28.6
Dudley	16.1	10.8	23.1
Shropshire	16.0	10.4	23.7
Worcestershire	12.5	8.8	17.2
Stoke-on-Trent	10.7	6.1	17.4
Staffordshire	10.5	7.7	14.0
Telford and Wrekin	9.6	4.6	17.7
Solihull	8.4	4.0	15.4



Source: Department for Transport, Road accidents and safety statistics.

Social care - Overall satisfaction of people who use services with their care and support (%)

Area	Value	Lower CI	Upper CI
England	64.4	64.0	64.8
West Midlands region	64.2	62.8	65.6
Shropshire	70.2	66.1	74.3
Sandwell	70.1	66.8	73.4
Herefordshire	69.7	65.7	73.7
Warwickshire	66.7	62.1	71.3
Telford and Wrekin	66.5	62.2	70.8
Stoke-on-Trent	66.0	61.4	70.6
Wolverhampton	65.9	61.2	70.6
Staffordshire	64.9	60.1	69.7
Dudley	64.5	61.1	67.9
Worcestershire	64.2	59.8	68.6
Solihull	62.4	58.4	66.4
Walsall	62.1	59.2	65.0
Coventry	61.6	56.6	66.6
Birmingham	57.2	53.1	61.3



Source: NHS Digital, ASCOF

Social care – Older people (65+) supported by adult social care throughout the year per 100,0000 population aged 65 and over

Area	Value	Lower CI	Upper CI
England	9,781	9,761	9,801
West Midlands region	9,405	9,345	9,465
Stoke-on-Trent	16,628	16,235	17,028
Birmingham	13,388	13,199	13,580
Staffordshire	12,529	12,362	12,698
Telford and Wrekin	10,344	9,960	10,740
Coventry	10,123	9,841	10,411
Solihull	9,481	9,189	9,779
Dudley	8,267	8,041	8,497
Herefordshire	7,922	7,655	8,196
Sandwell	7,732	7,486	7,985
Wolverhampton	7,424	7,165	7,689
Warwickshire	6,530	6,378	6,685
Shropshire	6,284	6,098	6,474
Walsall	5,882	5,667	6,104
Worcestershire	5,417	5,286	5,552

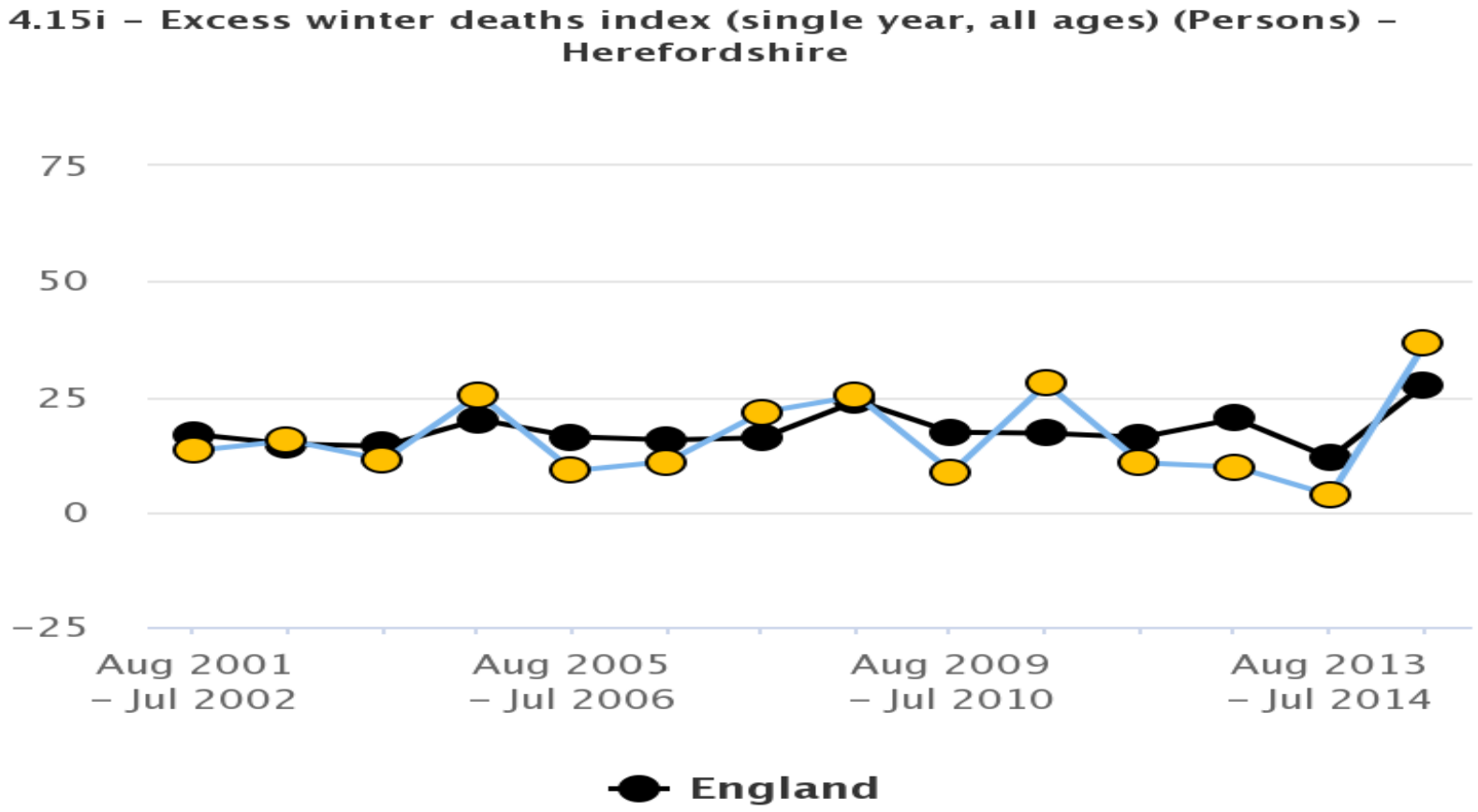
Source: Health and Social Care Information Centre - RAP P1

Social care – People aged 65+ receiving Attendance Allowance per 100,000 population aged 65 and over.

Area	Value	Lower CI	Upper CI
England	149.9	149.6	150.2
West Midlands region	165.5	164.7	166.3
Sandwell	216.5	212.3	220.7
Walsall	197.7	193.7	201.7
Birmingham	190.9	188.6	193.2
Wolverhampton	189.9	185.7	194.2
Coventry	178.8	175.0	182.6
Telford and Wrekin	176.5	171.3	181.7
Dudley	171.2	167.9	174.5
Stoke-on-Trent	161.8	157.9	165.8
Solihull	154.6	150.8	158.4
Shropshire	151.5	148.5	154.5
Worcestershire	150.2	148.0	152.4
Staffordshire	149.6	147.7	151.4
Herefordshire	145.8	142.1	149.5
Warwickshire	136.0	133.8	138.3

Source: DWP

Social care – Excess winter deaths index (single year, all ages)



Social care – Excess winter deaths index (single year, all ages)

4.15i - Excess winter deaths index (single year, all ages) (Persons) Aug 2014 - Jul 2015 Ratio

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	41,707	27.7	26.9	28.4
West Midlands region	–	4,403	26.3	24.2	28.5
Solihull	–	224	39.6	27.5	52.9
Shropshire	–	370	38.2	28.9	48.1
Herefordshire	–	225	36.4	25.0	48.9
Telford and Wrekin	–	139	31.4	18.3	45.9
Sandwell	–	254	28.1	19.0	37.9
Staffordshire	–	737	27.7	22.4	33.4
Dudley	–	258	25.7	17.2	34.9
Warwickshire	–	427	25.2	18.6	32.2
Worcestershire	–	455	24.7	18.4	31.4
Birmingham	–	634	23.5	18.3	29.0
Walsall	–	197	23.0	13.9	32.9
Wolverhampton	–	184	22.8	13.5	32.9
Coventry	–	166	18.6	9.9	27.9
Stoke-on-Trent	–	137	17.2	8.1	27.1

Source: Office for National Statistics: Public Health England Annual Births and Mortality Extracts

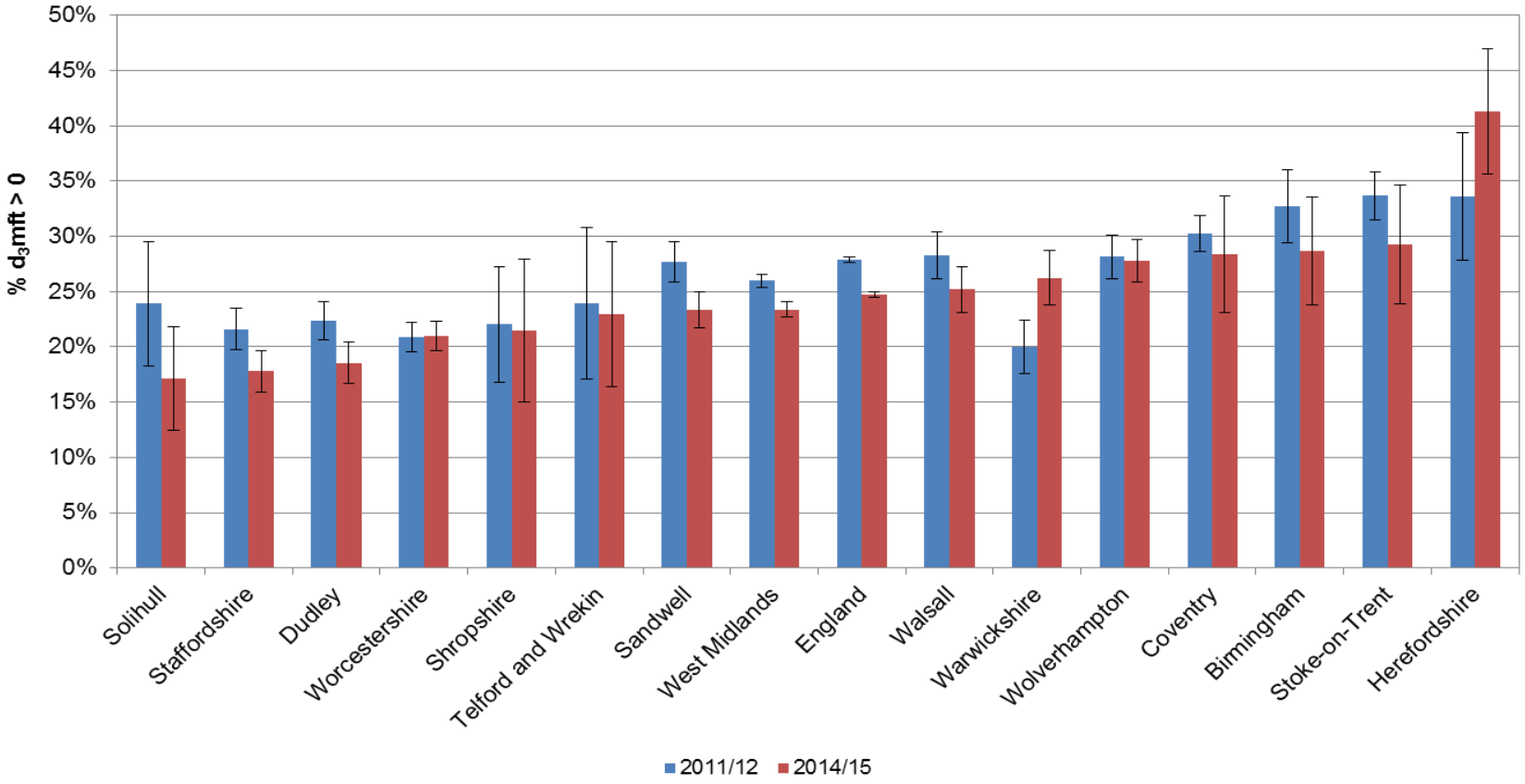
Starting well: mothers, babies and children

- In 2015-16 proportion of mothers who were smokers when giving birth was 8.9 % (national ambition 11%).

- In 2015/16 the proportion of mothers who breastfed their babies for at least six to eight weeks after birth was 52.3% (England average 43.2 %).

- In 2016-17 uptake rates of childhood immunisation, antenatal newborn and children screening have met the national targets

Starting well: Oral Health 5 year olds experienced decay (%dmft >0) (West Midlands Comparison)



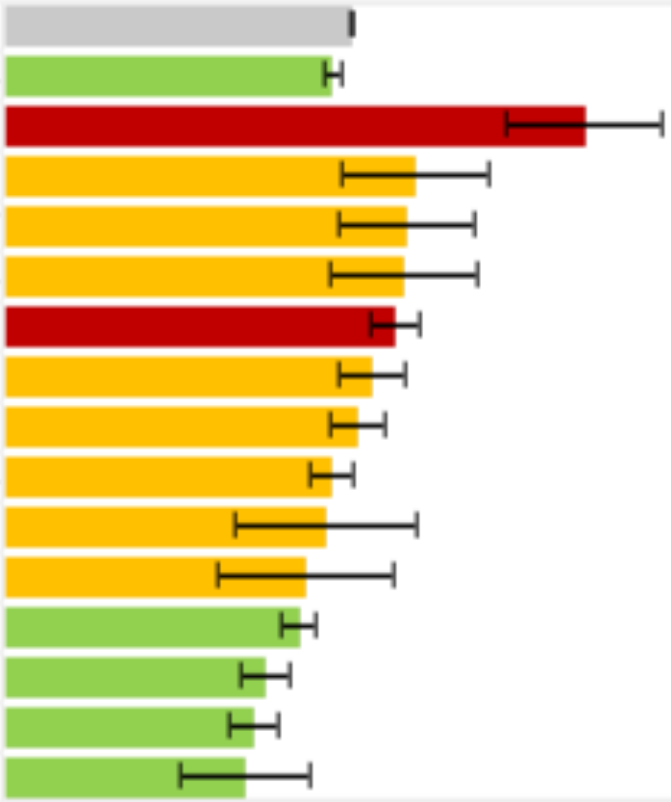
Starting well: Oral Health 5 year olds experienced decay (%dmft >0) 2014-15

Area	Value	Lower CI	Upper CI
England	24.8	24.5	25.0
Fourth less deprived decile (IMD2015)	-	-	-
Herefordshire	41.3	35.6	46.9
Hillingdon	37.8	33.0	42.5
Reading	28.1	23.0	33.1
Northamptonshire	27.1	24.6	29.6
Bedford	26.9	24.0	29.8
Warrington	24.5	16.5	32.5
Wandsworth	23.2	19.1	27.2
Derbyshire	22.2	20.1	24.3
Stockport	21.7	16.5	26.8
Milton Keynes	21.6	19.9	23.2
Nottinghamshire	21.0	18.9	23.1
Suffolk	20.9	19.0	22.8
Cheshire West and Chest...	20.3	14.6	26.1
East Sussex	20.3	16.6	24.1
Kent	16.4	15.1	17.7

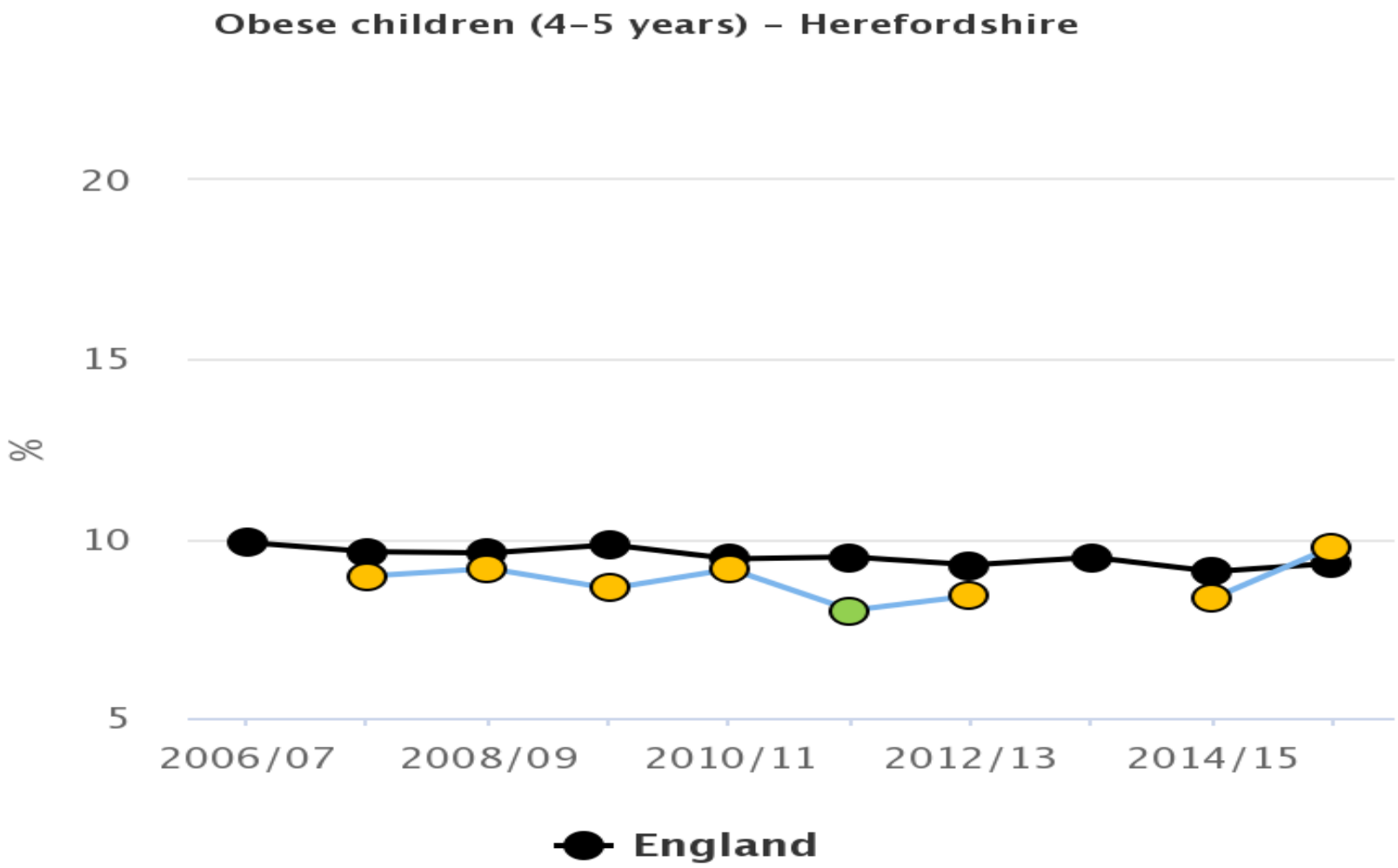
Source: National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2012

Starting well: Oral Health 5 year olds experienced decay (%dmft >0) 2014-15

Area	Value	Lower CI	Upper CI
England	24.8	24.5	25.0
West Midlands region	23.4	22.7	24.1
Herefordshire	41.3	35.6	46.9
Stoke-on-Trent	29.3	23.9	34.6
Birmingham	28.7	23.8	33.6
Coventry	28.4	23.1	33.7
Wolverhampton	27.8	25.9	29.7
Warwickshire	26.3	23.8	28.7
Walsall	25.2	23.1	27.3
Sandwell	23.4	21.7	25.0
Telford and Wrekin	23.0	16.4	29.5
Shropshire	21.5	15.1	27.9
Worcestershire	21.0	19.6	22.3
Dudley	18.5	16.7	20.4
Staffordshire	17.8	15.9	19.7
Solihull	17.1	12.4	21.8



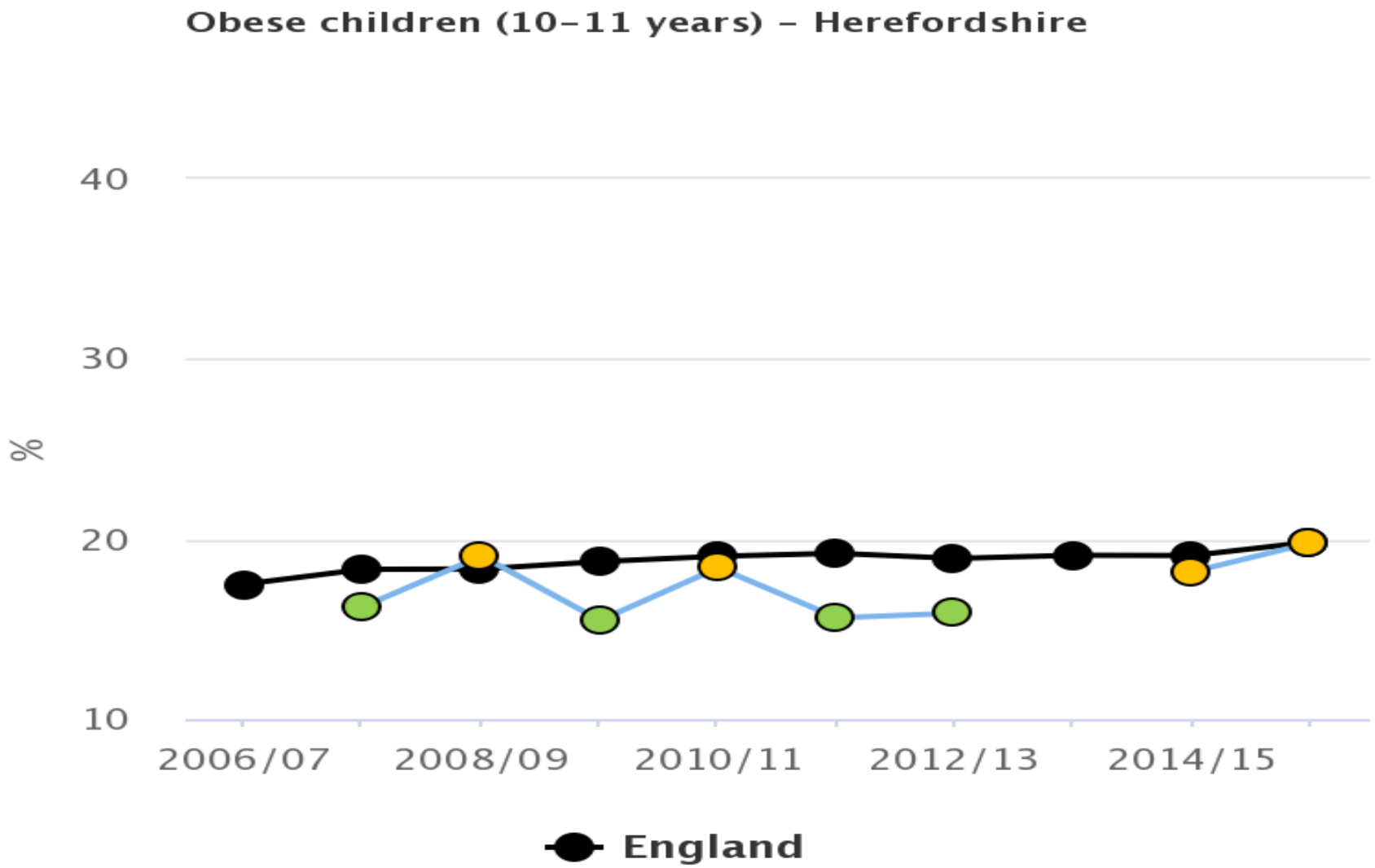
Source: National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2012


Obese children (4–5 years) – Herefordshire
20
15
10
5
%
2006/07
2008/09
2010/11
2012/13
2014/15
England

Starting well: % of Obese children 4-5 years (2015-16)

Area	Value	Lower CI	Upper CI
England	9.3	9.2	9.4
Fourth less deprived decile (IMD2015)	-	-	-
Herefordshire	9.8	8.5	11.2
Reading	9.7	8.6	11.1
Milton Keynes	9.6	8.7	10.6
Hillingdon	9.5	8.6	10.4
Derbyshire	9.4	8.8	10.1
Kent	9.2	8.8	9.6
Suffolk	9.1	8.5	9.8
Warrington	8.9	7.8	10.1
East Sussex	8.9	8.1	9.7
Northamptonshire	8.8	8.2	9.4
Nottinghamshire	8.8	8.2	9.4
Stockport	8.7	7.8	9.7
Cheshire West and Chest...	8.2	7.3	9.1
Bedford	8.1	7.0	9.3
Wandsworth	7.6	6.7	8.7

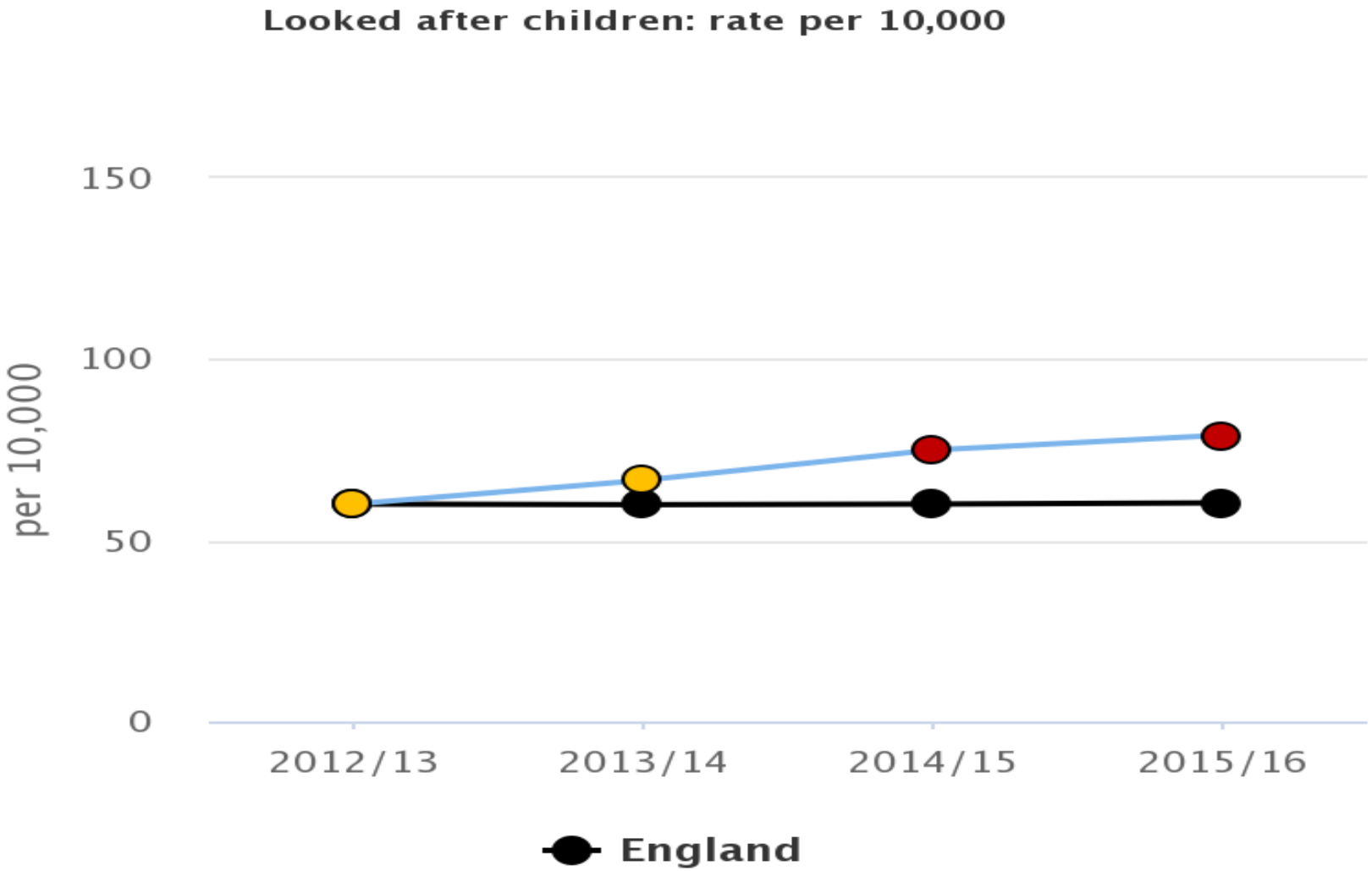
Source: NHS Digital, National Child Measurement Programme


Obese children (10–11 years) – Herefordshire
40
30
20
10
%
2006/07
2008/09
2010/11
2012/13
2014/15
England

Starting well: % of Obese children 10-11 years (2015-16)

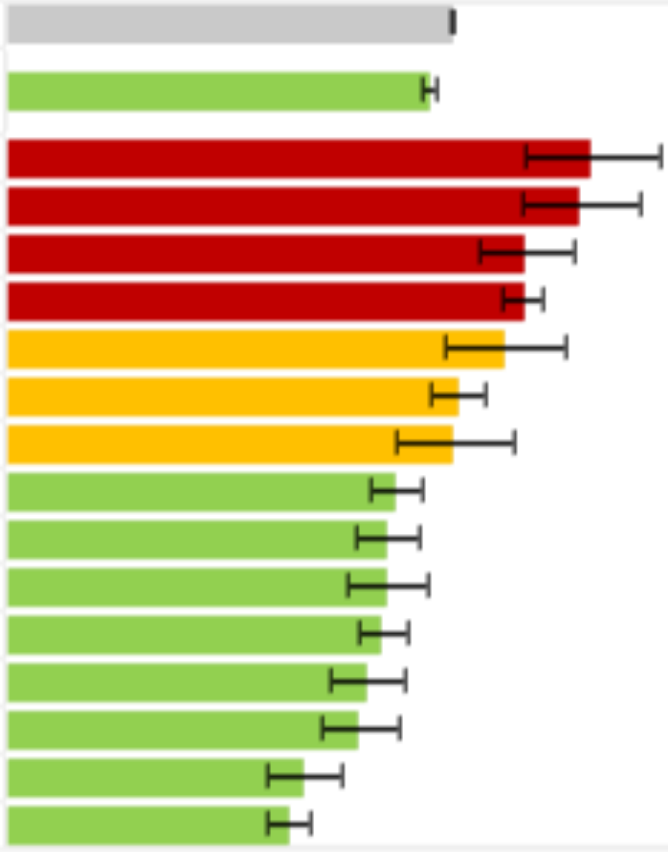
Area	Value	Lower CI	Upper CI
England	19.8	19.7	19.9
Fourth less deprived decile (IMD2015)	-	-	-
Reading	22.0	20.1	24.1
Hillingdon	21.2	19.9	22.7
Bedford	19.9	18.1	21.9
Herefordshire	19.8	17.9	21.8
Milton Keynes	19.0	17.7	20.4
Cheshire West and Chest...	18.8	17.5	20.2
East Sussex	18.8	17.7	19.9
Kent	18.7	18.1	19.4
Warrington	18.7	17.1	20.3
Northamptonshire	18.3	17.4	19.2
Wandsworth	18.0	16.4	19.8
Derbyshire	17.9	17.1	18.8
Suffolk	17.6	16.7	18.5
Nottinghamshire	16.7	15.8	17.6
Stockport	16.5	15.2	17.9

Source: NHS Digital, National Child Measurement Programme

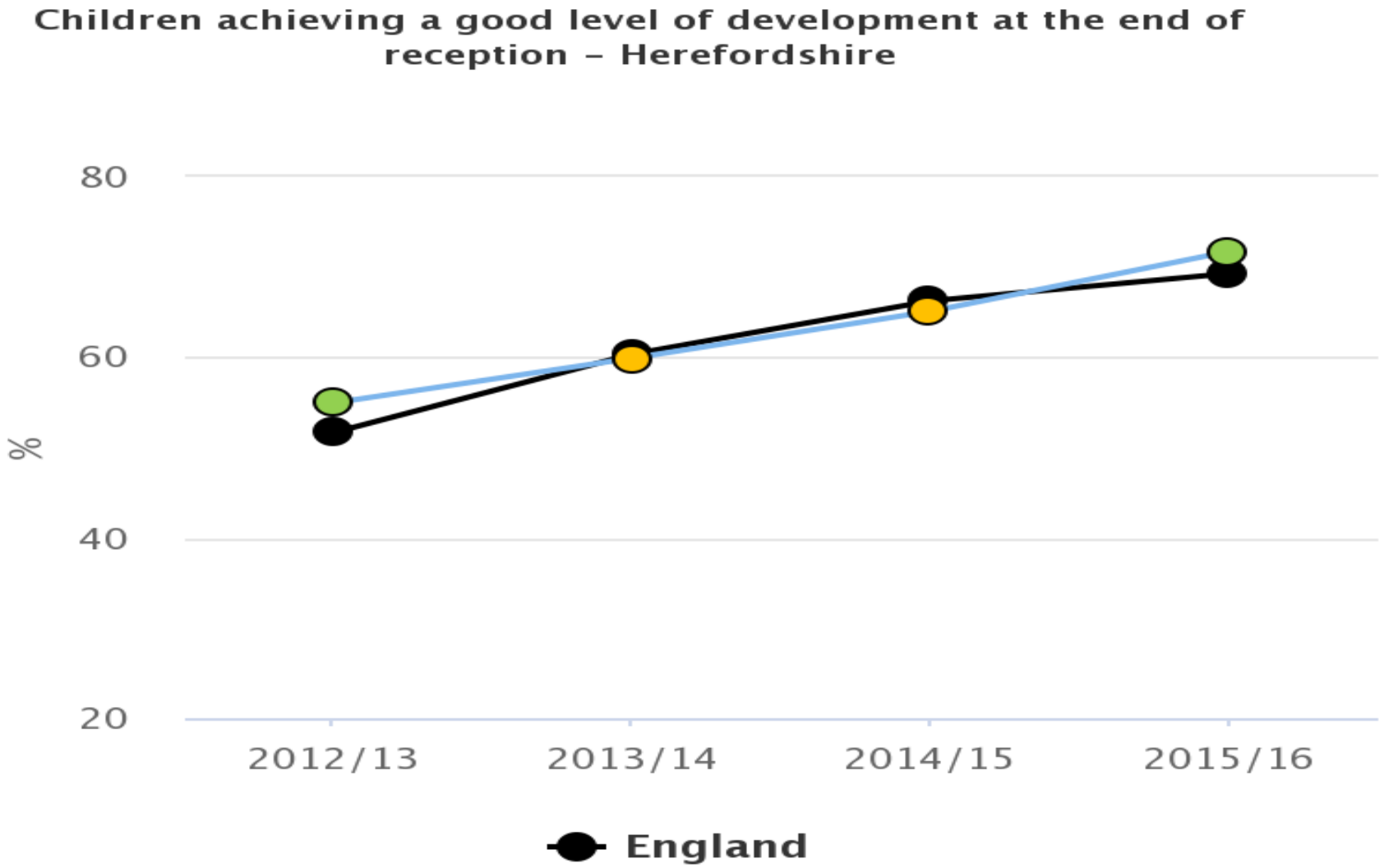

Looked after children: rate per 10,000
150
100
50
0
per 10,000
2012/13
2013/14
2014/15
2015/16
England

Starting well: Looked after children (crude rate per 10,000) 2015-16

Area	Value	Lower CI	Upper CI
England	60*	60	61
Fourth less deprived decile (IMD2015)	57*	56	58
Herefordshire	79*	70	89
Warrington	78*	70	86
Cheshire West and Chest...	70*	64	77
Kent	70*	67	73
Bedford	67*	59	76
Northamptonshire	61*	57	65
Reading	60*	53	69
Suffolk	53*	49	56
East Sussex	51*	47	56
Milton Keynes	51*	46	57
Nottinghamshire	51*	47	54
Hillingdon	49*	44	54
Stockport	48*	42	53
Wandsworth	40*	35	46
Derbyshire	38*	35	41



Source: Children looked after in England, Department for Education.

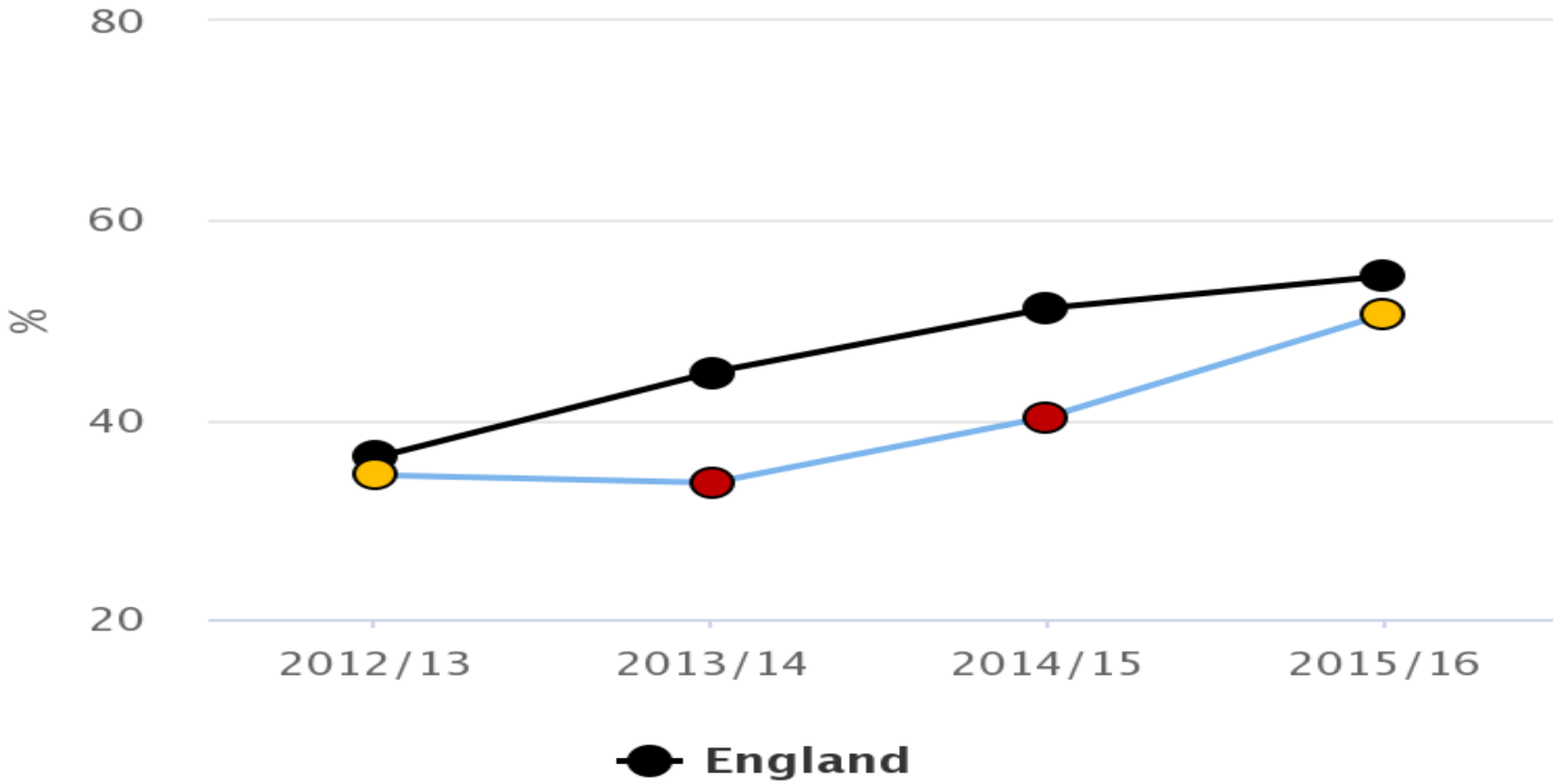

Children achieving a good level of development at the end of reception – Herefordshire
80
60
40
20
%
2012/13
2013/14
2014/15
2015/16
England

Starting well: GLD at end of reception (%) (2015-16)

Area	Value	Lower CI	Upper CI
England	69.3	69.2	69.4
Fourth less deprived decile (IMD2015)	71.0*	70.7	71.3
East Sussex	75.7	74.6	76.8
Kent	74.8	74.2	75.4
Wandsworth	72.5	70.9	74.0
Herefordshire	71.7	69.7	73.7
Milton Keynes	71.6	70.2	73.0
Warrington	71.5	69.7	73.2
Reading	71.0	69.0	72.9
Cheshire West and Chest...	70.9	69.5	72.3
Derbyshire	70.8	69.8	71.7
Suffolk	70.2	69.2	71.1
Stockport	69.6	68.1	71.1
Hillingdon	69.6	68.2	70.9
Northamptonshire	68.1	67.2	69.0
Nottinghamshire	67.0	66.1	68.0
Bedford	63.5	61.5	65.5

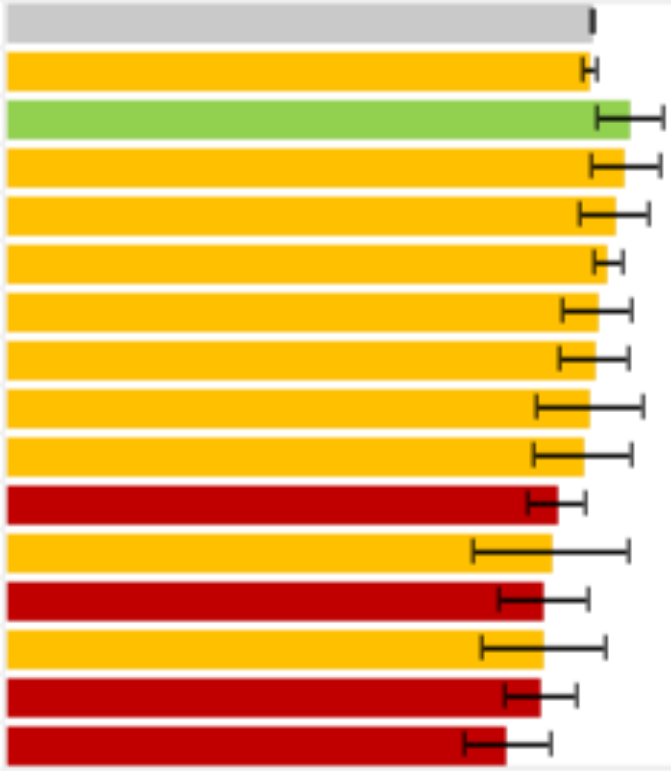
Source: Department for Education (DfE), EYFS Profile: EYFS Profile statistical series

School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception – Herefordshire



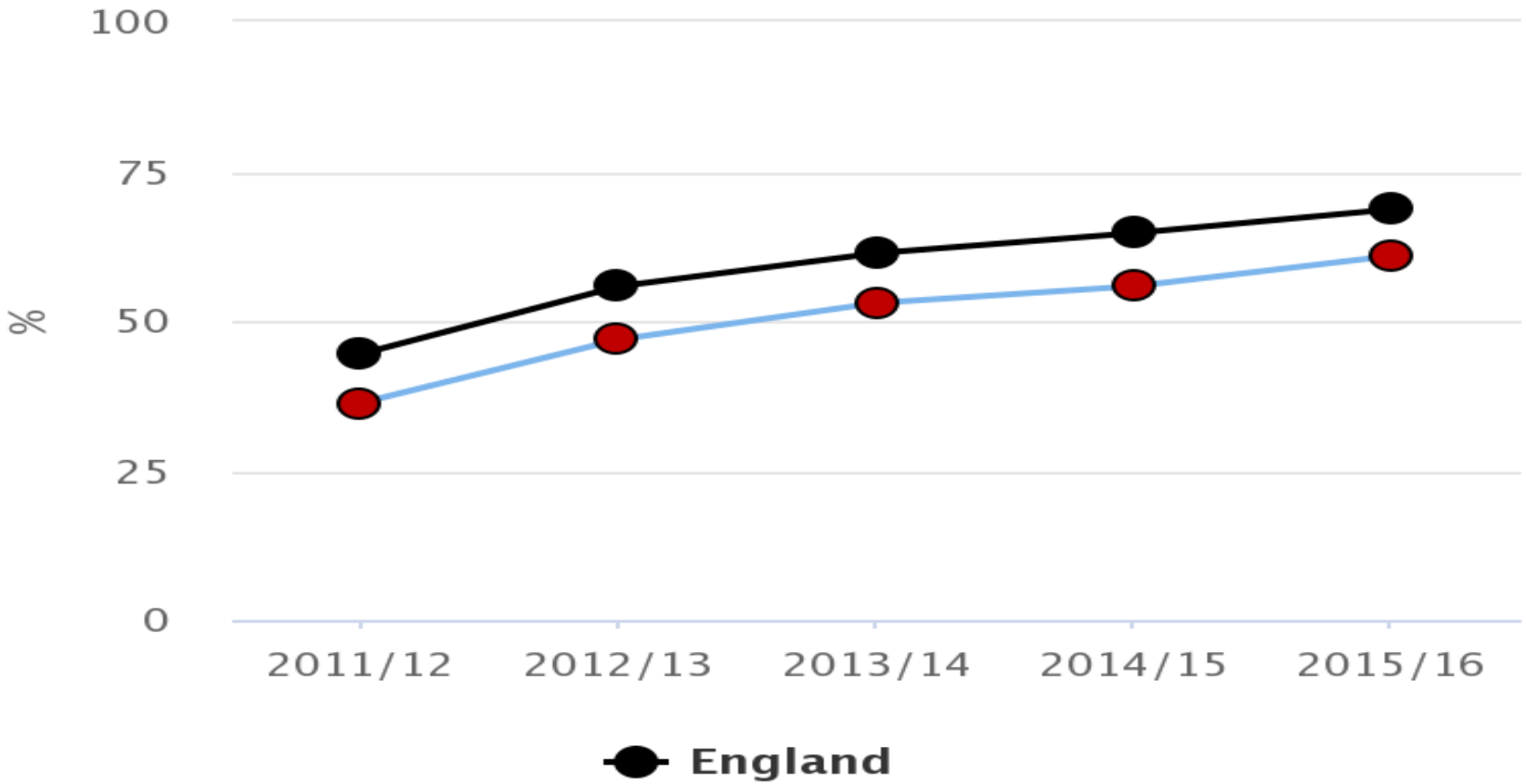
Starting well: GLD at end of reception with free school meal status (%) (2015-16)

Area	Value	Lower CI	Upper CI
England	54.4	54.1	54.7
West Midlands region	54.2	53.3	55.0
Staffordshire	57.9	54.7	61.1
Coventry	57.4	54.0	60.7
Stoke-on-Trent	56.4	52.9	59.8
Birmingham	55.8	54.3	57.3
Wolverhampton	54.8	51.4	58.2
Walsall	54.6	51.2	57.8
Telford and Wrekin	54.2	49.1	59.2
Solihull	53.5	48.8	58.2
Sandwell	51.1	48.2	53.9
Herefordshire	50.6	43.2	58.0
Warwickshire	49.9	45.7	54.1
Shropshire	49.8	43.8	55.8
Worcestershire	49.5	46.1	52.9
Dudley	46.5	42.2	50.7



Source: Department for Education, Early Years Foundation Stage Profile (EYFS Profile): Early Years Foundation Stage Profile statistical series

School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check – Herefordshire

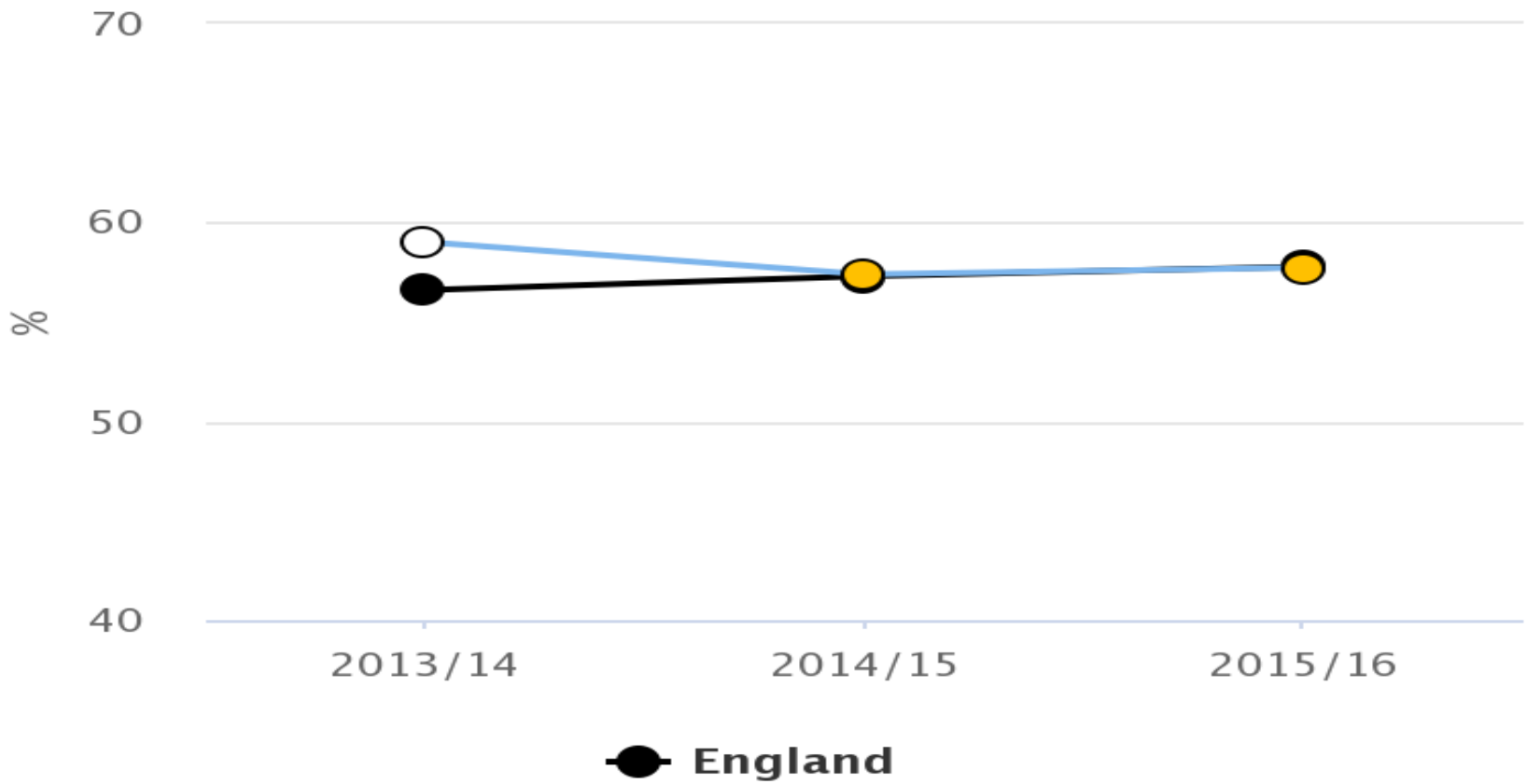


School Readiness: % of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check (2015-16)

Area	Value	Lower CI	Upper CI
England	68.6	68.3	68.9
West Midlands region	70.4	69.6	71.2
Walsall	73.6	70.5	76.5
Solihull	73.0	68.6	76.9
Birmingham	72.9	71.6	74.2
Telford and Wrekin	72.5	67.6	76.9
Sandwell	71.1	68.1	73.8
Stoke-on-Trent	70.5	67.2	73.7
Wolverhampton	70.3	67.0	73.5
Coventry	70.1	67.0	73.1
Staffordshire	67.9	64.8	70.8
Warwickshire	66.0	62.1	69.8
Shropshire	66.0	59.9	71.6
Worcestershire	64.4	60.9	67.7
Dudley	64.1	60.1	67.9
Herefordshire	60.9	53.7	67.6

Source: Department for Education, Teacher Assessments: Phonics screening check statistical series

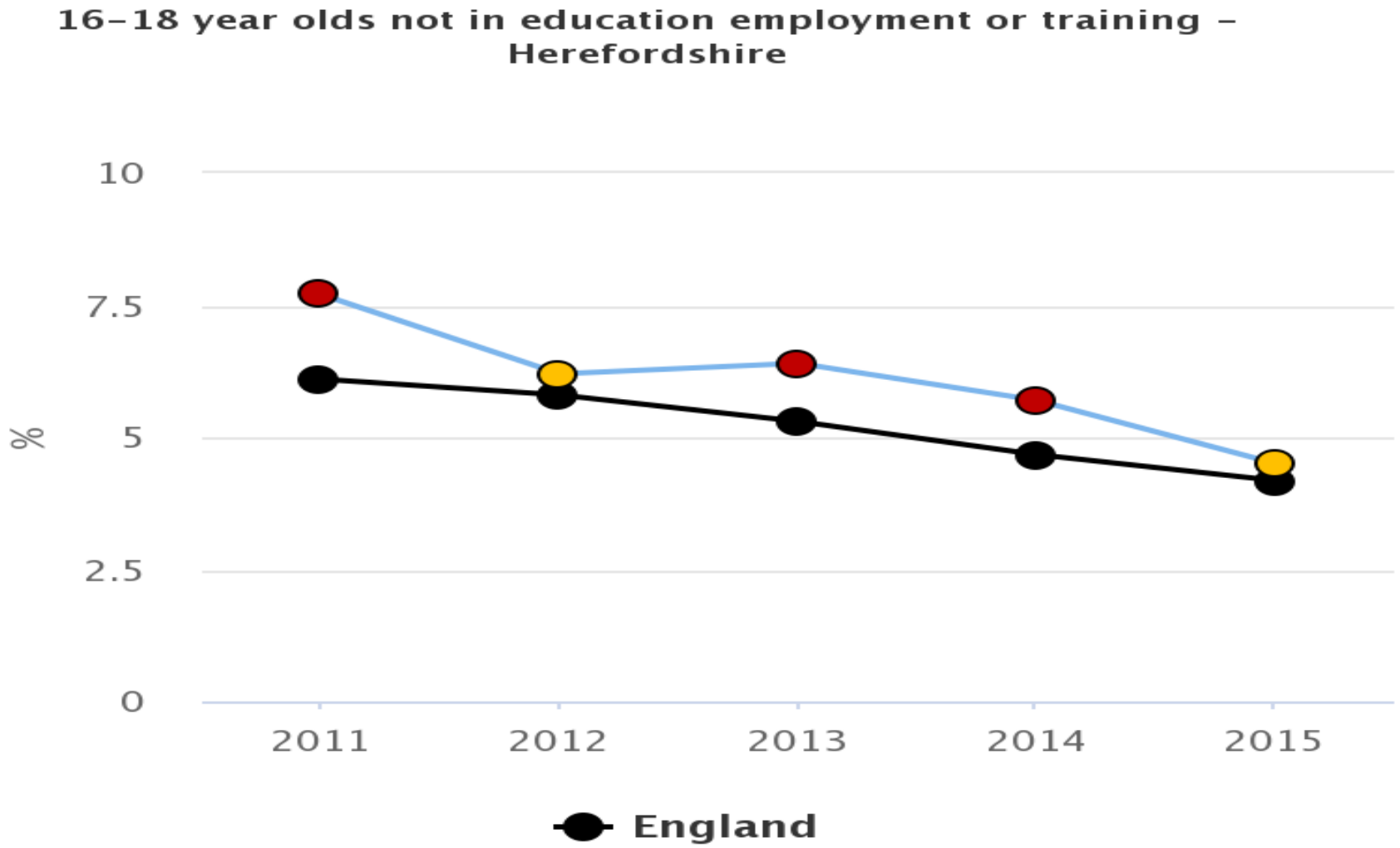
GCSEs achieved (5A*–C including English & Maths) – Herefordshire



Educational Attainment: % of pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) 2015-16

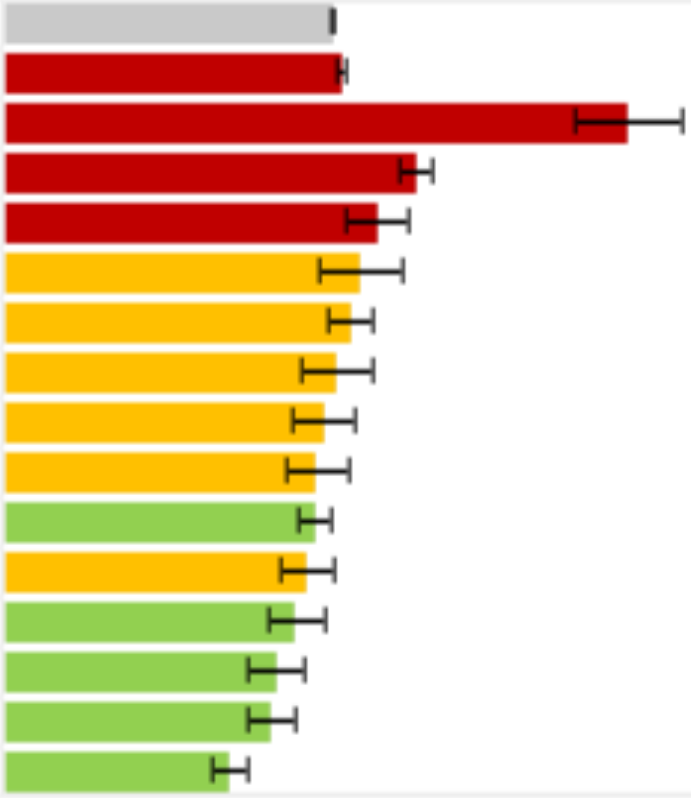
Area	Value	Lower CI	Upper CI
England	57.8	57.6	57.9
West Midlands region	54.8	54.4	55.2
Solihull	64.6	62.6	66.5
Warwickshire	61.9	60.6	63.2
Worcestershire	60.9	59.6	62.2
Herefordshire	57.7	55.4	60.0
Shropshire	57.3	55.5	59.1
Staffordshire	56.1	55.0	57.1
Coventry	54.3	52.6	56.0
Birmingham	52.3	51.4	53.2
Wolverhampton	52.1	50.2	53.9
Telford and Wrekin	50.6	48.4	52.8
Walsall	50.2	48.5	52.0
Dudley	50.0	48.3	51.7
Sandwell	48.5	46.9	50.1
Stoke-on-Trent	48.4	46.4	50.3

Source: Data downloaded from the Department for Education website


16–18 year olds not in education employment or training – Herefordshire
10
7.5
5
2.5
0
%
2011
2012
2013
2014
2015
England

Starting well: % of 16-18 year olds not in education, employment or training (2015)

Area	Value	Lower CI	Upper CI
England	4.2	4.2	4.2
West Midlands region	4.3	4.2	4.4
Telford and Wrekin	7.9*	7.2	8.6
Birmingham	5.2*	5.0	5.5
Coventry	4.7	4.3	5.1
Herefordshire	4.5	4.0	5.1
Warwickshire	4.4*	4.1	4.7
Solihull	4.2	3.8	4.7
Shropshire	4.1	3.7	4.5
Stoke-on-Trent	4.0	3.6	4.4
Staffordshire	3.9	3.7	4.2
Dudley	3.8	3.5	4.2
Walsall	3.7	3.3	4.1
Wolverhampton	3.4	3.1	3.8
Sandwell	3.4	3.1	3.7
Worcestershire	2.9	2.6	3.1



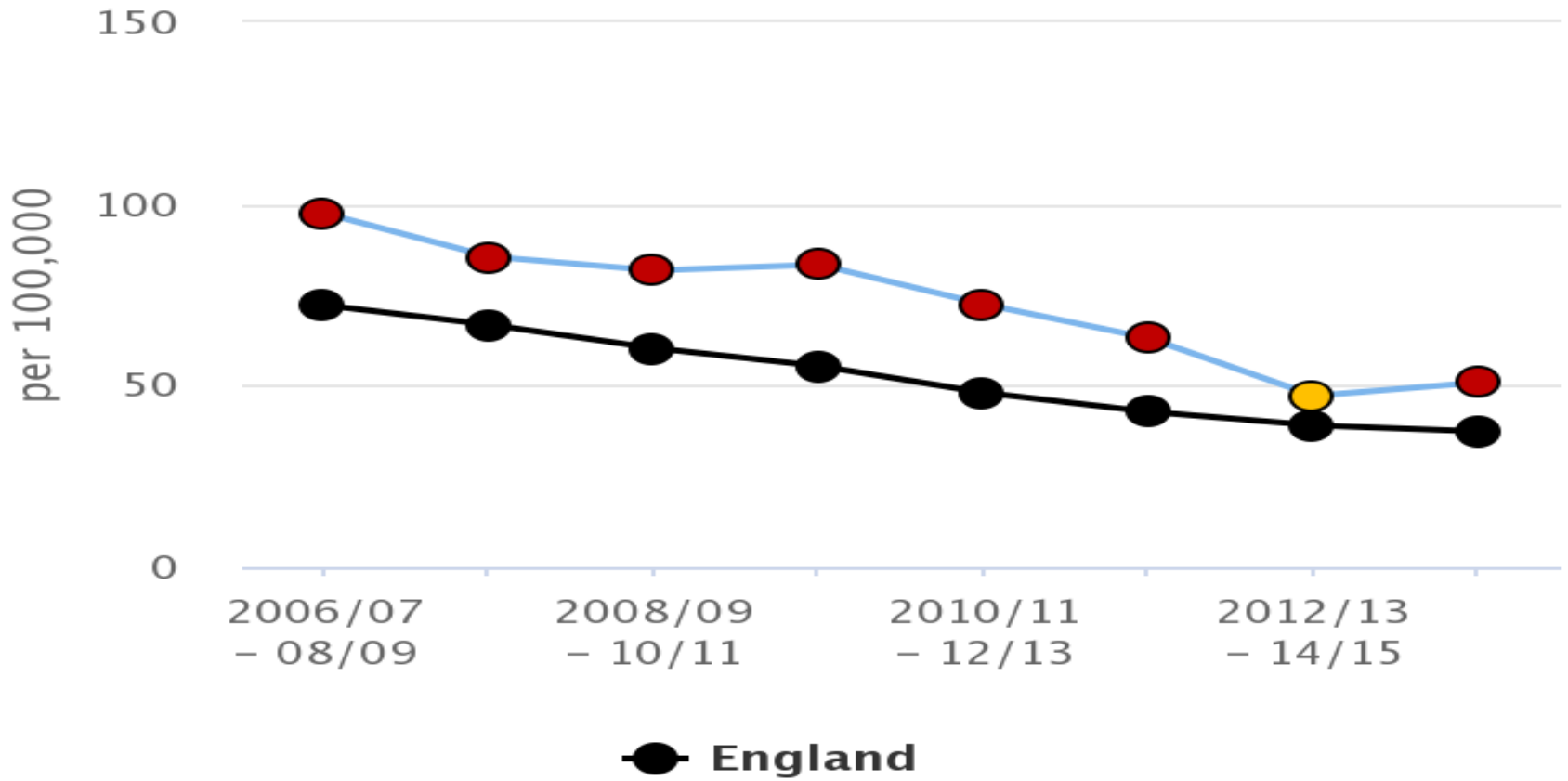
Source: Department for Education

Starting well: % of 15 year olds drinking regularly

Area	Value	Lower CI	Upper CI
England	6.2	6.0	6.4
West Midlands region	5.5	5.1	5.9
Dudley	8.9	7.3	10.5
Warwickshire	8.5	6.9	10.1
Herefordshire	7.8	6.3	9.2
Shropshire	7.1	5.7	8.5
Staffordshire	6.5	5.1	8.0
Worcestershire	6.1	4.8	7.5
Telford and Wrekin	6.0	4.7	7.3
Stoke-on-Trent	5.7	4.4	7.0
Solihull	5.4	4.1	6.7
Wolverhampton	5.0	3.7	6.3
Walsall	4.8	3.6	6.0
Sandwell	4.4	3.2	5.6
Coventry	4.3	3.1	5.4
Birmingham	2.8	1.8	3.7

Source: What About YOUth (WAY) survey 2014/15

5.02 – Admission episodes for alcohol–specific conditions – Under 18s (Persons) – Herefordshire

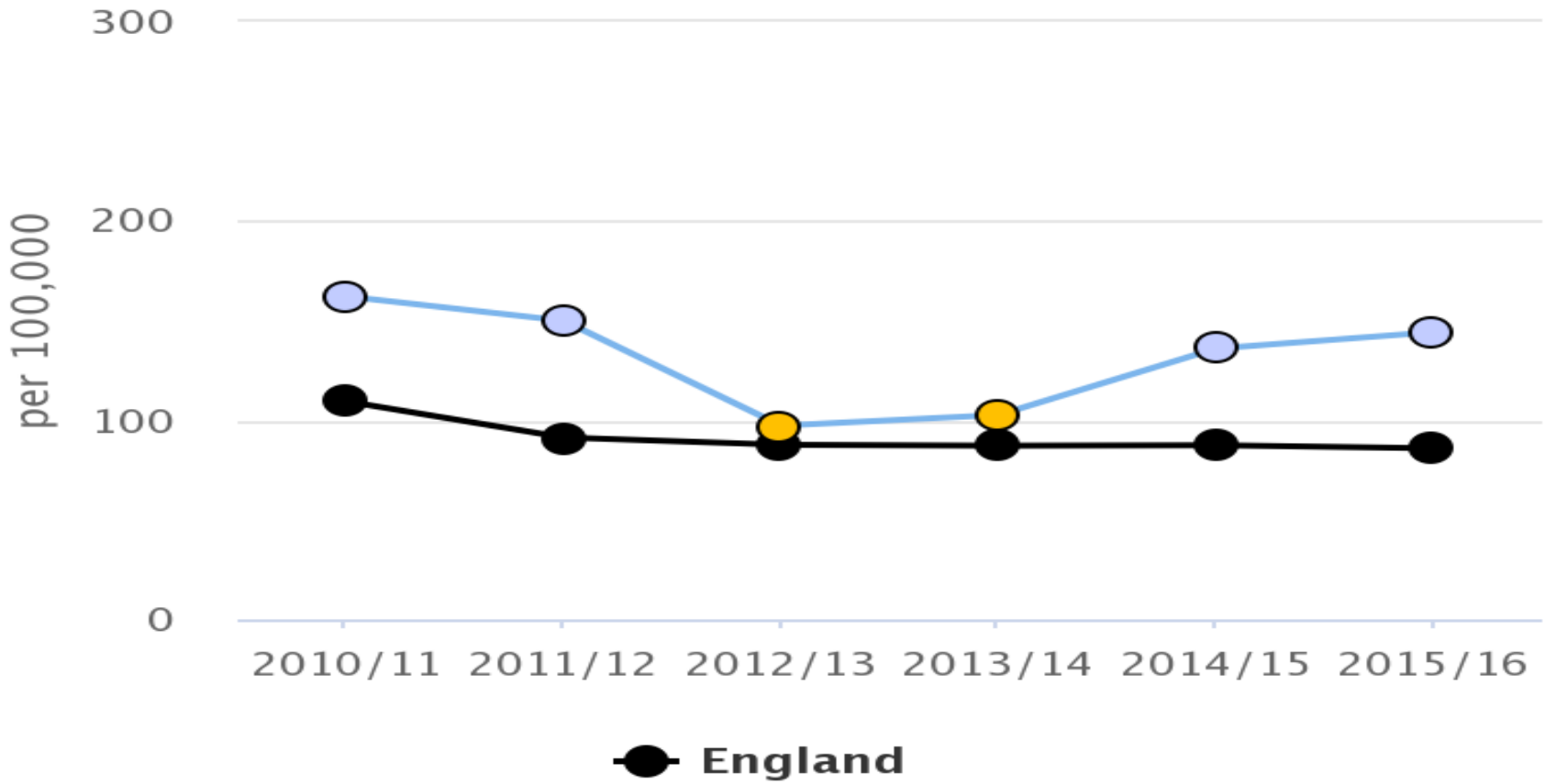


5.02 - Admission episodes for alcohol-specific conditions - Under 18s (Persons) 2013/14 - 15/16 Crude rate - per 100,000

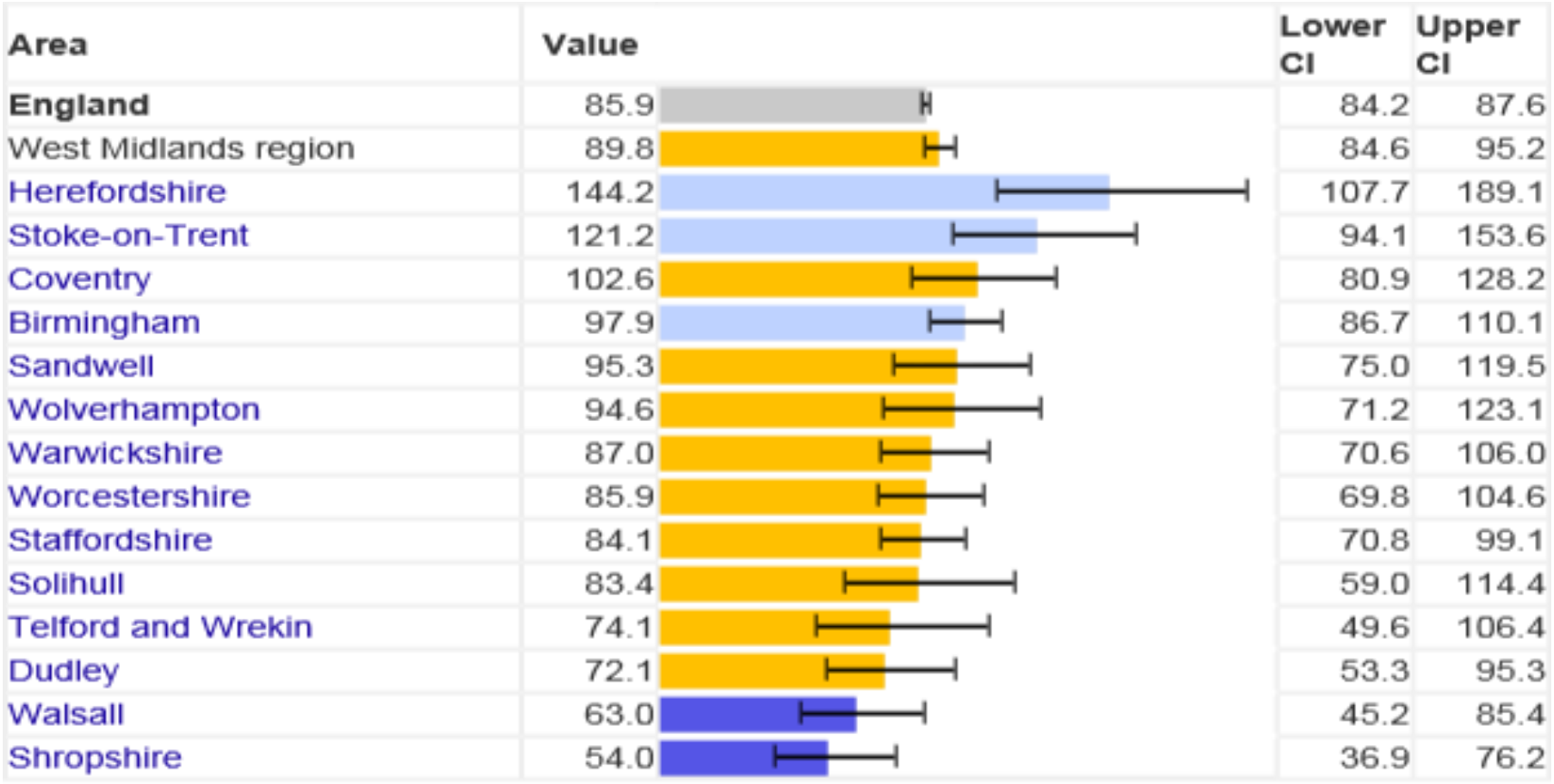
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	12,998	37.4	36.7	38.0
West Midlands region	-	1,228	32.6	30.8	34.4
Herefordshire	-	55	50.8	38.3	66.2
Warwickshire	-	155	46.0	39.1	53.9
Coventry	-	99	44.5	36.2	54.2
Dudley	-	77	37.8	29.9	47.3
Staffordshire	-	192	37.7	32.6	43.5
Sandwell	-	83	35.6	28.3	44.1
Solihull	-	48	35.2	26.0	46.7
Stoke-on-Trent	-	58	34.7	26.4	44.9
Shropshire	-	60	33.5	25.6	43.1
Telford and Wrekin	-	38	32.5	23.0	44.5
Worcestershire	-	105	30.4	24.9	36.8
Wolverhampton	-	52	30.1	22.5	39.5
Walsall	-	56	28.9	21.9	37.6
Birmingham	-	150	17.7	15.0	20.8

Source: Calculated by Public Health England: Risk Factors Intelligence team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Child hospital admissions for mental health conditions: rate per 100,000 aged 0 –17 years – Herefordshire

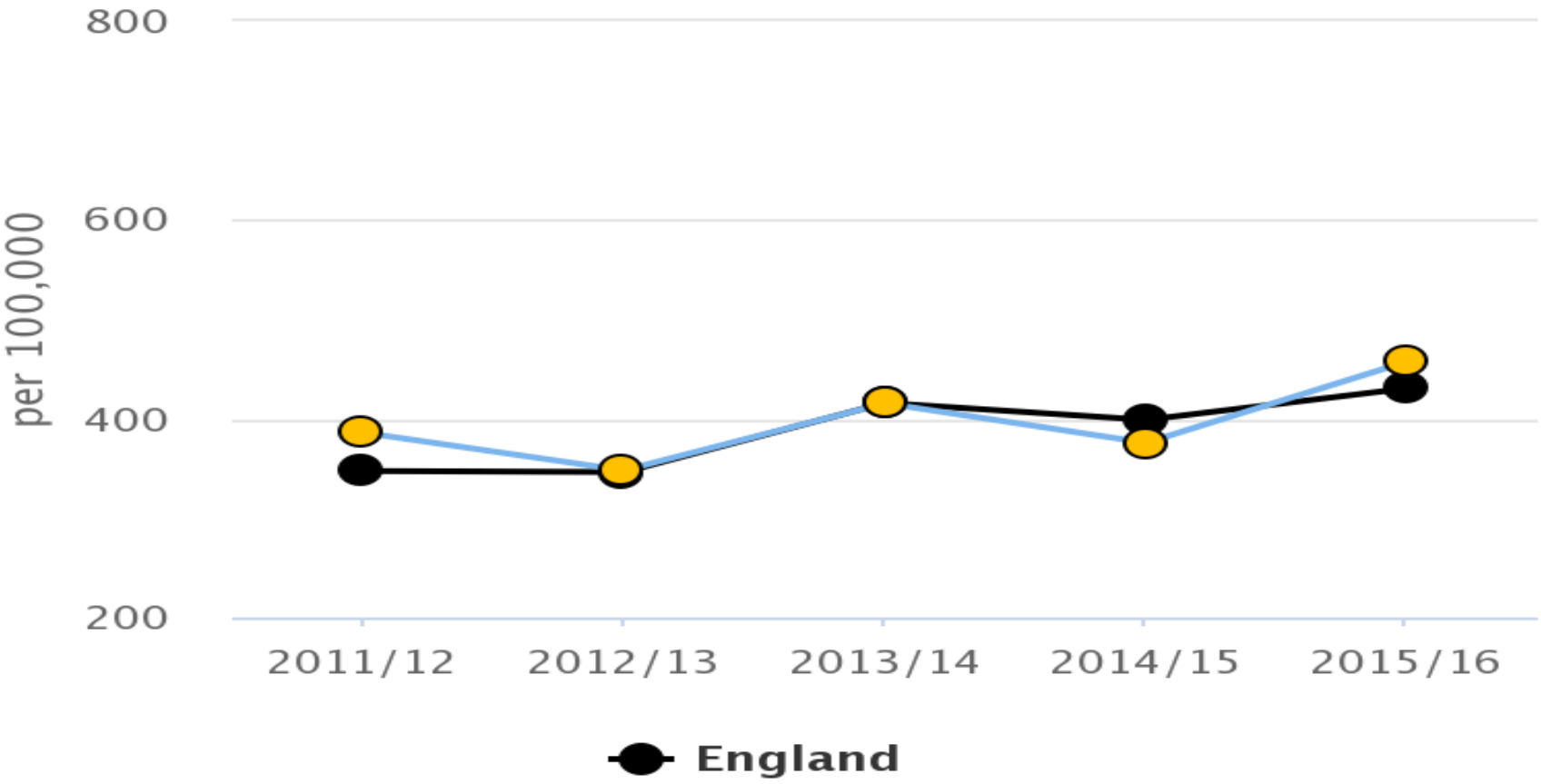


Child hospital admissions for mental health conditions: rate per 100,000 aged 0 -17 years 2015-16



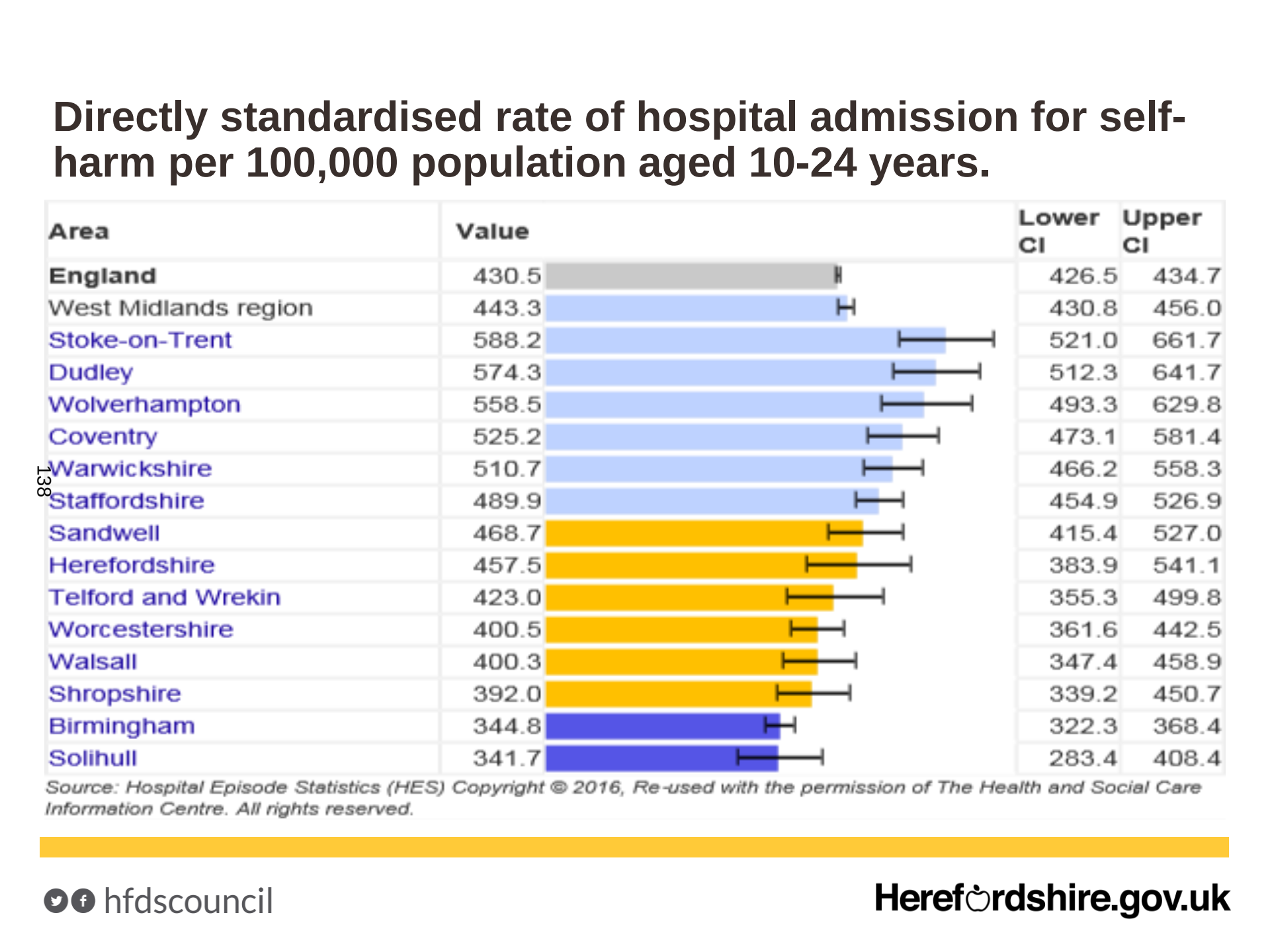
Area	Value	Lower CI	Upper CI
England	85.9	84.2	87.6
West Midlands region	89.8	84.6	95.2
Herefordshire	144.2	107.7	189.1
Stoke-on-Trent	121.2	94.1	153.6
Coventry	102.6	80.9	128.2
Birmingham	97.9	86.7	110.1
Sandwell	95.3	75.0	119.5
Wolverhampton	94.6	71.2	123.1
Warwickshire	87.0	70.6	106.0
Worcestershire	85.9	69.8	104.6
Staffordshire	84.1	70.8	99.1
Solihull	83.4	59.0	114.4
Telford and Wrekin	74.1	49.6	106.4
Dudley	72.1	53.3	95.3
Walsall	63.0	45.2	85.4
Shropshire	54.0	36.9	76.2

Hospital admissions as a result of self-harm (10-24 years): directly standardised rate per 100,000 population aged 10-24 - Herefordshire

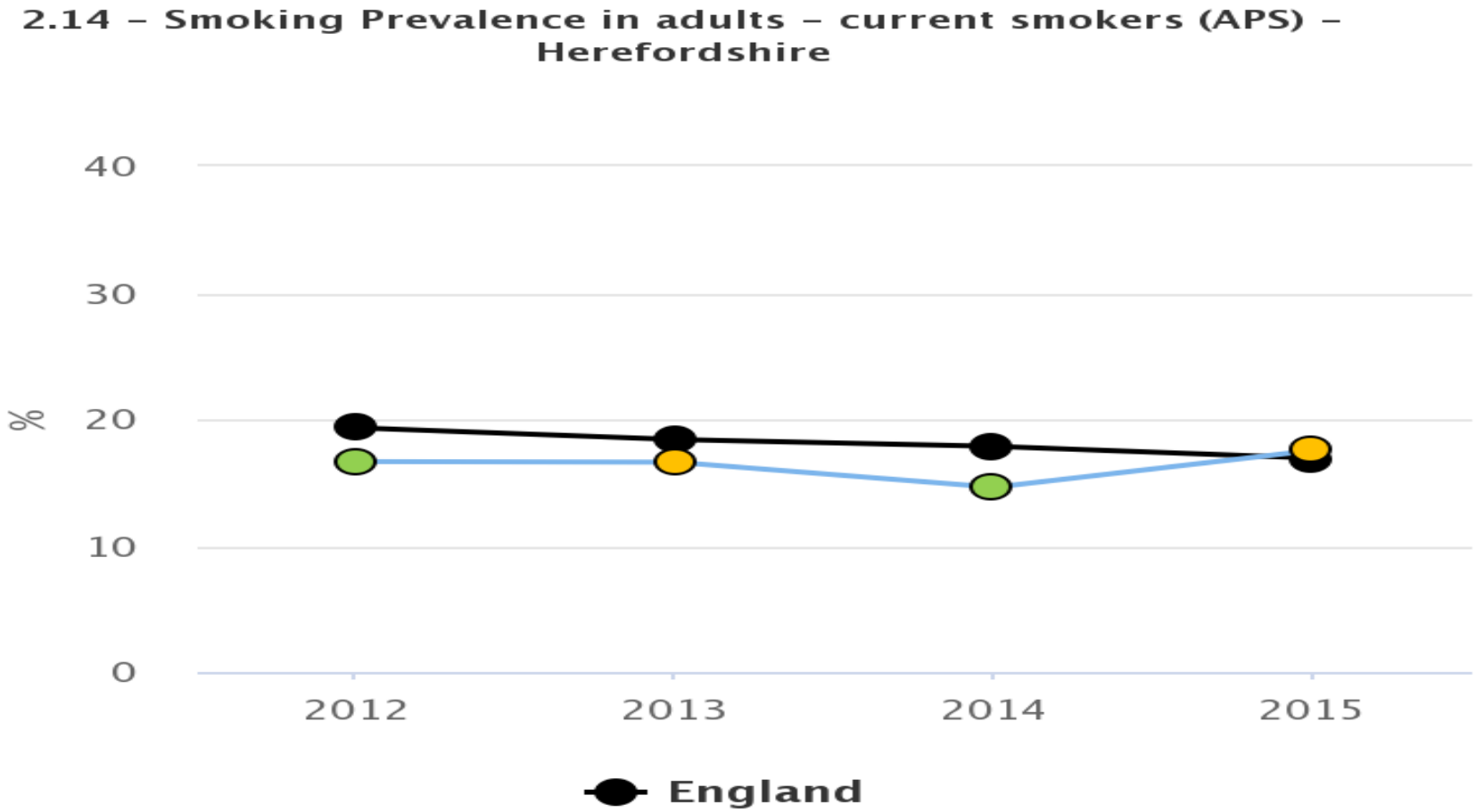


Directly standardised rate of hospital admission for self-harm per 100,000 population aged 10-24 years.

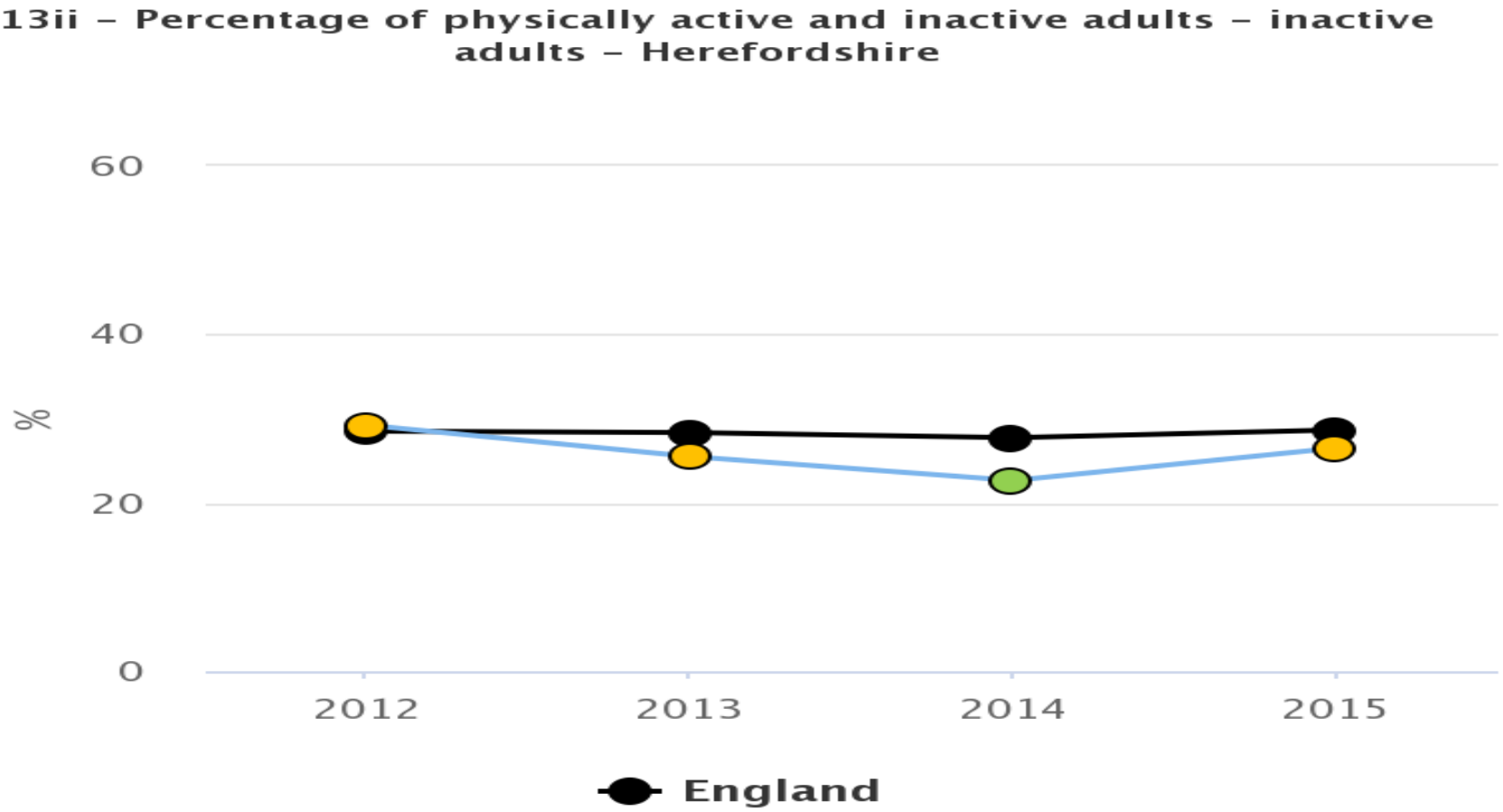
Area	Value	Lower CI	Upper CI
England	430.5	426.5	434.7
West Midlands region	443.3	430.8	456.0
Stoke-on-Trent	588.2	521.0	661.7
Dudley	574.3	512.3	641.7
Wolverhampton	558.5	493.3	629.8
Coventry	525.2	473.1	581.4
Warwickshire	510.7	466.2	558.3
Staffordshire	489.9	454.9	526.9
Sandwell	468.7	415.4	527.0
Herefordshire	457.5	383.9	541.1
Telford and Wrekin	423.0	355.3	499.8
Worcestershire	400.5	361.6	442.5
Walsall	400.3	347.4	458.9
Shropshire	392.0	339.2	450.7
Birmingham	344.8	322.3	368.4
Solihull	341.7	283.4	408.4



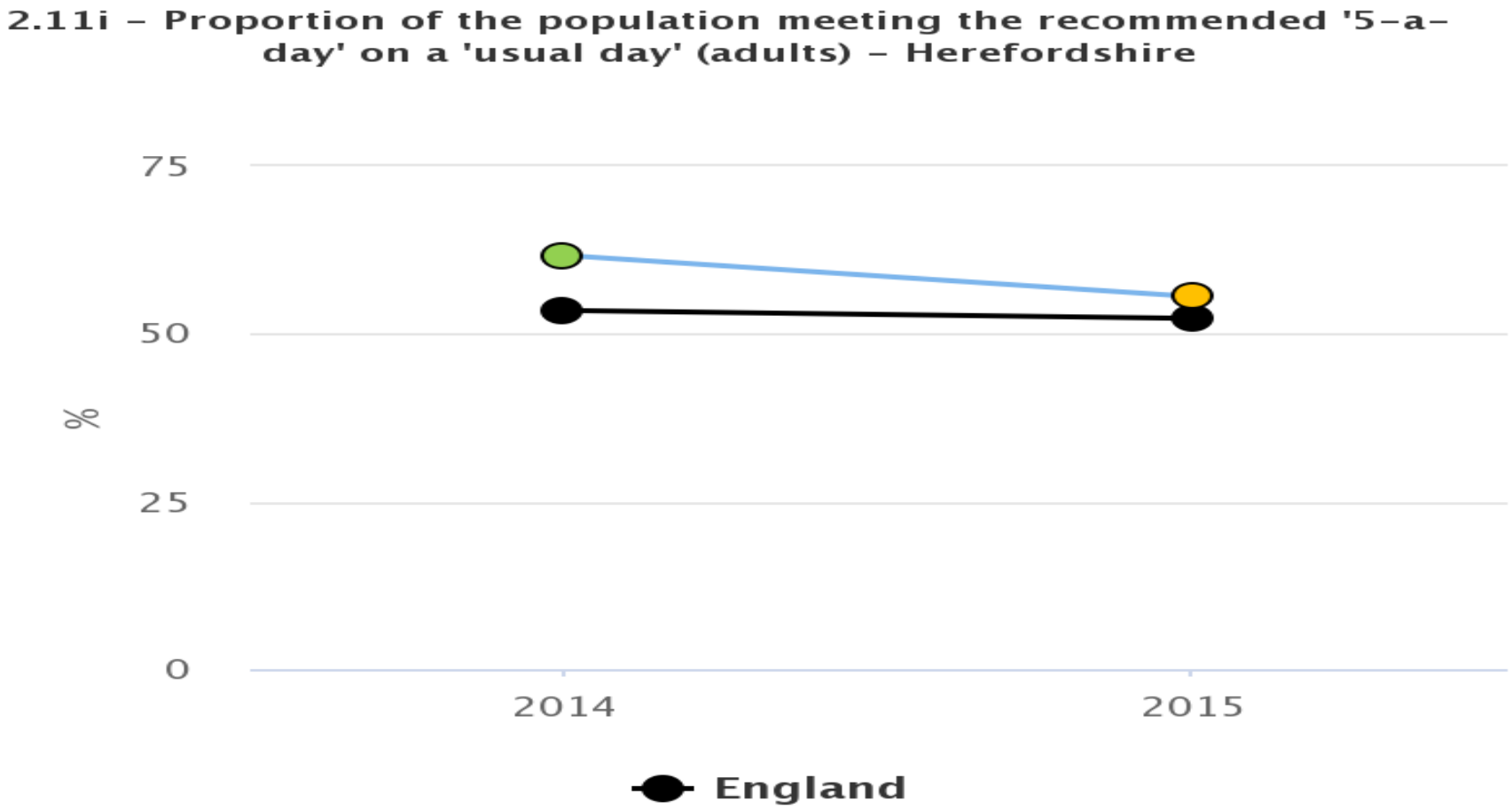
Living well: Healthy Lifestyles



Living well: Healthy Lifestyles



Living well: Healthy Lifestyles



Living well: Healthy Lifestyles (population %) (2015-16)

Lifestyle	Hereford	England Average	England Best
Smoking	17.5	16.9	9.5
Excess Weight	63.9	64.8	46.5
Physically Active	63.3	57.0	69.8
Physically Inactive	26.5	28.7	17.5
5 A Day Fruit/Veg	58.3	52.4	67.6
Alcohol consumption >14units/week	25.9	25.7	-

Living Longer – Prevalence of Long Term Conditions (%) (2015-16)

Long Term Medical Condition (LTC)	Herefordshire	England
Cancer	3.2	2.4
Coronary Heart Disease	3.5	3.2
Stroke	2.2	1.7
Hypertension	16	13.8
Diabetes	6.4	6.4
Chronic Kidney Disease (CKD)	4.8	4.1
Asthma	6.2	5.9

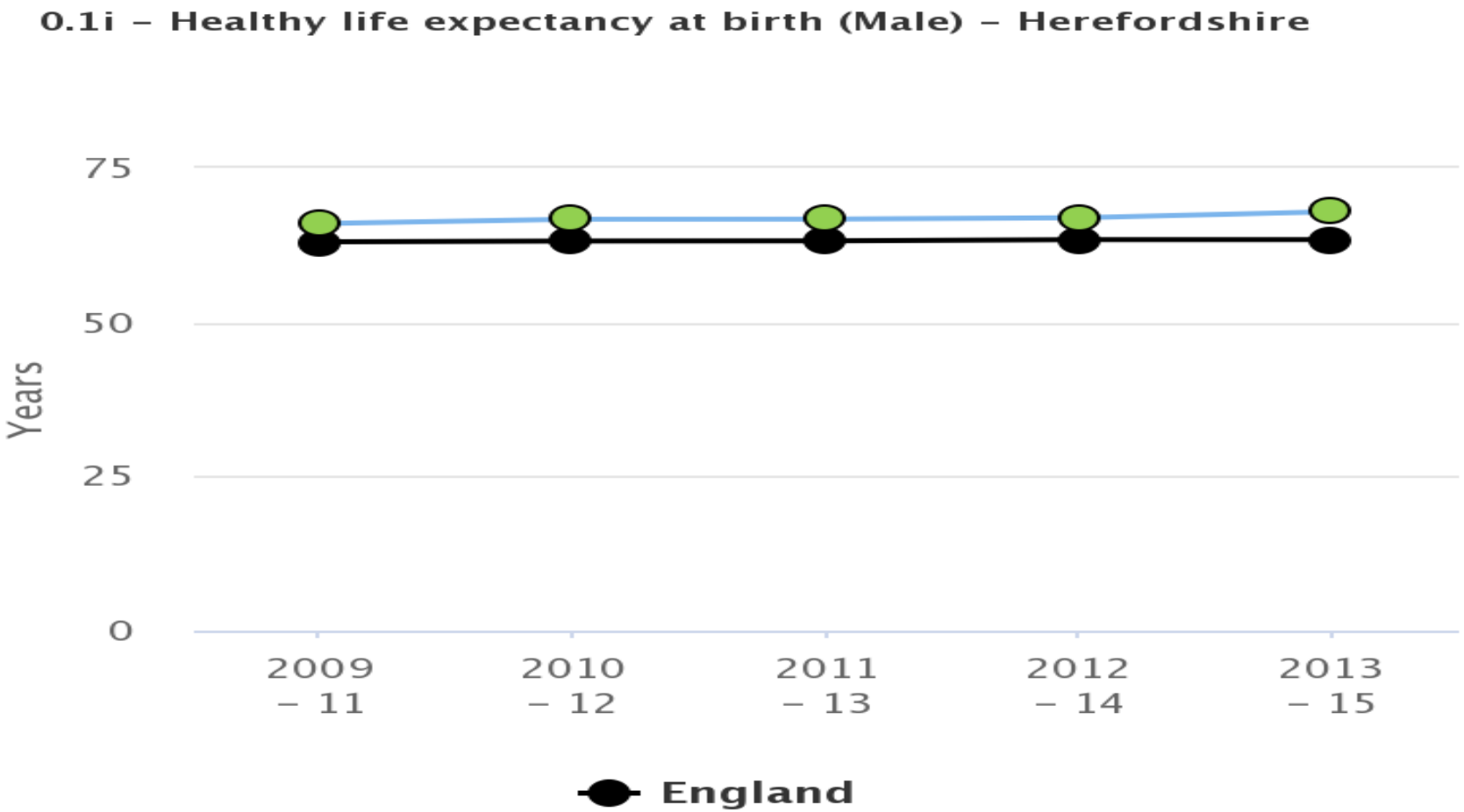
Living Longer – Prevalence of Long Term Conditions (%) (2015-16)

Long Term Medical Condition (LTC)	Herefordshire	England
COPD	2.1	1.9
Depression	7.4	8.3
Learning Disabilities	0.52	0.5
Dementia	0.87	0.8
Osteoporosis	0.34	0.3
Rheumatoid Arthritis	0.99	0.7
Over all LTC Prevalence	**55.4**	**53.2**

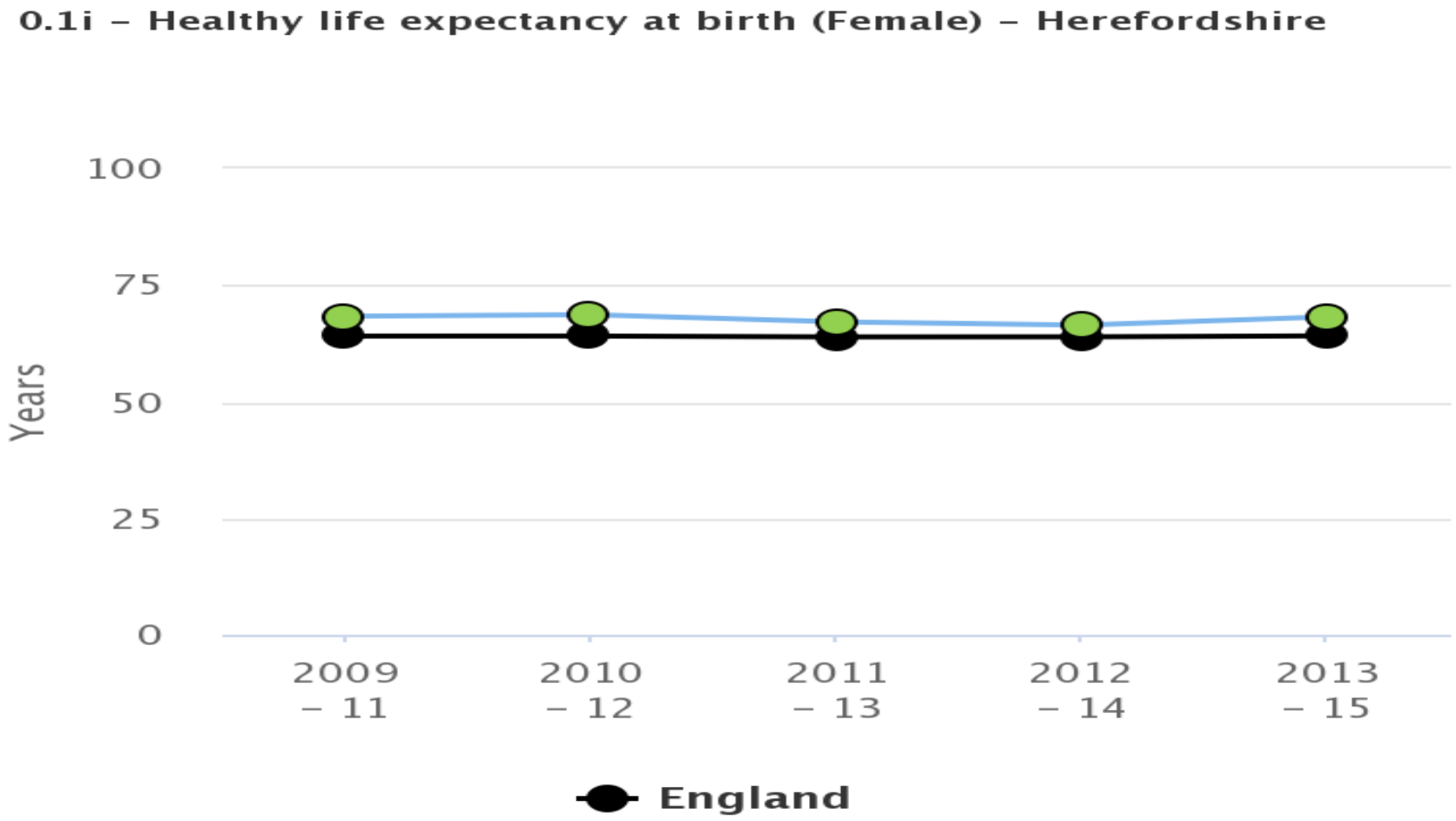
Living Longer - Life expectancy 2013-15

Life Expectancy	Male (Years)	Female (Years)	Gap (years)
Healthy Life Expectancy at Birth	67.1	68.2	1.1
Life Expectancy at Birth	80.4	83.9	3.5
Life Expectancy at 65 years	19.5	21.7	2.4
Inequality in life expectancy at birth by deprivation deciles (male)	-	-	4.3
Inequality in life expectancy at birth by deprivation deciles (female)	-	-	2.3

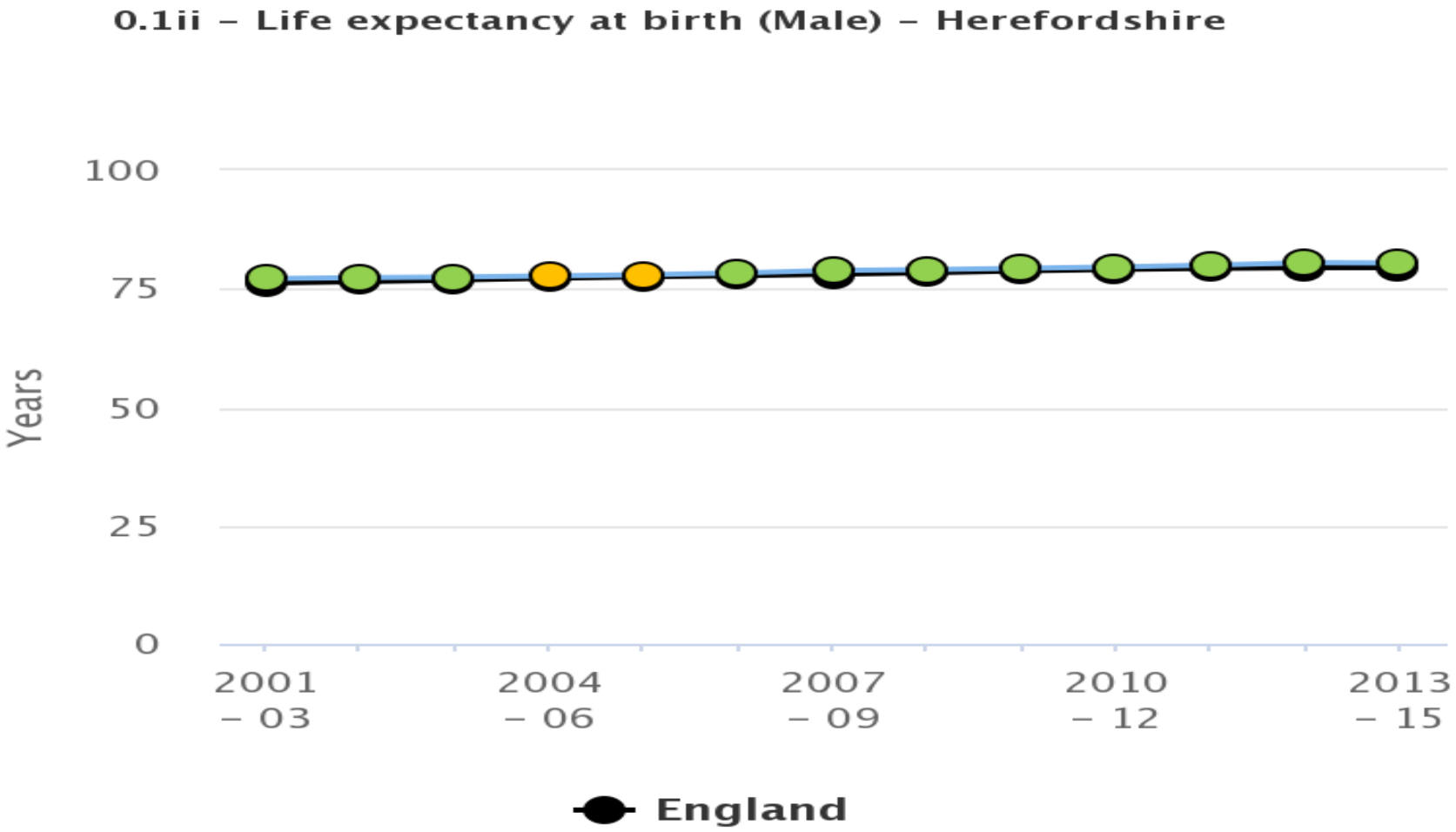
Living Longer



Living Longer



Living Longer



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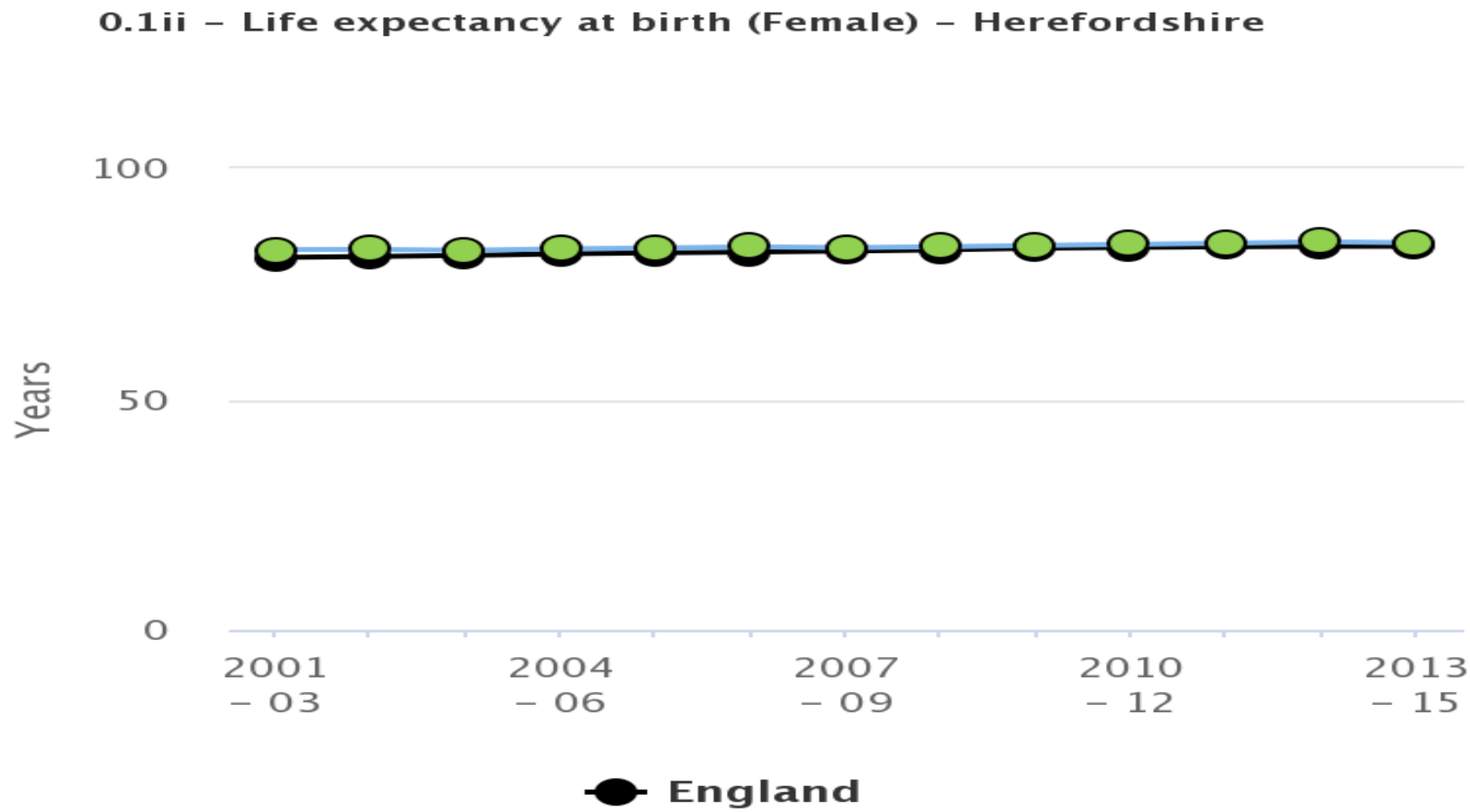

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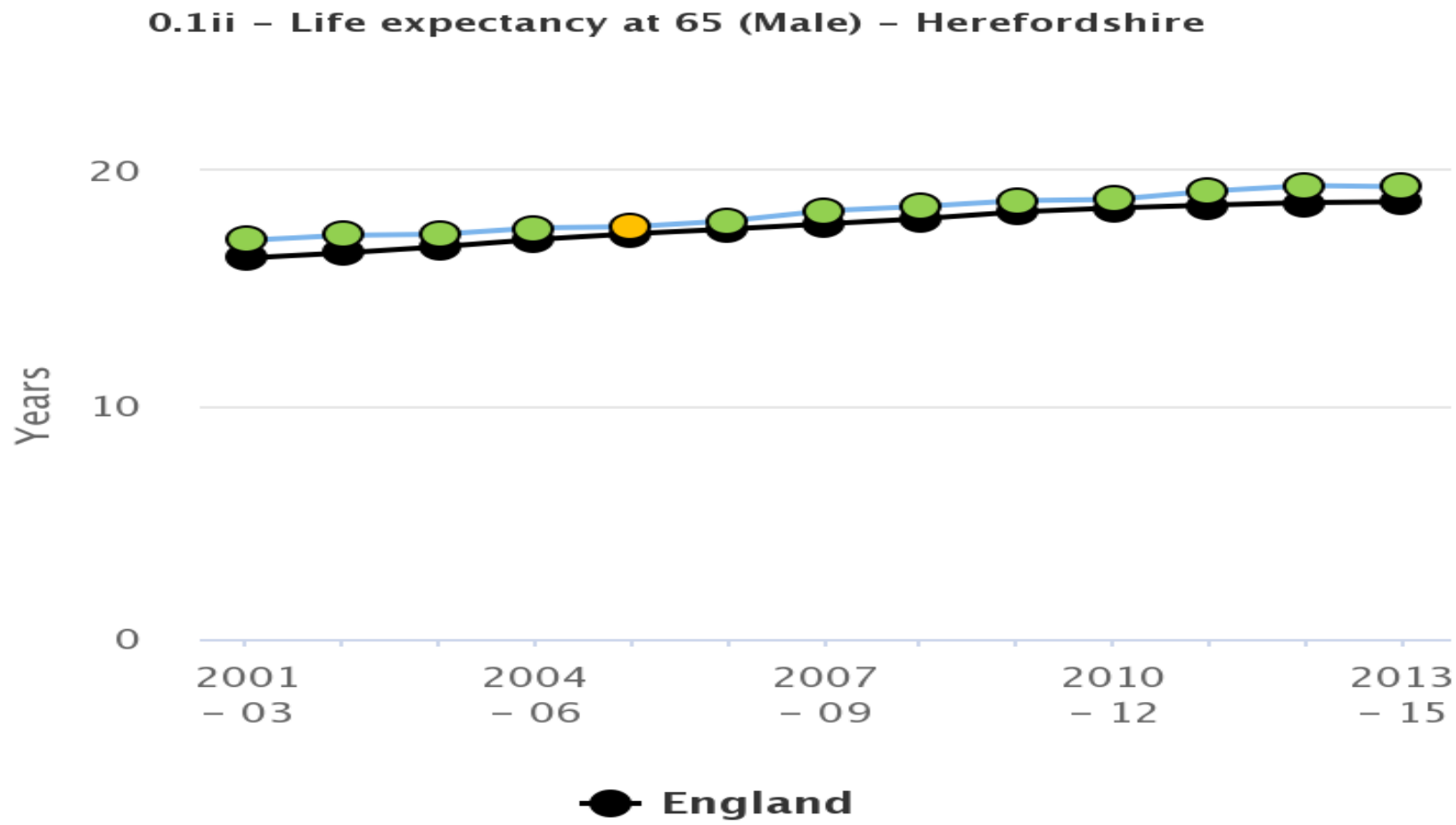
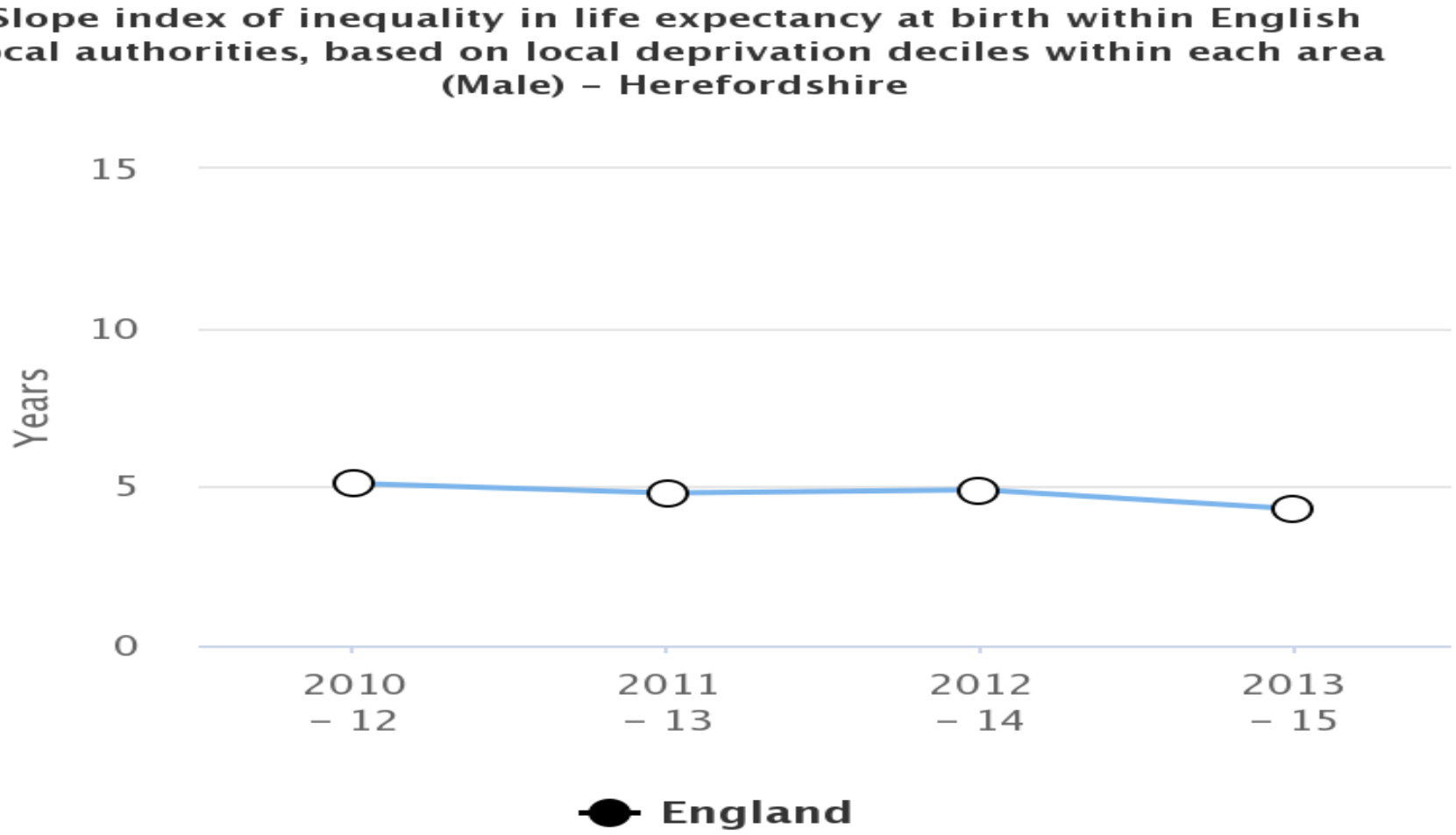


Living Longer

Living Longer



Living Longer

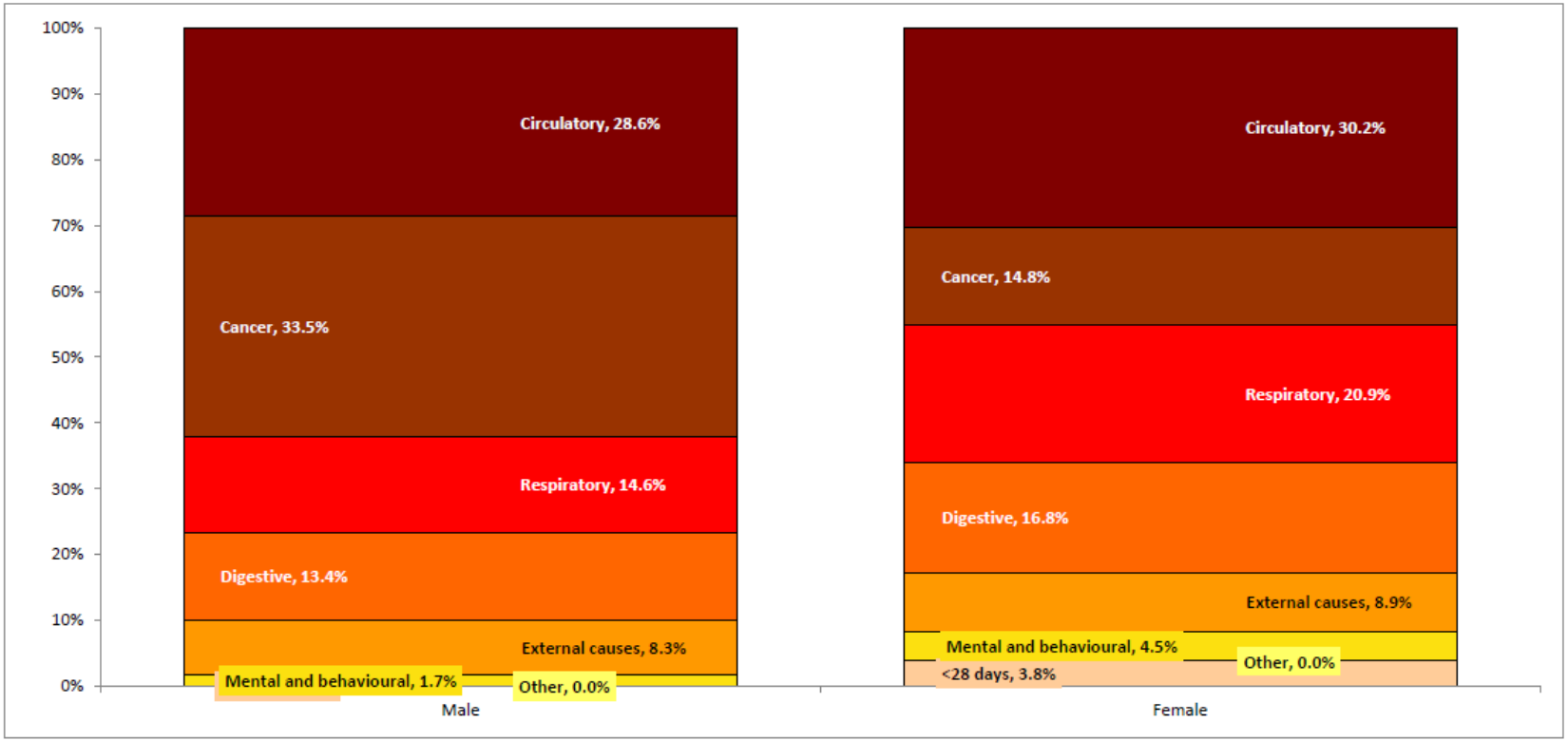
THE SEGMENT TOOL

SEGMENTING LIFE EXPECTANCY GAPS BY CAUSE OF DEATH

Public Health England

Within area inequalities: Life expectancy gap between the most deprived quintile and least deprived quintle of Herefordshire

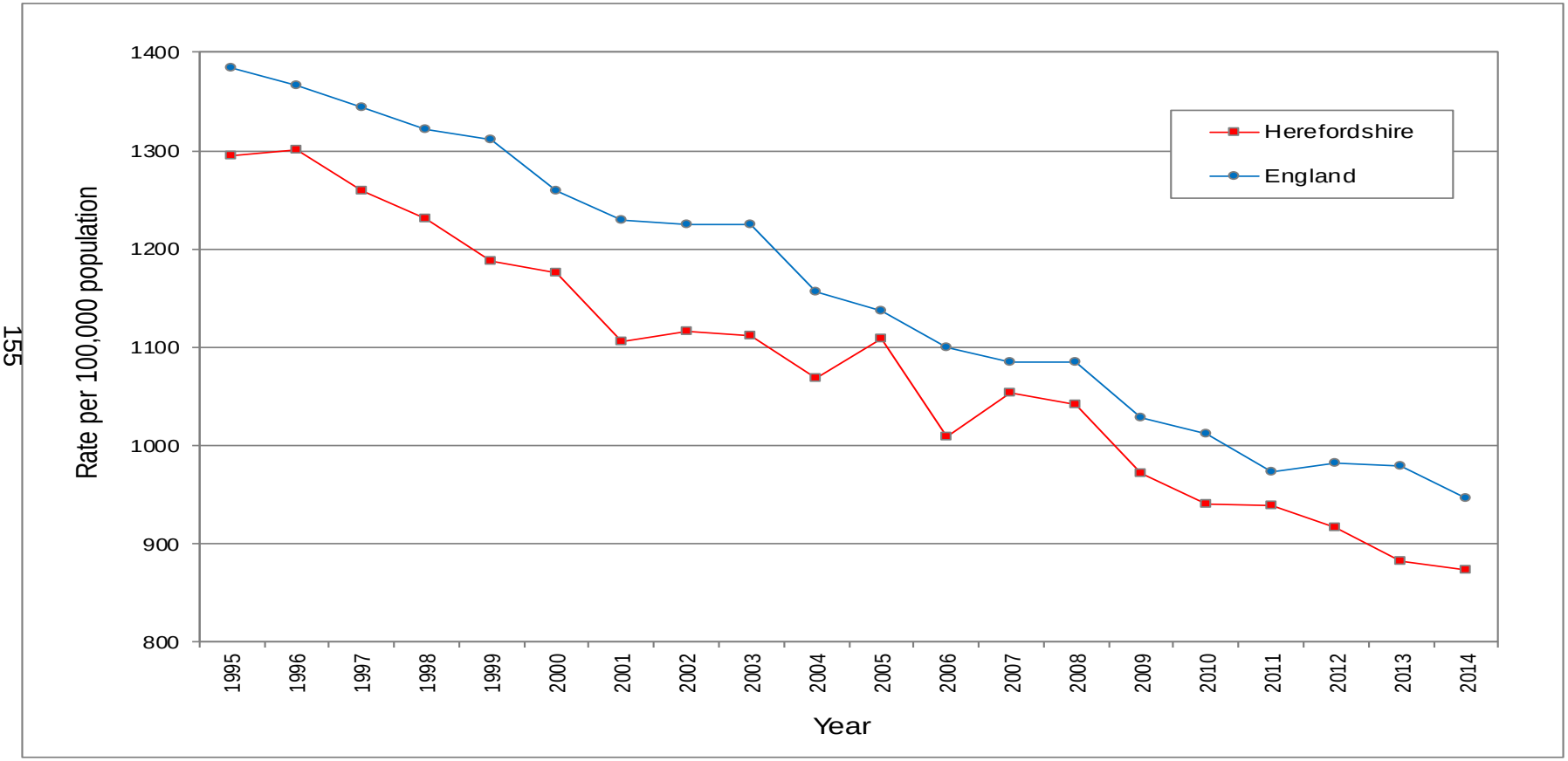
Chart 5: Scarf chart showing the breakdown of the life expectancy gap between Herefordshire most deprived quintile and Herefordshire least deprived quinitle, by broad cause of death, 2012-2014



Footnote: Circulatory diseases includes coronary heart disease and stroke. Respiratory diseases includes flu, pneumonia and chronic obstructive airways disease. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis. External causes include deaths from injury, poisoning and suicide. Mental and behavioural includes dementia and Alzheimer's disease.

Living Longer

All cause directly age-standardised mortality rates for Herefordshire and England, 1995 - 2014.



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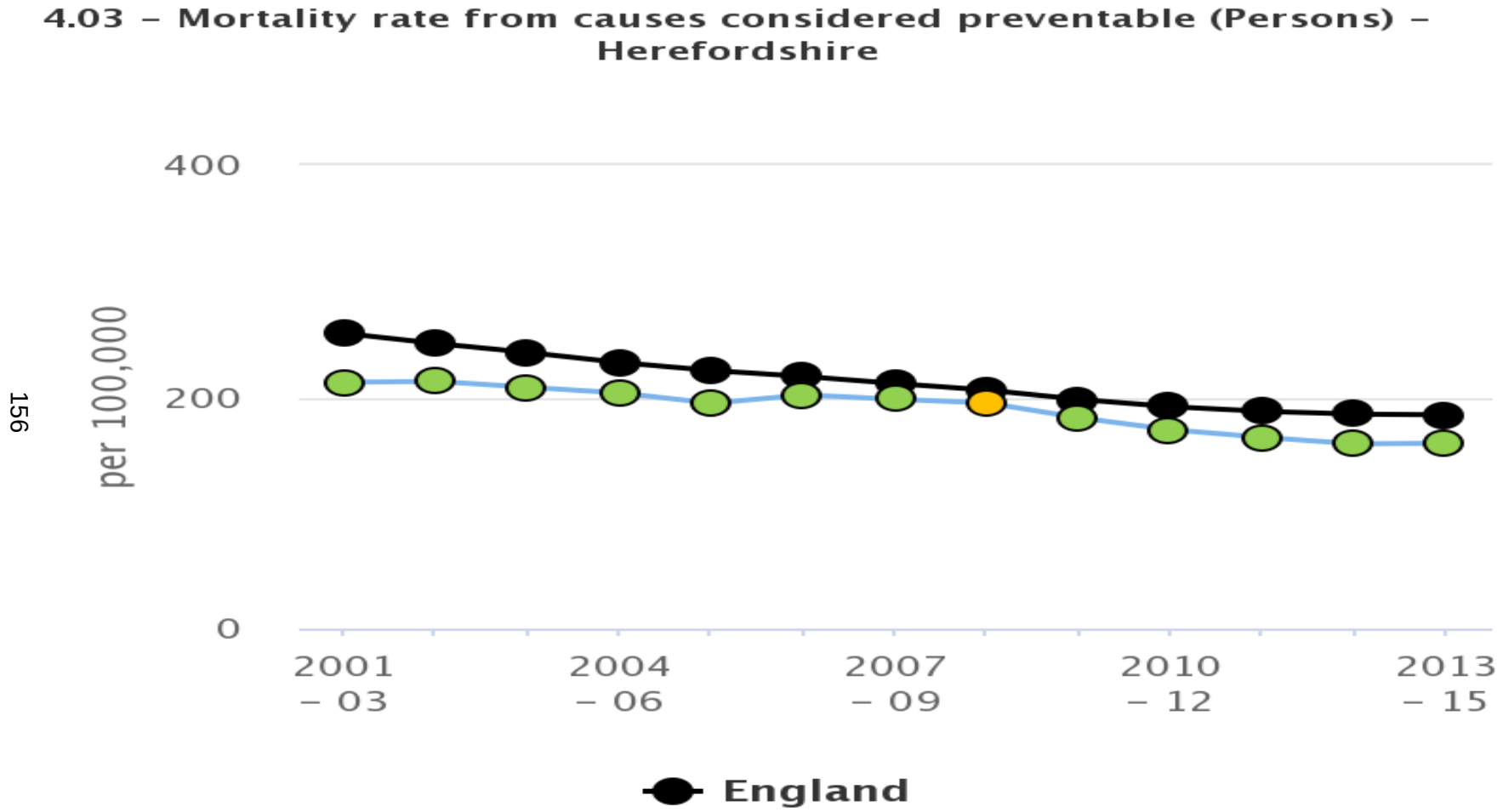

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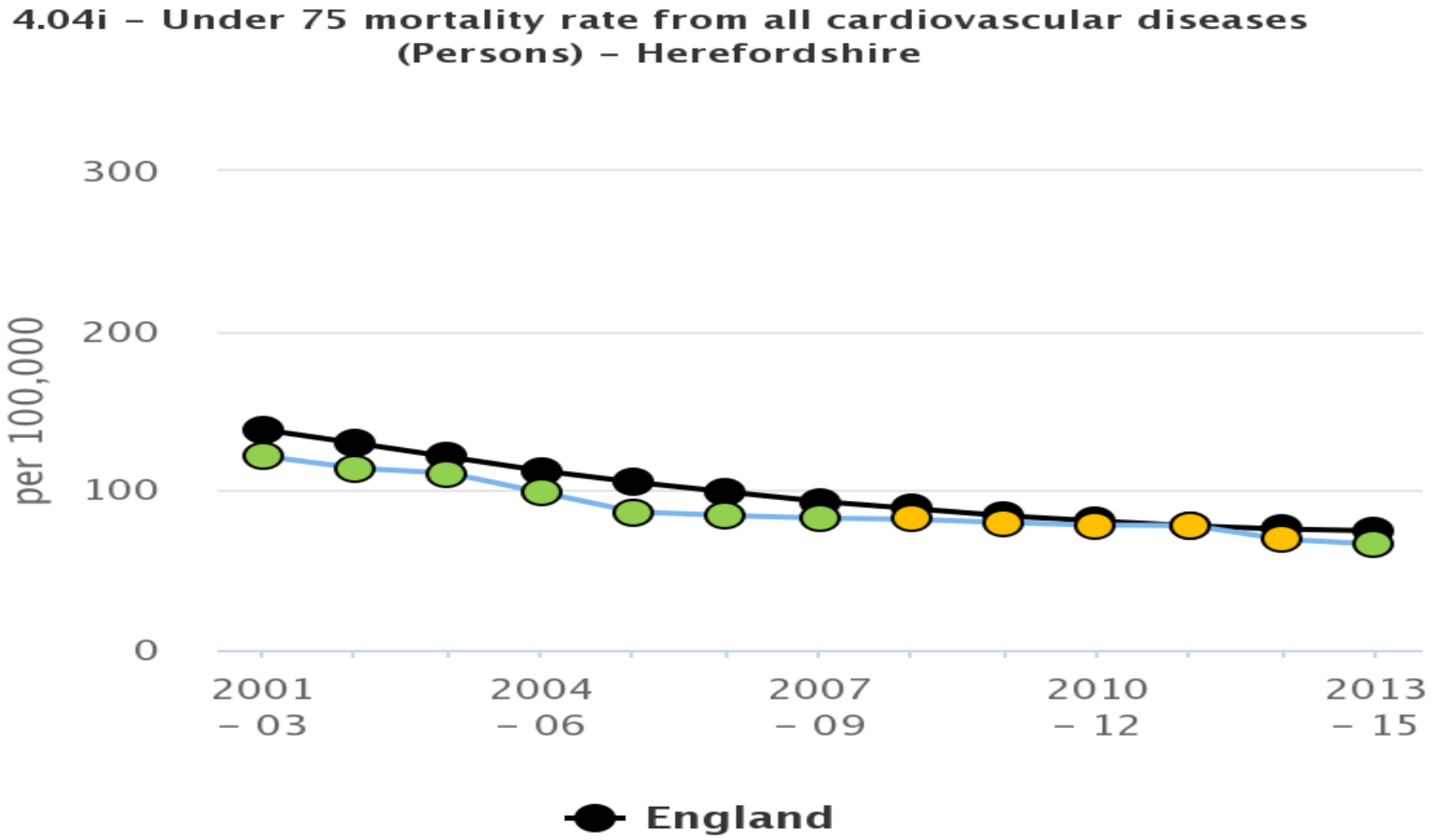

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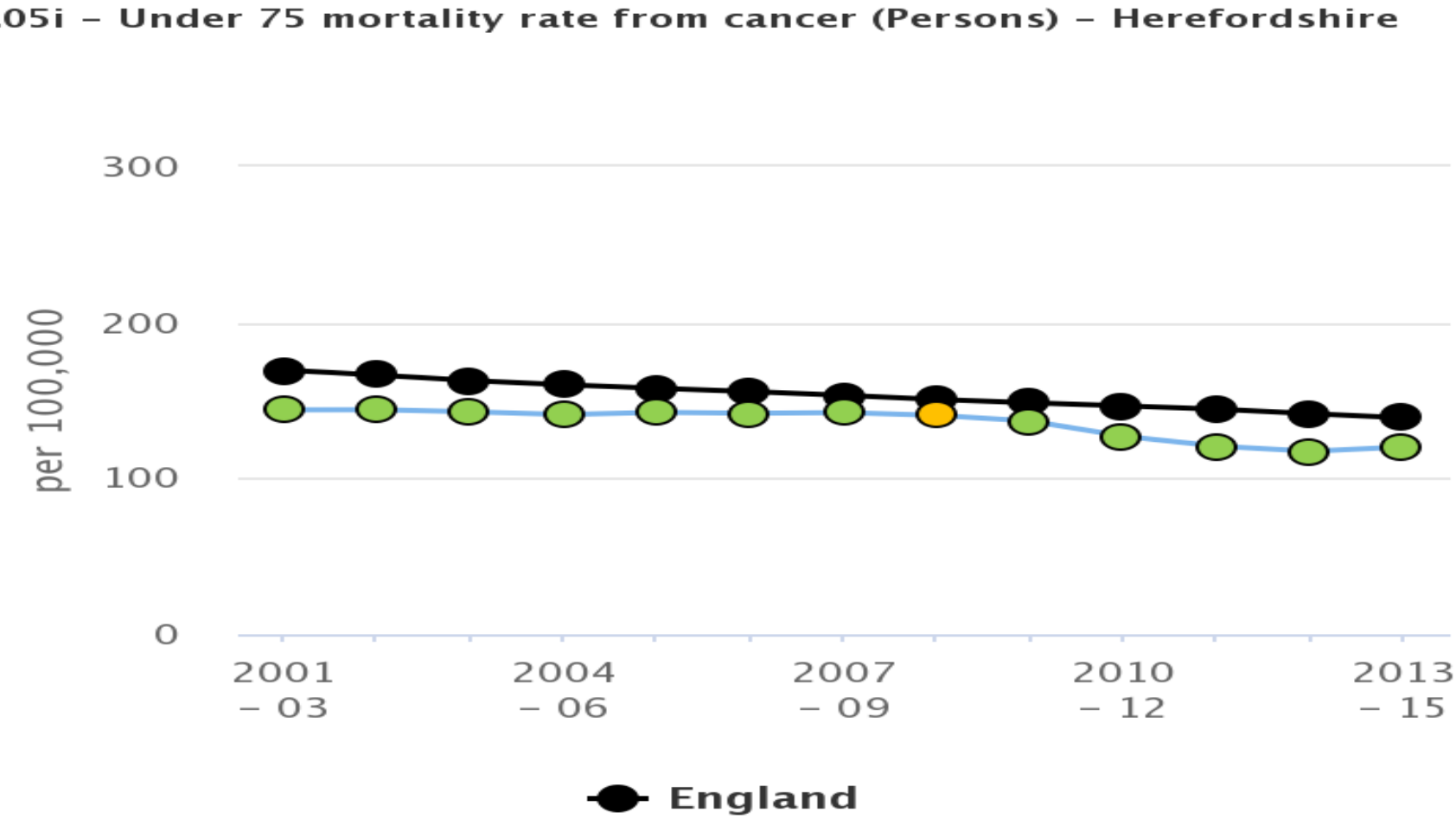

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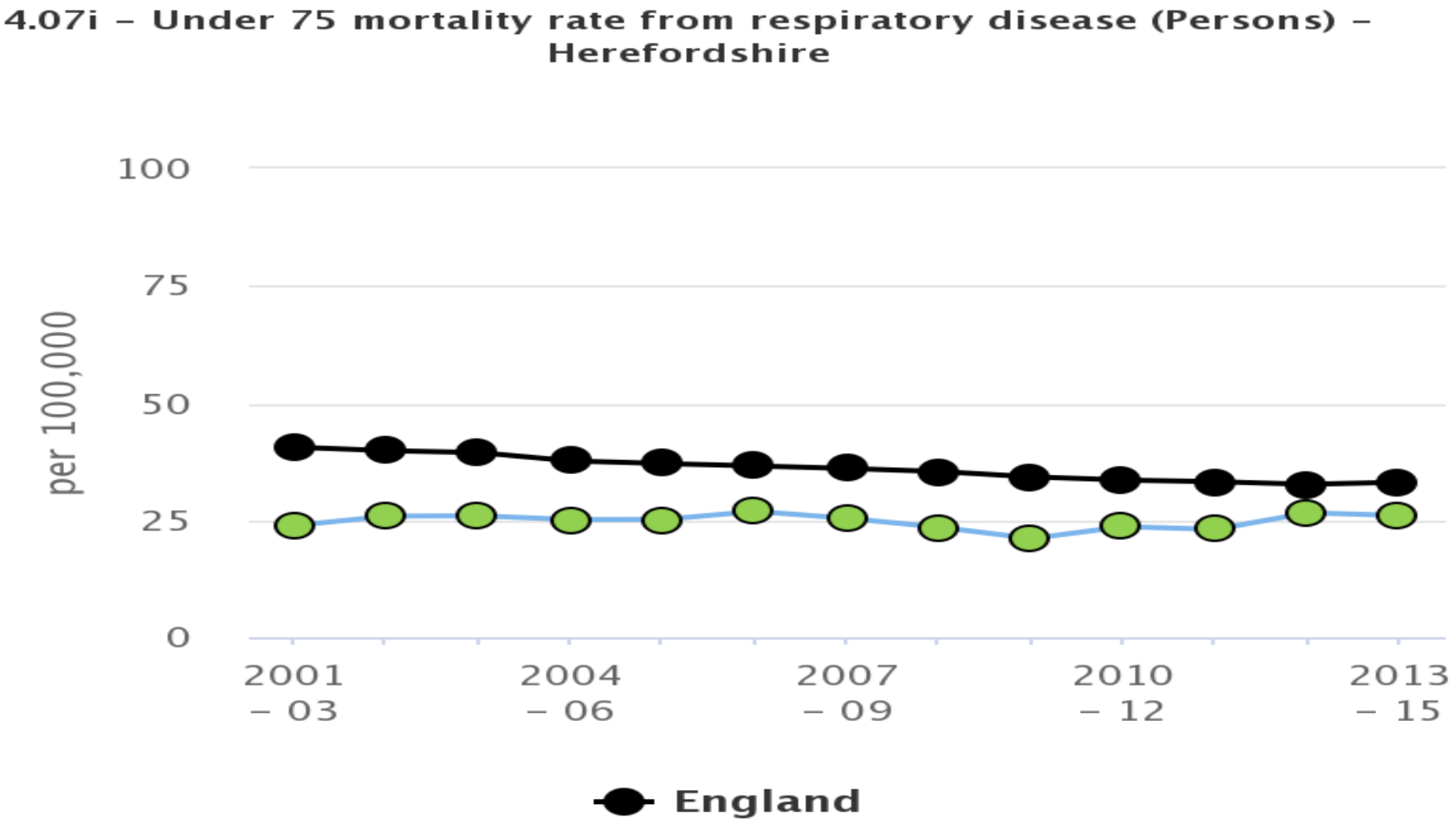

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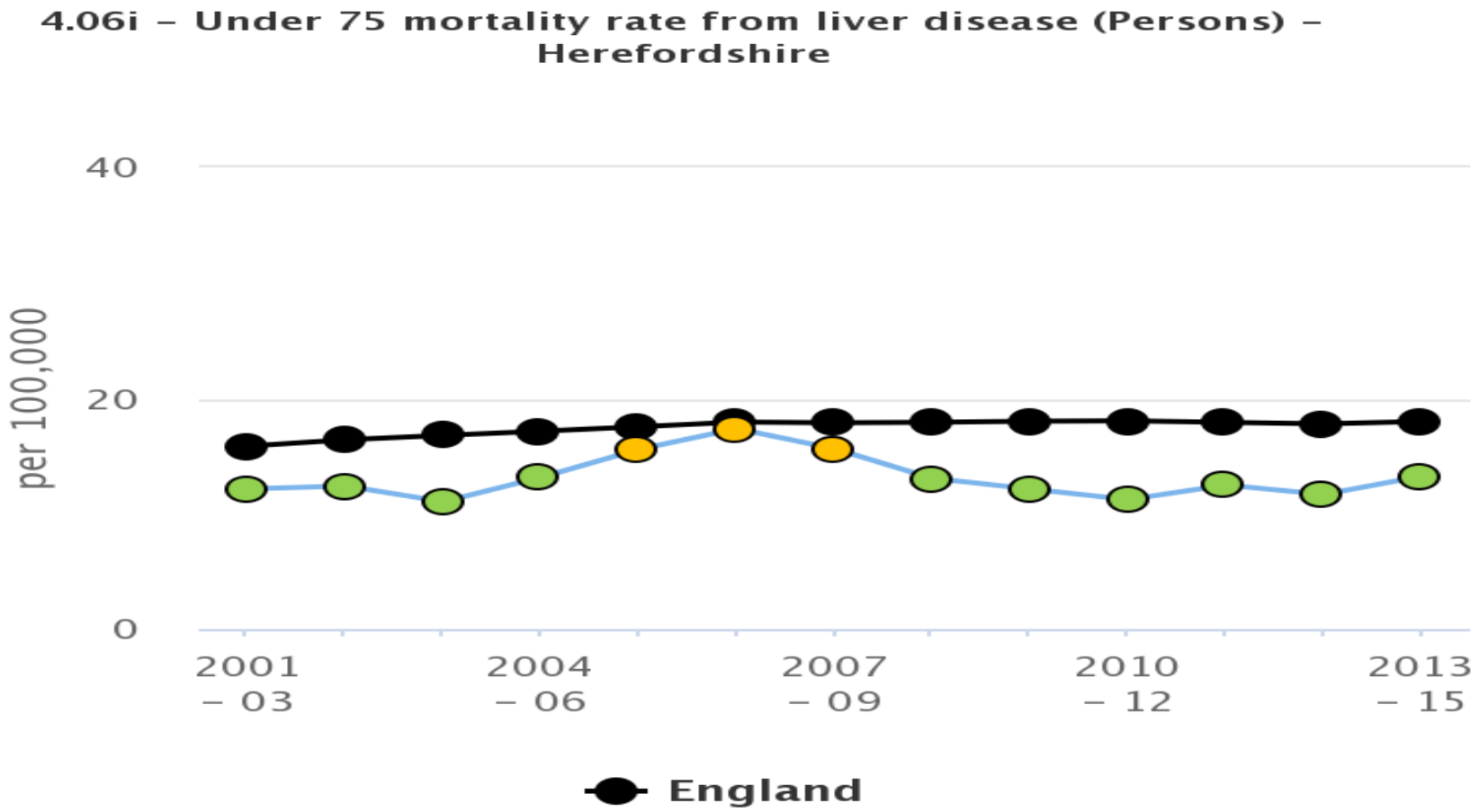

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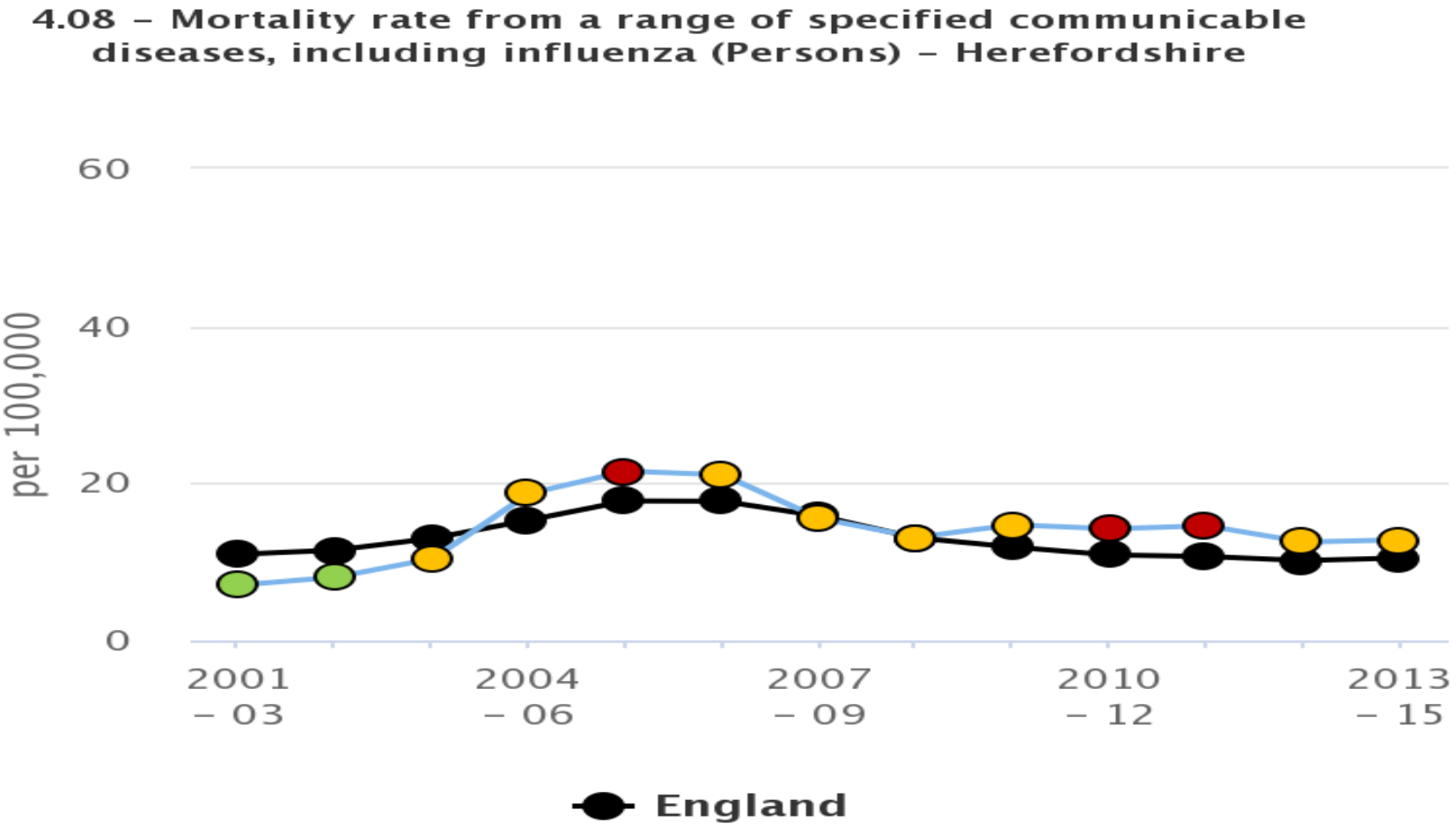


Living Longer

4.08 - Mortality rate from a range of specified communicable diseases, including influenza (Persons) 2013 - 15

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	15,660	10.5	10.3	10.6
West Midlands region	–	2,005	12.6	12.1	13.2
Wolverhampton	–	124	17.7	14.7	21.1
Sandwell	–	136	17.3	14.5	20.5
Coventry	–	134	16.8	14.1	19.9
Birmingham	–	398	16.2	14.6	17.9
Warwickshire	–	245	14.6	12.8	16.5
Dudley	–	131	14.2	11.8	16.8
Walsall	–	100	13.5	11.0	16.5
Herefordshire	–	85	12.8	10.2	15.8
Stoke-on-Trent	–	64	10.3	7.9	13.2
Solihull	–	65	9.6	7.4	12.3
Staffordshire	–	246	9.6	8.4	10.9
Worcestershire	–	161	8.7	7.4	10.1
Shropshire	–	88	8.3	6.7	10.2
Telford and Wrekin	–	28	7.0	4.6	10.1

Source: Public Health England (based on ONS source data)

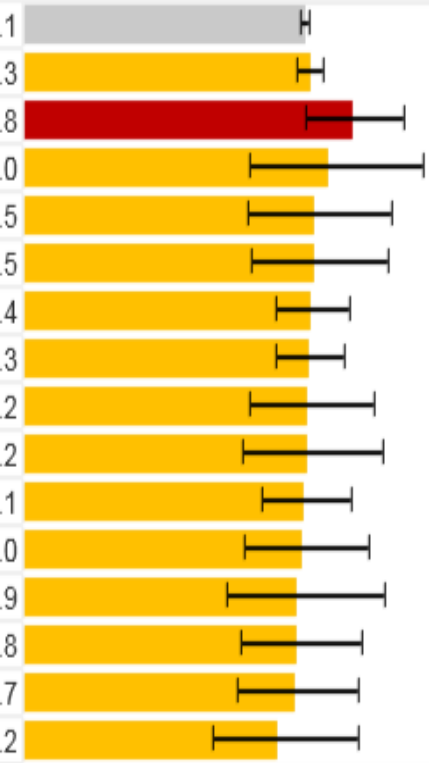
Living Longer

Living Longer

4.10 - Suicide rate (Persons) 2013 - 15

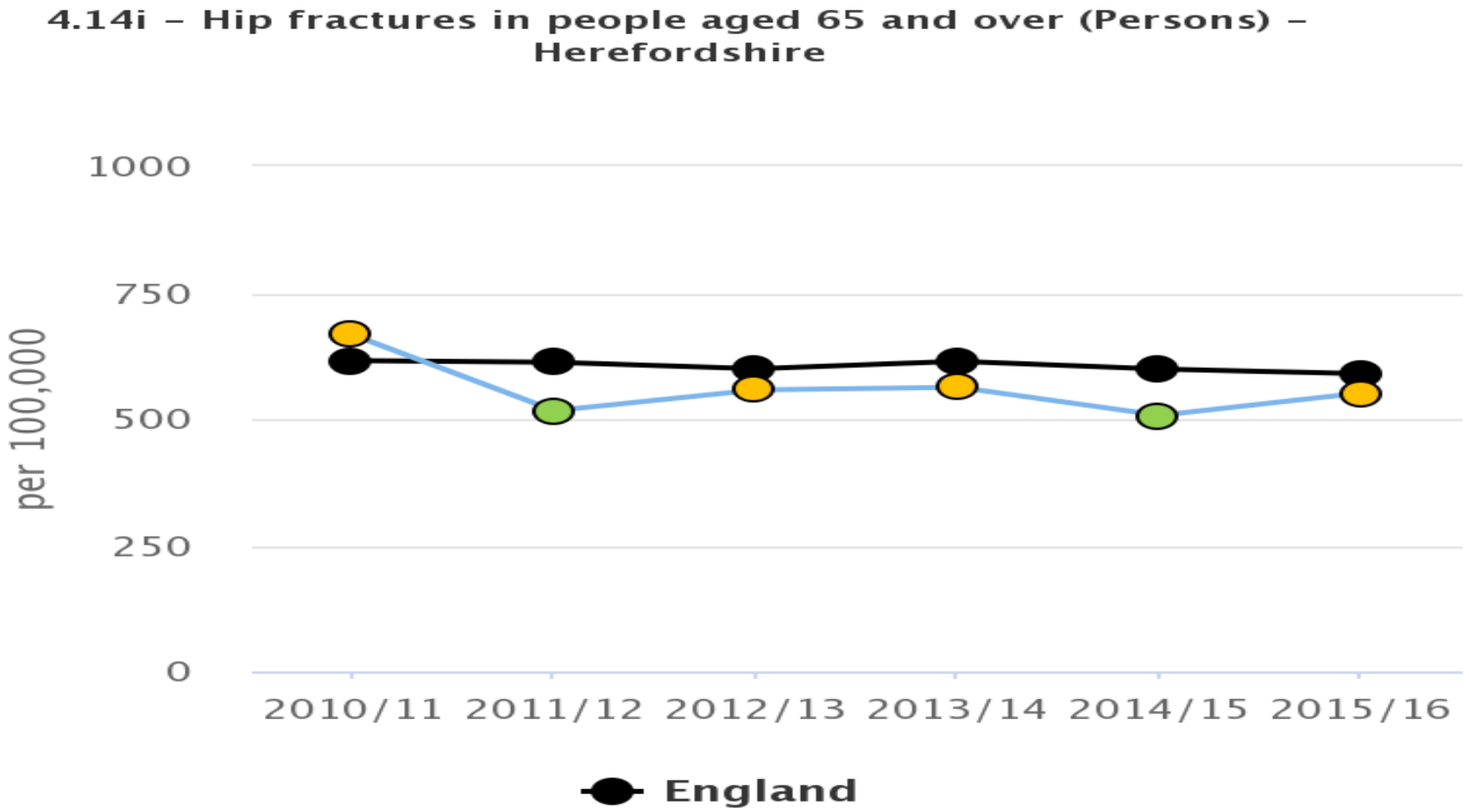
Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	14,429	10.1	10.0	10.3
West Midlands region	–	1,525	10.3	9.8	10.9
Warwickshire	–	175	11.8	10.2	13.7
Telford and Wrekin	–	50	11.0	8.1	14.5
Stoke-on-Trent	–	67	10.5	8.1	13.3
Walsall	–	72	10.5	8.2	13.2
Staffordshire	–	240	10.4	9.1	11.8
Birmingham	–	276	10.3	9.1	11.6
Sandwell	–	82	10.2	8.1	12.7
Wolverhampton	–	66	10.2	7.9	13.0
Worcestershire	–	152	10.1	8.5	11.8
Coventry	–	83	10.0	7.9	12.5
Herefordshire	–	50	9.9	7.3	13.0
Dudley	–	81	9.8	7.8	12.2
Shropshire	–	81	9.7	7.7	12.1
Solihull	–	50	9.2	6.8	12.1



Source: Public Health England (based on ONS source data)

Living Longer



Living Longer

4.14i - Hip fractures in people aged 65 and over (Persons) 2015/16

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	57,659	589	585	594
West Midlands region	-	6,452	619	604	634
Wolverhampton	-	325	710	634	792
Stoke-on-Trent	-	281	708	627	797
Sandwell	-	322	654	585	730
Warwickshire	-	724	645	599	694
Birmingham	-	967	633	594	674
Dudley	-	380	621	560	687
Walsall	-	299	610	543	684
Staffordshire	-	1,025	609	572	647
Coventry	-	310	602	537	673
Telford and Wrekin	-	151	601	508	705
Solihull	-	276	591	523	666
Shropshire	-	427	589	534	647
Worcestershire	-	721	578	537	622
Herefordshire	-	244	551	484	625

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Questions?

Supporting Technical Information

The Population of Herefordshire 2016. Version 2.0, August 2016 https://factsandfigures.herefordshire.gov.uk/media/48832/population-of-herefordshire-2016-v20.pdf

Economic Activity of Residents. https://factsandfigures.herefordshire.gov.uk/about-a-topic/economy/economic-activity-of-residents.aspx#economic

Employment. https://factsandfigures.herefordshire.gov.uk/about-a-topic/economy/employment.aspx

Businesses in Herefordshire: size and industry. https://factsandfigures.herefordshire.gov.uk/about-a-topic/economy/businesses-in-herefordshire-size-and-industry.aspx

Environment https://factsandfigures.herefordshire.gov.uk/about-a-topic/environment-conservation-and-sustainability

Crime and Safety https://factsandfigures.herefordshire.gov.uk/about-a-topic/community-safety

Children and young people https://factsandfigures.herefordshire.gov.uk/about-a-topic/children-and-young-people

Evaluation of Herefordshire Community Health Services for Children and Young People

Obesity Report 2017

Alcohol Report 2017

Smoking Report 2017

Sexual Health 2017

Life Expectancy Report 2017

Mortality Report 2016

Suicide Report 2016

Population Health Overview 2016

Child Sexual Exploitation Report 1: Local profile of children assessed for CSE

The Armed Forces Community in Herefordshire 2016

Domestic Violence and Abuse: Evaluation of Local Response in Herefordshire 2017

Overview of Child Health http://fingertips.phe.org.uk/profile/child-health-overview/data#page/1/ati/102/are/E06000019

Child and Maternal Health http://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy/

Sexual and Reproductive Health Profiles http://fingertips.phe.org.uk/profile/sexualhealth

Health Matters – Combating Blood Pressure (PHE Publication)

High Blood Pressure – How could we do better? British Heart Foundation and PHE publication

References

The Marmot Review. Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010. http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Dahlgren, G. and Whitehead, M. (1992). European strategies for tackling social inequalities in health. World Health Organization. http://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf

Other Information

New University http://nmite.org.uk/

Joint Strategic Needs Assessment Work Programme 2017-20

Project	Project Officer	Project Lead	Sponsor Director	Completion Date	Current status
JSNA Refresh 2017	Latha Unny	Arif Mahmood	Prof Rod Thomson	April 2017	Complete
Older people needs assessment	Katie Spanjers	Arif Mahmood	Jade Brookes	November 2017	Data sources identified
Learning disabilities needs assessment (all ages)	Chris Nikitik	Arif Mahmood	Martin Samuels	December 2017	Being scoped
Children needs assessment refresh	TBC	Arif Mahmood	Chris Baird	January 2018	To be commenced in September 2017
Intermediate care service data analysis	Hannah Blower	Amy Pitt	Martin Samuels	March 2018	Being scoped
Mental health needs assessment refresh	TBC	Arif Mahmood	Jade Brookes	March 2019	To be commenced in September 2018
Housing & health	TBC	Ewan Archibald	Martin Samuels	March 2019	To be commenced in September 2018
Veterans' needs assessments	TBC	TBC	TBC	March 2019	To be commenced in September 2018
Maternity services	TBC	Arif Mahmood		March 2020	To be commenced in September 2019
Cancer services review	TBC	Arif Mahmood		March 2020	To be commenced in September 2019

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**18 July 2017**
Title of report:	**Better care fund 2016/17 quarter four performance report**
Report by:	**Senior commissioning officer – better care and integration**

Classification

Open

Key decision

This is not an executive decision.

Wards affected

Countywide

Purpose

To review the better care fund 2016/17 quarter four national performance report as per the requirements of the programme.

Recommendation(s)

THAT:

(a) the better care fund (BCF) quarter four performance report at appendix 1 as submitted to NHS England be reviewed; and

(b) the board determine any actions it wishes to recommend to secure future improvement in efficiency or performance.

Alternative options

1 There are no alternative options. The content of the return has already been approved by the council's director for adults and wellbeing and Herefordshire Clinical Commissioning Group's (CCG) accountable officer and submitted to NHS England prior to the deadline of 31 May 2017.

Reasons for recommendations

2 At its meeting in July 2016 the board agreed that, on such occasions when board meetings do not coincide with submission dates, the director for adults and wellbeing

would be authorised, 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.

Key considerations

3 The national submission deadline for this quarterly return was 31 May 2017 and the board is asked to review the completed data, following its submission to NHS England.

4 The quarter four report, as located at appendix 1, provides an update on quarter four performance and also offers the opportunity to summarise the key achievements and challenges experienced throughout 2016/17.

5 As detailed in the report, delayed transfers of care (DTOC) presented significant issues throughout the health and social care system in Herefordshire during 2016/17. A number of schemes are being delivered to help address the pressures, including earlier identification of potential discharges, rapid access to assessment and care (RAAC) capacity, brokerage, additional support to self-funders and care homes. The council and CCG are actively working together to monitor and reduce the levels of DTOC and ensuring that new schemes are developed and implemented, where appropriate. A number of reporting mechanisms have been introduced during 2016/17, including a daily update and review of DTOCs being carried out by Herefordshire Council's operational teams.

6 The report identifies that the performance in relation to the rate of permanent admissions to residential care (per 100,000 population, 65+) has worsened since 2015/16 year end. This performance data is currently awaiting final validation as part of the council's year end performance processes. There continues to be an increased level of scrutiny of all placements following the introduction of a more rigorous process over the past 18 months. The quality assurance panel challenge the appropriateness of all residential placements. Partners are working together to establish a managing the care home market strategy, which will include the delivery of enhancing quality of care, reducing admissions into hospital and continuing to monitor demographic challenges. Partners are currently exploring developments in assistive technology in care homes.

7 The reduction in non-elective admissions target was on track to be met at the end of 2016/17. The BCF funded a number of schemes during 2016/17 to address the increased demand and reduce the levels of non-elective admissions. These included rapid response, fallers first response, virtual wards, hospital at home and the community reablement service.

8 A number of key successes are identified within the quarter four report, including the Intermediate Rehabilitation Service (IRS). During 2016/17, the existing rapid access to assessment and care (RAAC) provision was reviewed and an IRS pilot was introduced. The aim of the scheme was to deliver rehabilitation to those who would otherwise face unnecessarily prolonged hospital stays, inappropriate admission to acute inpatient care or long term residential care. The focus of the scheme was active therapeutic interventions, with the aim to maximise the independence of individuals. The service provided the opportunity for admission avoidance and also to facilitate earlier hospital discharge. A full pilot evaluation is currently being finalised and will be used to inform future commissioning decisions.

9 Another key success identified is the unified contract, an approach introduced by the council and the CCG during 2016/17. The bringing together of terms and conditions from two organisations into one unified contract, in relation to all residential and nursing placements for adults, has resulted in a number of benefits. The move from net payments to gross has been introduced to achieve improvements in cash flow and reduce back office administration. Contract termination and payment on death clauses have now been aligned.

10 Herefordshire's Better Care Partnership Group (BCPG), which includes representatives from both the council and the CCG, have met on a monthly basis throughout 2016/17 and worked together to monitor the delivery of the schemes within the 2016/17 BCF plan. These regular meetings, as well as working more closely on the delivery of several projects throughout the year, have assisted in improving joint working. A number of schemes have been jointly commissioned, including the introduction of the IRS pilot, and joint integration plans are also being progressed.

11 A risk share arrangement restricted to a cohort of individuals was implemented throughout 2016/17. At the end of quarter four, of the 27 clients in the risk share cohort, 17 had been reviewed, 5 had passed away and 5 were awaiting review. The pool2 risk share agreement has not been triggered as a result of the reviews undertaken during the financial year.

12 The national guidelines for the completion of the 2017/18 and 2018/19 better care fund plans were formally published on 4 July 2017. Partners are currently working together to proceed with planning delivery, agreeing budgets and formalising Herefordshire's submission. The national deadline for submitting final BCF plans is 11 September 2017. A regional assurance process will follow. The HWB will be required to agree the content of Herefordshire's plan.

13 Previous advice was that the national policy framework and planning guidance would be published during November 2016, however significant delays have been experienced and a definite publication date is yet to be confirmed. Partners continue to work together to proceed with planning delivery and agreeing budgets, where possible.

14 In addition to the core BCF, the spring budget 2017 recognised that adult social care services are under significant pressure nationally, one expression of this being the increased number of patients whose discharge from hospital has been delayed whilst they wait for a social care placement. As a consequence, the chancellor announced an additional £2 billion for councils to spend on adult social care over the next three years (2017/18 to 2019/20). Of this, the allocation for Herefordshire is £7.3 million.

15 Clear grant conditions have been set jointly by the Department of Health (DH) and the Department for Communities and Local Government (DCLG) in relation to this additional funding. A set of clear funding principles have been agreed locally and the council, CCG and providers are currently working together to allocate and align spend to enable focus on key areas to allow for the greatest impact to meet the needs of Herefordshire residents.

Community impact

16 The BCF plan is set within the context of the national programme of transformation 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 in order to achieve the priorities of the health and wellbeing strategy in the most cost effective way.

Equality duty

17 The council and CCG are committed to equality and diversity using the public sector equality duty (Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. All equality considerations are considered as part of the development and implementation of the plan.

Financial implications

18 The attached quarter four performance report reflects the continuing budget pressures being experienced. The quarter four forecast reflects the increase of £1.312m in the cost of funded nursing care (FNC) placements which are included in the additional BCF pool. This has, in part, been offset by a reduction in direct expenditure on fast track cases; this has been offset by the CCG investment in the Hospice at Home service, the cost of which is outside the BCF.

19 Also reflected in this report are the council budget pressures seen in both residential and nursing care, particularly within 'in-county' nursing placements, which are included in the additional BCF pool.

20 The 2016/17 protection of adult social care (PASC) final year-end position is a net overspend of £16k. The key components relate to:

a. a net increase in rapid response of £53k after utilising some of the inflationary uplift to support hospital discharges by short term expansion of the team;

b. the increase in demand for deprivation of liberty safeguards (DoLS) continues and has cost an additional £180k this year, whilst demand for older people nursing placements has also increased above the planned levels (£100k);

c. these pressures have been offset by the previously reported reduction in financial support to carers (£224k); and

d. a reduction in the rapid access to assessment and care (RAAC) scheme following the redesign and launch of the IRS pilot in January (£101k)

20 Both the council and CCG have seen increases in residential based care placements (care home market management) since quarter two. In quarter three, an over spend of £1,858k was reported (£1,342k in council funded support and £516k in CCG placement costs). The outturn for 2016/17 is a total over spend of £1,606k, which is an improvement on quarter three. The breakdown of the £1,606k is council £1,266k and CCG £340k. Each partner carries the risk of their own budget. See the following table:

Financial Position: 2016/17	BCF		
Partner	Scheme Full Year Budget £'000	Scheme Full Year Forecast £'000	Over / (Under) spend £'000
Council	19,468	20,734	**1,266**
CCG	9,272	9,612	**340**
Other	0	0	**0**
Total	**28,740**	**30,346**	**1,606**

Legal implications

21 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding. The council is legally obliged to comply with grant conditions, which have been complied with.

Risk management

22 The board is required to note the content of the performance template, which is based on statistical and financial information and therefore the risk is minimal.

23 There are no direct implications on funding in relation to targets not being achieved; however those not achieved will affect the experience of individuals of Herefordshire, for example, delays in transfers of care. In order to mitigate these impacts, partners are working together to ensure sufficient schemes are in place.

24 A quarter four update in relation to the risk share arrangement is provided at point 11 of this report.

Consultees

25 None.

Appendices

Appendix 1 – Better care fund quarter four template

Background papers

- None identified.

Cover

Q4 2016/17	
Health and Well Being Board	**Herefordshire, County of**
completed by:	Emma Evans
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Who has signed off the report on behalf of the Health and Well Being Board:	Martin Samuels, Director for Adults and Wellbeing

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
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Budget Arrangements

Selected Health and Well Being Board:	Herefordshire, County of

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Herefordshire, County of

The Spending Round established six 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 the year (in-line with signed off plan) and how this is being addressed?

Condition	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide 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?
1) Plans to be jointly agreed	Yes	Yes	Yes	Yes	
2) Maintain provision of social care services	Yes	Yes	Yes	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	No - In Progress	No - In Progress	No	Partners continue to deliver and develop 7 day service where demand requires and budget allows.
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	No - In Progress	No - In Progress	No	7 day services form part of the Service Development and Improvement Plan (SDIP) in CCG contracts with main providers of Acute, Community and Mental Health Services- progress is assessed regularly through monthly contract monitoring meetings.
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	Yes	Yes	Yes	
ii) Are you pursuing Open APIs (ie system that speak to each other)?	No - In Progress	No - In Progress	No - In Progress	No	Further developments to be achieved during 2017/18
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes	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	Yes	Yes	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	Yes	Yes	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes	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 2016-17.

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

prevent unnecessary non-elective (physical and mental health) admissions to acute

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

where funding is used for integrated packages of care, there will be an accountable

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.

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.

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.

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.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

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

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
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	£10,561,500	£10,829,500	£10,110,000	£43,905,300	
	Actual*	£12,404,300	£10,389,800	£10,829,500			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
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	£10,561,500	£10,829,500	£10,110,000	£43,905,300	
	Actual*	£12,404,300	£10,389,800	£10,829,500	£9,858,000	£43,481,600	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	The actuals reflect the final outturn which shows an increase of £1.3m in the cost of FNC placements which are included in the additional BCF pool. This has been largely offset by a reduction in fast track expenditure. Also reflected are the LA budget pressures seen in both residential and nursing, particularly within 'in-county' nursing placements which are included in the additional BCF pool.

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
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	£10,511,800	£10,511,800	£10,511,800	£10,511,768	£42,047,168	£42,047,168
	Forecast	£10,605,700	£10,786,300	£11,449,000	£11,064,300	£43,905,300	
	Actual*	£10,605,700	£10,786,300	£11,449,000			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
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	£10,786,300	£11,449,000	£11,064,300	£43,905,300	
	Actual*	£10,605,700	£10,786,300	£11,449,000	£10,812,300	£43,653,300	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	The actuals reflect the final outturn which shows an increase of £1.3m in the cost of FNC placements which are included in the additional BCF pool. This has been largely offset by a reduction in fast track expenditure. Also reflected are the LA budget pressures seen in both residential and nursing, particularly within 'in-county' nursing placements which are included in the additional BCF pool.
Commentary on progress against financial plan:	The Herefordshire BCF plan includes 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 an even profile with the exception of the 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.

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 to meet target
Commentary on progress:	A number of schemes have been set up to address the increased demand. These include rapid response, fallers first response, virtual wards and hopital at home.

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:	Early results indicate that this has worsened since year end last year. These are awaiting final validation as part of our year end performance processes.

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:	Local measure is reduction in spending on falls-related hospital attendances and admissions, and in falls-related ambulance conveyances. Performance continues to be better than target

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?	On track to meet target
Commentary on progress:	Overall satisfaction has improved by a fraction of a percentage, although this reflects maintenance of performance as one of the upper quartile performing authorities

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:	Early results indicate that this has worsened since year end last year. These are awaiting final validation as part of our year end performance processes.

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

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Performance has improved on last year. Figures subject to change as part of year end statutory data collections

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.
For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Year End Feedback on the Better Care Fund in 2016-17

Selected Health and Well Being Board: Herefordshire, County of

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	Herefordshire's Better Care Partnership Group (BCPG), which includes representatives from both the local authority and the CCG, have met on a monthly basis throughout 2016/17 to monitor the delivery of the schemes within the 2016/17 BCF plan. These regular meetings, as well as working more closely on the delivery of several projects throughout the year, have assisted in improving joint working. A number of schemes have been jointly commissioned, including the introduction of the IRS pilot. Joint integration plans are also being progressed.
2. Our BCF schemes were implemented as planned in 2016/17	Agree	Several key initiatives have been delivered during 2016/17 through the BCF. These include the introduction of the Intermediate Rehabilitation Service pilot (IRS) and the unified contract, in relation to adult residential and nursing placements. Also the introduction of the alignment of fees, from 1 April 2017.
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Agree	Several cross agency integration workshops have taken place during 2016/17. Further developments will be achieved during 2017/18.
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Agree	The BCF has funded a number of schemes to address the increased demand and reduce the levels of non-elective admissions. These include rapid response, fallers first response, virtual wards and hospital at home.
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	Both the local authority and CCG are actively working together to monitor and reduce the levels of DTOC. A number of reporting mechanisms have been introduced during 2016/17, including a daily update and review of DTOCs being carried out by Herefordshire Councils Operational teams.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	The reablement service, funded through the BCF, has continued to deliver its target throughout 2016/17 and performance has improved from 2015/16.
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	There is an increased level of scrutiny of all placements following the introduction of a more rigorous process over 18 months ago, at the quality assurance panel, where the appropriateness of all residential placements is challenged. Partners are working together to establish a managing the care home market strategy, which will include the delivery of enhancing quality of care and reducing admissions into hospital. Partners are also working together to explore developments in assistive technology in care homes.

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	IRS pilot - during 2016/17 the existing RAAC provision was reviewed and an Intermediate Rehabilitation Service (IRS) pilot was introduced. The aim of the scheme was to deliver rehabilitation to those who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care or long term residential care. The focus of the scheme was active therapeutic interventions, with the aim to maximise the independence of individuals. The service provided the opportunity for admission avoidance and also to facilitate earlier hospital discharge. A full pilot evaluation is currently taking place.	3. Collaborative working relationships
Success 2	Unified contract - A unified contract approach has been introduced by Herefordshire Council and Herefordshire CCG during 2016/17. The bringing together of terms and conditions from two organisations into one unified contract, in relation to all residential and nursing placements for adults, has resulted in a number of benefits. The move from net payments to gross has been introduced to achieve improvements in cash flow and reduce back office administration. Contract termination and payment on death clauses have now been aligned.	8. Joint contracts and payment mechanisms
Success 3	Regular scheme monitoring - throughout 2016/17 the Better Care Partnership Group have worked together to establish a clear monitoring template and have been meeting on a regular basis to monitor the delivery of schemes within the fund.	5. Evidencing impact and measuring success

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Financial pressures continue to present challenges to both organisations.	Other
Challenge 2	DTOC continues to present significant issues throughout the health and social care system in Herefordshire. A number of schemes are being delivered to help address the pressures, including earlier identification of potential discharges, RAAC capacity and brokerage, additional support to self-funders and care homes. Partners continue to work together, with providers, to ensure that further schemes are developed to assist and service redesigns are implemented, where appropriate. Further work to support and develop the care market is currently being scoped, in order to ensure that both non-elective admissions are reduced and hospital discharges are supported in a timely manner.	5. Evidencing impact and measuring success
Challenge 3	During 2016/17 the amount of 'new money' was extremely limited, which caused challenges in the ability to introduce or test new schemes and service delivery approaches. This resulted in having limited contingencies. The introduction of additional funding for 2017/18 has been welcomed, however the rapid increase in pace to deliver schemes with the additional funding has posed challenges.	Other

Footnotes:

Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Shared vision and commitment
2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change

Other

Additional Measures

Selected Health and Well Being Board: Herefordshire, County of

1. Proposed Metric: 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 Metric: 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	Not currently shared digitally	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	Unavailable	In development	In development	Unavailable
Projected 'go-live' date (dd/mm/yy)	31/08/18	31/08/18	31/08/18	31/08/18	31/08/18	31/08/18

3. Proposed Metric: 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?	No pilot underway

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

Total number of PHBs in place at the end of the quarter	10
Rate per 100,000 population	5

Number of new PHBs put in place during the quarter	1
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 2017)	190,252

5. Proposed Metric: 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
Population figures were updated to the mid-year 2017 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Herefordshire, County of

Remaining Characters	31,868

Please provide a brief narrative on overall progress, reflecting on performance in Q4 16/17 and the year as a whole. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

* Highlights and successes:

Key outcomes and progress achieved during 2016/17 include the following:

- Introduction of unified contract;
- Introduction of IRS pilot scheme;
- Delivery of DFG;
- Continued successful delivery of falls prevention service;
- Improvements in performance monitoring of schemes within the BCF;
- Agreement of funding split between organisation and continued delivery of an Integrated Community Equipment Service; and
- Developments in an integrated redesign of community services, to integrate health and social care provision throughout Herefordshire.

* Challenges and concerns

All partner organisations continue to experience financial pressures.

* Potential actions and support

Continued delays in the publication of the 2017/19 guidance has caused some delays in meeting local governace timescales. An update and estimated publication date would be useful.

Herefordshire Council

Meeting:	**Health and Wellbeing Board**
Meeting date:	**18 July 2017**
Title of report:	**Sustainability and Transformation Partnership**
Report by:	**Director for Adults and Wellbeing**

Classification

Open

Key decision

This is not an executive decision.

Wards affected

Countywide

Purpose

To adopt the refreshed Sustainability and Transformation Partnership (STP) plan, which has been revised in light of comments received, including from the board.

Recommendations

THAT:

(a) the refreshed STP plan be adopted and tested against the Herefordshire Joint Health and Wellbeing Strategy, the needs identified in the Joint Strategic Needs Assessment (JSNA), and the existing plans of Herefordshire Clinical Commissioning Group (CCG) and the council;

(b) assurance be sought from members of the HWB that the implications of the refreshed STP plan for the commissioning intentions of their organisations are understood and are being taken into account; and

(c) the board determine how it wishes to be engaged in overseeing implementation of the STP plan.

Further information on the subject of this report is available from
Martin Samuels on Tel (01432) 260339

Alternative options

1 The Health and Wellbeing Board (HWB) could decide not to adopt the refreshed STP plan – STPs have no legal standing and the development of a plan is purely an NHS management requirement. The national guidance is clear that the HWB is not a body that is required to adopt the plan. Should the HWB conclude that the plan did not have due regard to the Joint Strategic Needs Assessment (JSNA) and the Herefordshire Health and Wellbeing Strategy, which is a statutory duty on all local bodies, it could decide not to adopt it. This would have no formal effect, but would send a signal to the Herefordshire and Worcestershire STP. If necessary, the HWB could refer the STP plan to the Secretary of State as not having due regard to the Health and Wellbeing Strategy and the JSNA. This is not recommended, as the plan has been drafted in order to have due regard to those documents.

2 The HWB could decide not to seek assurances from the organisations represented on the HWB that the implications of the refreshed STP plan for their commissioning intentions were understood and were being taken into account – As noted, STPs have no legal standing and the development of a plan is purely an NHS planning requirement. Nonetheless, since all NHS bodies are required to contribute to, and be guided by, the STP plan, which will therefore influence Herefordshire CCG's commissioning intentions, and review of partners' commissioning intentions is one of the statutory functions of the board, it is not recommended that the HWB decide not to seek assurances from the organisations represented on it.

Reasons for recommendations

3 As part of the governance process for the STP, the refreshed STP plan is being considered in public session by the boards and governing bodies of all of the NHS bodies within Herefordshire and Worcestershire. Since the HWB is not a statutory NHS body, this requirement does not apply to it. The STP plan is intended to set the framework for the local health and social care system over the next several years.

Key considerations

4 HWB members received a briefing on the draft STP plan on 13 June at a joint informal session with members of the Worcestershire HWB. The issues and the context were then considered at a formal meeting of the HWB that afternoon. Subsequent to that meeting, more detailed comments from members of the HWB were collated and summarised in a letter from the Director for Adults and Wellbeing, sent to the Lead Accountable Officer for the STP, attached at Appendix 1.

5 The draft plan has been further refreshed in light of the comments made by the members of the HWB, as well as those received from the Worcestershire HWB. Examination of the text suggests that the comments made have been appropriately taken into account. The final document is attached at Appendix 2.

6 The STP plan is now being considered by the boards and governing bodies of all the NHS bodies across the footprint and is due to be adopted by them as the foundation for their ongoing local plans. On that basis, the STP plan is intended to set the context for the commissioning plans of Herefordshire CCG, and should also influence the plans of all parts of Herefordshire Council. This will be done as part of the process to refresh the council's Medium Term Financial Strategy (MTFS). Since one of the functions of the HWB is to ensure that the commissioning plans of partner organisations take due regard of the Herefordshire Health and Wellbeing Strategy,

the HWB will wish to seek assurance from the partners that the impact of the STP plan on those plans is understood and being taken into account in ways that are consistent with that strategy.

7 Moving forward, the STP is expected to shift from planning into implementation. Unlike the Better Care Fund, where national guidance requires plans to be signed off by the local HWB, there is no formal role for HWBs in the STP process. That said, national guidance is that STPs should continue to seek to engage with local partners, and each of the organisations represented on the HWB are members of the STP Programme Board. The HWB will want to determine how it wishes to be involved in, and informed about, the STP process as it moves into its next stages.

Community impact

8 The STP plan is based on the Triple Aim philosophy that the desired outcomes of population health and wellbeing, quality of service delivery, and financial sustainability are mutually interdependent, such that none can be achieved over the longer-term without the others. The plan is therefore designed to set the context for changes across the entire health and social care system for Herefordshire and Worcestershire, identifying key workstreams, in order to enable achievement of the Triple Aim. Its central purpose is therefore to secure the best possible outcomes for all communities across the Herefordshire and Worcestershire footprint.

9 At this stage, it is not possible to determine the detailed implications of the STP plan on achievement of the council's priorities, as the specific service changes will be developed through the individual workstreams and will be subject to appropriate public engagement and consultation prior to formal decisions being taken through the relevant governance process for each issue. The intention set out in the STP plan is that there should be a positive impact on communities, based on the Triple Aim philosophy.

Equality duty

10 The STP plan identifies how support is provided to vulnerable people with a range of tailored services.

11 The recommendations support the Public Sector Equality Duty, under section 149 of the Equality Act 2010, which are to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act;
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it;
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

Financial implications

12 The STP plan is intended to set out the strategic direction of travel not just for healthcare services but also for social care, which will guide the development of local plans by individual organisations. Financial decisions will be made through governance of those local plans. Overall, the intention of the STP plan is to support achievement of financial sustainability by all parts of the health and social care system across Herefordshire and Worcestershire, ensuring that forecast expenditure

is within the available budgets. This will require expenditure to be reduced from its current 'do nothing' projections, though the absolute level of funding will continue to increase, given existing commitments regarding healthcare budgets, where growth exceeds expected reductions in social care budgets.

Legal implications

13 There is no legal duty to prepare an STP plan, but guidance issued by NHS England requires all NHS organisations to be actively involved in preparing such a plan, with strong encouragement on councils to be engaged.

14 With regard to the duty to consult, councils and CCGs have a general duty to consult on significant changes to services as well as specific duties under equality legislation. The guiding principles are fairness and proportionality, taking into account the extent of the change and the number of people affected. The Gunning principles outline that consultation must take place when the proposal is at a formative stage, sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response, adequate time must be given for consideration and response, and the product of consultation must be conscientiously taken into account.

Risk management

15 There are no direct risks associated with the STP plan itself, as this is not a formal document of the HWB.

16 The STP Programme Board has identified a number of risks associated with the wider health and social care system, and the implementation of the service changes provisionally identified in the refreshed plan. Through their membership of that board, the organisations that are members of the HWB are able to secure assurance that the risk management processes operated by the STP are robust.

Consultees

17 The STP plan has been subject to public and staff engagement, which was considered by the HWB at its meeting on 13 June.

Appendices

Appendix 1: Letter from the Director for Adults and Wellbeing, sent to the Lead Accountable Officer for the STP, summarising the comments of the HWB on the draft plan.

Appendix 2: Refreshed STP plan.

Background papers

- None identified.

Herefordshire Council

Adults and Wellbeing
Director: Martin Samuels

Sarah Dugan

Sent via email

Our Ref: MS/md
Please ask for: Martin Samuels
Direct line / Extension: 01432 260339
E-mail: Martin.samuels@herefordshire.gov.uk

5 July 2017

Dear Sarah,

Herefordshire Health and Wellbeing Board
Comments on Herefordshire and Worcestershire Draft STP Plan Submission 03 July 2017

I have been asked by the HWB to write to you, summarising the board's views regarding the STP plan.

The Herefordshire Health and Wellbeing Board welcomes the opportunity to comment on the draft Herefordshire and Worcestershire Sustainability and Transformation Partnership's (STP) plan at this latest stage in its development.

The board has received regular reports and presentations on the developing STP plan since the national process was first announced in December 2015. Sarah Dugan, as the lead Accountable Officer for the STP, and members of the STP project team, have attended these discussions. Every opportunity has been taken to answer board members' questions.

The Herefordshire Health and Wellbeing Board also met with the Worcestershire Health and Wellbeing Board on 13 June 2017 in a private joint development session to further discuss the STP plan.

Throughout these discussions, a number of points have been raised consistently by board members as being areas where further focus or strengthening was required within the plans:

- Herefordshire Health and Wellbeing Strategy priorities – The board has examined the draft STP plan and approach to provide assurance that the latest draft document has full regard to the priorities identified in the strategy. These priorities are:
    - Mental health and wellbeing and the development of resilience in children, young people and adults;
    - For children, starting well with pregnancy, maternal health, smoking in pregnancy, 0-5 immunisations, breastfeeding, dental health, pre-school checks, children with disabilities, young offenders, young people not in education, employment or training, looked after children;
    - For older people, quality of life, social isolation, fuel poverty;
    - For adults, long term conditions, lifestyles (alcohol, weight, active lifestyles, smoking prevention, mental health);
    - Special consideration, reducing health inequalities - carers, returning veterans and armed forces families, the homeless, non-English speaking communities, women -

domestic abuse and sexual violence, families with multiple needs, those living in poverty, travellers, people with learning disabilities;
    - Impact of housing, fuel poverty and poverty and the impact of health and wellbeing; and
    - Hidden issues, alcohol abuse in older men and women and young mothers.

- Mental health and children and young people – The board note that there is very limited reference to these important issues, which represent the first priority within the Health and Wellbeing Strategy. This will need to be addressed in future drafts.

- Triple Aim – The board welcomes the conceptual basis of the STP plan, expressed in the triple aim of population health and wellbeing, quality services, and financial sustainability, with the recognition that these three are mutually interdependent. The board feels that the aspects of population health and wellbeing need to be more explicitly presented in the revised plan, with greater emphasis on people maintaining and regaining their independence, rather than just a focus on self-care.

- Housing – The board believes that housing and social exclusion are central securing individual wellbeing outcomes and has asked for the STP plan to include reference to closer working on housing across the whole system. This connects with the need, highlighted by the board, for connections to be reinforced with the voluntary sector and with the police, as well as other key partners.

- Transport – Members of the board believe that the very rural nature of the county must be recognised as a central factor in maintaining good access to services. The STP plan needs to have a clear travel component, recognising that many of the issues may be very locally specific, and should connect to the transport teams within the council. In so doing, the plans should have regard to the distinction between inconvenience and inaccessibility, linking to wider work around social exclusion and also the scope to provide more services through telecare.

- One Herefordshire – The board notes that there continues to be a close alignment between the One Herefordshire work and that being undertaken through the STP. It is felt to be a great strength that Herefordshire is speaking with one voice in influencing the overall direction. The board is reassured that the two processes are mutually reinforcing and supportive. Nonetheless, the board recognises that Herefordshire cannot solve its problems alone and that there will be a need to work across a greater footprint to tackle some issues. Worcestershire is the prime partner, but will not be the only partner engaged with.

- Details of STP plans – Members of the board have regularly asked for the detail of the plans. They have been broadly in agreement with the high level aims, but have wanted to see more detail about specific impact on local residents.

The STP has been amended during the period of time that the Board has held its meetings. The Board will next discuss the STP in public session at its meeting on 18 July.

Yours sincerely,

Martin Samuels

Martin Samuels
Director for Adults and Wellbeing
Herefordshire Council

Herefordshire & Worcestershire Sustainability and Transformation Plan

5th July 2017 - Publication

www.yourconversationhw.nhs.uk

Your Health & Wellbeing
#YourConversation

Worcestershire Acute Hospitals NHS Trust
Herefordshire Clinical Commissioning Group
Redditch and Bromsgrove Clinical Commissioning Group
South Worcestershire Clinical Commissioning Group
Wyre Forest Clinical Commissioning Group
Wye Valley NHS Trust
Worcestershire Health and Care NHS
2gether NHS Foundation Trust
Taurus Healthcare
worcestershire county council
Herefordshire Council

Name of footprint	Herefordshire and Worcestershire
Region	Midlands and East
Nominated Lead	Sarah Dugan, Chief Executive Worcestershire Health and Care NHS Trust
Contact Email	whcnhs.yourconversationhw@nhs.net

Partners involved	
GP Practices	90
CCGs	4
Acute Trusts	1
Combined Acute and Community Trusts	1
Combined Community and Mental Health Trusts	1
Mental Health Trusts	1
HealthWatch bodies	2
District and Borough Councils	6
Councils with Health & Well Being Boards	2

Key Statistics	
Population	780,000
Area	1,500sq m
Annual NHS Allocation – 2016/17	£1.168bn
Annual NHS Allocation – 2020/21	£1.327bn
STF allocation in 2020/21	£50m
NHS "Do Nothing" financial gap to 2020/21	£288.1m
NHS Residual Gap after applying national planning assumptions	£61.3m

Herefordshire and Worcestershire

Sustainability and Transformation Plan

5th July 2017

Redditch and Bromsgrove CCG
South Worcestershire CCG
Wyre Forest CCG
Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust
4 Primary Care Collaborations (covering 66 practices)
Worcestershire County Council

Herefordshire CCG
Wye Valley NHS Trust
2gether NHS Foundation Trust
Taurus GP Federation (representing 24 practices)
Herefordshire Council

#yourconversationHW

Contents and foreword

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Foreword by Mark Yates, Independent STP Chair

Herefordshire and Worcestershire have some unusual challenges compared to many of the other STP areas. We are one of the largest STP areas in terms of geography – covering 1,500 sq miles, but one of the smallest in terms of population – covering about 780,000 people. By way of example the distance between Hereford County Hospital and Worcestershire Royal Hospital is more than 30 miles and typically takes more than an hour to drive on single carriageway roads.

Our counties are also unusual in that they provide hospital services for 40,000 people from the Welsh health system who are external to the area. Powys has no district general hospitals and the people of mid-Powys rely on the County Hospital in Hereford and with Powys being even more sparsely populated than Herefordshire, for some residents, the nearest acute hospital after Hereford is some considerable distance away in Aberystwyth. Service provision in this area is characterised by long travel times for patients and staff and we have the challenge of achieving a balance of what can be provided locally in Wales and centrally in England.

Partners across the two counties recognise that the solution to the sustainability and efficiency challenges facing health and social care cannot be dealt with by partners nor organisations working alone. Individuals, families, local communities, Voluntary and Community Sector Partners all have a core role to play in developing solutions. We need to place equal if not greater focus on helping communities and individuals to live healthily, be resilient and avoid the need to access organised services for things that many people are able to deal with themselves. Carers play a vital role in this vision and are a hugely important asset to the NHS and social care system. We need to do more to help identify, support and recognise their vital roles. We will do this by working towards achieving system wide agreement to implement the "Commitment to Carers – Carers Toolkit". Helping carers to provide better care and to stay well themselves will contribute to better lives for those needing care and more effective use of NHS and social care resources.

These are just a few of the many challenges faced by the two counties, but all partners continue to be equally committed to providing the best and most cost effective services to our communities and patients. We've been working very closely together throughout 2016 and this commitment to the STP process will see our collective journey forge well into the future. However, partners also recognise the magnitude of the difficulty of providing health and social care services to a very diverse and widespread population within a very tight cost envelope. We recognise that this submission is not an end point – it is merely a stage in our collective journey towards a better health and social care system for the population of Herefordshire and Worcestershire and we are committed to engaging with our communities to ensure this is the case going forward.

What has changed since we published our draft plan in November 2016?

On 22nd November the Herefordshire and Worcestershire Sustainability and Transformation Plan was published for the first time. The document was an "umbrella" plan bringing together all the current changes happening across the two health and social care systems. It started by outlining the gap that health and social care services in the two counties face, using the triple aim mantra of (i) Health and well being, (ii) Care and quality and (iii) Finance and efficiency.

The document incorporated 12 proposed programmes of work across four priority change areas, supported by three key enabling processes. These programmes and processes each contained a series of first ideas and outline proposals for how local partners and stakeholders felt we could begin to tackle the challenges we face.

At the time of publication we were acutely aware of the public's nervousness around the plan and how it would affect local communities and services that they rely on. We also recognised that due to the process and timelines we were working to, the opportunities for public engagement before publication in November were fairly limited.

For these reasons we specifically chose to enter a period of public engagement and discussion on the contents of the plan post publication of the draft in November. This was **not a consultation** because we were not seeking views on specific worked up service changes.

Consultations will be undertaken for specific service changes that are made under the guise of the STP in the coming months and years where appropriate.

The "***Your Conversation***" engagement began in November 2016 and ran through to the end of February 2017. Unfortunately due to the restrictions of pre-election Purdah, firstly for Worcestershire's Local Authority Elections in May and subsequently for the General Election in June, we have been unable to publish our refreshed plan until July 2017.

We are pleased to be able to do so now and we welcome further feedback from the public and local stakeholders to help us inform and develop our delivery plans. Please provide further comments to whcnhs.yourconersationhw.nhs.net

Further information and supporting information is available at our website:

www.yourconversationhw.nhs.uk

The public engagement identified broad support for the direction of travel that we outlined in the draft plan. However, there were a number of areas that were highlighted as requiring further consideration as we develop further detail.

The vision and key priorities remain the same, however we have updated some parts of this document. The more significant changes made during the refresh process include:

- **Public engagement - pages 5 to 9** - A whole new section to preface the original plan which outlines the key themes arising from the engagement and how we intend to address these as we develop more detailed proposals.
- **Financial context – page 22** – As people would expect, the financial landscape has changed over the last 6 months. The finance section has been refreshed to reflect this.
- **Programme Management and Governance arrangements – pages 26** – We have refined our processes to oversee delivery of the STP and ensure that we use existing forums to take ownership for delivery of the plan.
- **Prevention , self care and promoting independence– pages 41 to 45** – We have updated the section to reflect emerging changes in the two counties health and well being strategies.
- **Urgent Care – Pages 61 to 71** – following a challenging winter and the emergence of A&E Delivery Boards to oversee improvements in urgent care, we have refreshed this section to reflect the revised priorities and delivery arrangements. We have also refreshed the bed numbers for Worcestershire to reflect agreed changes that were implemented during 2016/17.
- **Mental health – pages 55 to 60** – Whilst the shared ambition to invest in mental health services and parity of esteem has not changed, partners have recognised that that financial conditions have meant we are not going to be able to achieve as much as we originally intended in the early years of the plan. The refreshed version reflects this and the revised timelines.

Other than these areas and points of factual accuracy this document is broadly unchanged from the version published in November 2016.

Communications and Engagement

Our STP priorities are not new; they have been central to our engagement for a number of years and include extensive engagement around our strategies for Urgent Care, the reconfiguration of acute hospitals services, increasing out of hospital delivery and the promotion of self care and prevention. The collaborative focus of the STP process has enabled us to bring the learning from these activities together to develop a consistent approach to our future work, namely to effectively scale up the engagement and interaction with our local communities, clinicians and staff.

Throughout the STP process we have engaged on the direction of travel and post publication on the 21st November 2016 we have undertaken a period of formal public engagement on the full plan. This concluded at the end of February 2017 with ongoing further engagement with our workforce. Overall the engagement has focused on some high level ideas and concepts, to ascertain initial views on the suggested direction of travel and key priorities identified. The engagement has been supported by a dedicated website (www.yourconversationhw.nhs.uk) where a number of documents have been made available including the full plan and a summary document, plus an online questionnaire. In addition to online information, events and drop in sessions have been held across the two counties where patients, carers and members of the public have been able to meet with members of the communications and engagement work stream to discuss thoughts, concerns and ideas and to complete a questionnaire.

A further opportunity to engage with the community has been presented by the consultation events on the Future of the Acute Hospital Services in Worcestershire. Across the two counties, presentations have also been made at a number of community, voluntary and statutory sector meetings, groups and forums. Attendance at these groups has allowed us to share information, promote discussion and gather the views of various health and care groups/patient and carer groups, and also to gather the views of those considered seldom heard. Other comments have been received through letters, emails and enquiries.

By the end of the engagement period, 1195 public and patient engagement questionnaires had been completed and over 165 events had been attended. There were 10,769 hits to the website supported by social media activity. The final STP engagement report is available at (www.yourconversationhw.nhs.uk

A review of feedback half way through the engagement period indicated the need to enquire more deeply into two areas that respondents seemed concerned about – notably transport and the use of technology. To this end, a focused piece of work with a number of groups and individuals has allowed us to explore these issues in more detail. This work is continuing and recommendations will embedded in the specific workstreams and subsequent proposals where appropriate.

Specific engagement with staff around the STP began in February 2017 and by the end of April we had 372 survey responses that highlighted staff understanding about the STP and early views around the general direction of travel. The next phase of engagement will scale up internal communications around our delivery plans and widen the involvement with STP developments with our workforce.

#YOURCONVERSATION

YOUR HEALTH AND WELLBEING IN HEREFORDSHIRE AND WORCESTERSHIRE

1195

surveys completed in Worcestershire

478

surveys completed in Herefordshire

165 engagement events and attended VCS group meetings in Worcestershire and **25** in Herefordshire

206

10,769

hits to our dedicated STP webpage from November.

6 'STP launch' articles in the local papers across Herefordshire and Worcestershire

25 STP related articles
– most relating to bed reductions

2,567

people viewed the STP summary document.

46

retweets on our Twitter posts

12,607

impressions

2567

people reached through our Facebook posts

Current engagement activity paused at the end of February 2017.

Key themes from our engagement activity:

The engagement that has been undertaken has indicated general support for the direction of travel:

Out of hospital care

Many respondents support the idea of having well-publicised, local services provided by a range of health care professionals who are available at known community bases/health hubs. Decisions around which service/professional a patient should access should be made by clinical, not administrative staff. There is strong support for much routine, non-urgent and non-specialist care to be provided at home/in the community/out of hospital. Many respondents would like to see many more services provided locally and support the idea of local health teams caring for patients at home.

General Practice

Access to services at present is not straightforward and is more complex for particular groups. Many respondents believe that access to GP services needs to be changed with good support for the idea that some might see a professional other than a GP, and the proposal that GP appointments should be kept for those who really need them. Respondents support the suggestion that GPs should support local health teams and believe that more professional time should be allocated to those who need it. However, many do not support the idea of Skype being used for routine appointments.

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Accident and Emergency services

A lack of 24/7 local options and out of hours GP services are seen as key contributors to the challenges being faced by A&E. Respondents want A&E to only treat those who need to be in A&E and many people support the proposal to re-direct people to more appropriate sources of treatment. Whilst some respondents feel that information could help in this regard and offer suggestions where and how this could be provided, others believe that the issue is more about education that needs to be provided at the point of access so that people start to learn what is provided where.

Prevention , self-care and promoting independence

Most people recognise they have a responsibility to look after their own health but currently, information about health and services and what people can do for themselves is difficult to access, sometimes contradictory, and often confusing. Respondents want clear information about all services/conditions provided in one trusted place or by trusted individuals or organisations that are known to them and their community. Some respondents recognise that information is not enough for those with entrenched or habitual behaviour, calling for health coaching/motivational interviewing support. Much more prevention and self-care information should be communicated through schools and workplaces.

Key themes from our engagement activity:

Technology

Views on technology are mixed; some people like it, some do not, and this engagement would suggest that preferences do not reflect gender or age variables. However, in Worcestershire, it would suggest that preferences are linked to ethnicity, with minority ethnic groups much less supportive of technology than White British groups. The feedback across the two counties indicates that overall, different people like different IT solutions. The perception of whether or not it is useful, often depends on the service/groups it is being proposed for and many respondents felt they had insufficient detail at this stage to comment more fully.

Transport and Travel

For the majority of people who responded through the Your Conversation engagement transport and travel was not a issue but the data does suggest that transport remains a challenge for some particular groups. In Worcestershire this seems to include some patients in the North of the county, as well as some carers, both of whom indicate that they do not have access to transport options. Similar concerns were expressed by some Herefordshire residents who are concerned that they will not be able to access appointments when they no longer drive as there are reduced or no public transport options in some places. It is suggested that greater flexibility and a broader system response is taken to address the issues identified around travel and transport challenges and that these are considered early in relation to specific STP proposals.

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Bed reductions

There is concern about reducing the number of beds, based on the view that beds are still needed and a lack of knowledge/understanding about the alternatives on offer. This was mainly relating to Community Hospital bed reductions and limited detail around the skills and capacity required to support and care for people in their home.

Carers

If carers are going to be asked to do more and to become care partners, more work is required to identify, support, train and involve them. Many carers asked for breaks or respite periods.

Better use of resources

Many respondents were keen to offer views around how services could be made more efficient; including better use of resources like pharmacists, mobile units and community venues.

Communications and Engagement: Next Steps

To date, the patients and public we have engaged with have expressed their appreciation for the opportunity to be involved. It is important that as our plan becomes more detailed we scale up our communication and engagement activity accordingly, with a focus on specific changes that are being considered and how people can engage with these. Therefore, each workstream is developing a bespoke approach to communication and engagement, reflecting the themes from the engagement activity to date and involving key stakeholders to develop the detail around priorities and proposals. There is a dedicated Communication/Engagement Officer on each workstream – they provide advice around best practice and ensure links are made to the established structures across our system. The Communications and Engagement workstream meets monthly, aggregating the workstream activity to advise Partnership Board around the ongoing system wide messages/context setting to support the overall direction of travel. This workstream is also supported by NHSE to develop and embed models of enhancing system wide approaches Community Citizenship and co-production.

Next Steps:

- A Communication and Engagement Plan is in development which outlines the expected activity across all the workstreams including an early assessment on equality impact, areas for formal consultation and the timelines for these. This focused work will be supported by ongoing overarching engagement around the content of our Summary Document, ie the case for change, the scaling up of out of hospital models and prevention, self care and promoting independence.
- Through current public sector partnerships we will seek to align our ambitions and developments to maximise wider place based delivery where possible. This will include modelling around impact across the wider determinants of health including housing, employment, community safety etc
- A key part of our work around carers is about involving them as expert care partners but our engagement has shown that carers need support and training to step fully into this role. To help us with this we applied for, and were successful in being selected, to receive support from the Building Health Partnerships scheme. This year-long project will see voluntary and statutory sector working together to establish a Carers Reference Group that will help ensure existing initiatives are mapped and good practice around carers (including support for carers to participate as experts in the care planning process) embedded within work streams and across the two counties.
- Targeted engagement work will continue around transport, travel and digital to further understand the issues and explore the opportunities to work differently with partners. Responding to our Your Conversation feedback this will also scope out the varying approaches that maybe developed for different communities, including younger and older people as well as black and ethnic minority groups and rural communities.
- We will continue to work with NHSE as a STP exemplar site for Communication and Engagement to strengthen our approach to Community Citizenship. We anticipate that our Building Health Partnerships work will provide us with an opportunity to test ideas around Lay Reference Groups and VCS involvement which can then be extended and adapted to support all the activities outlined in our STP.
- We will continue to work with Communication and Engagement colleagues from neighbouring STPs and beyond to align messages (especially at our county's borders) and adopt best practice and innovation where possible.

Our vision for 2020/21

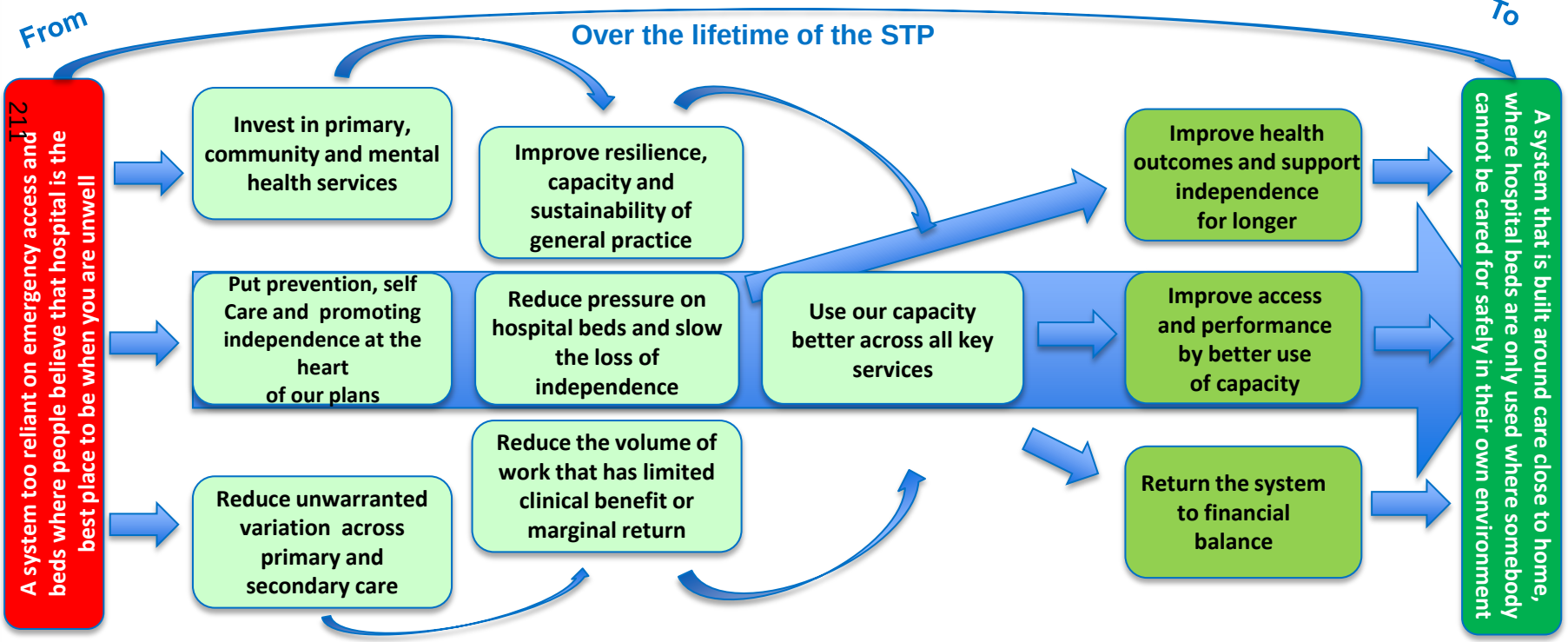
"Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people".

What we mean	
Live well in a supportive community…	There is collective agreement across the wider public and voluntary/community sector that one of the most effective ways to improve health is for people to live well within supportive resilient communities taking ownership of their own health and well-being. We will be better at helping residents to draw on the support available from their local communities and voluntary groups, and we will help those communities and groups develop the capacity to meet these needs. We will use social impact bonds and social prescribing to support this. This will apply across all age groups.
…with joined up care…	Where individuals have a health or care need this will be delivered in an integrated way, with a single plan developed with and owned by the individual in true partnership and available wherever people access the system. Local integrated delivery teams will be in place which recognise the central role of the GP and reflect a broad range of skills and expertise from across the organisations. We will make care boundaries invisible to people using our services by removing operational boundaries between organisations and we will ensure that co-production is embedded in everything we do.
…underpinned by specialists…	Specialist care will always be needed, but there are times when care could be safely provided under the remote supervision of a specialist across a digital solution. For example, by developing better digital links between practices and hospitals we believe that more care can be provided locally by GPs and other health or social care staff based in the community. This is particularly important given our rurality challenge. Our workforce, organisational development and recruitment plans will focus on making sure that we make Herefordshire and Worcestershire an attractive place to work so we have a stable and committed workforce, with much less reliance on agency employment.

What we mean	
…delivered in the best place…	We will have completely adopted and embraced the principle of "home first" and will deliver as many services as possible close to home. We will carefully balance the need and benefit of local access against that of service consolidation for quality, safety and cost effectiveness. We will reduce as far as possible the need for people to travel out of their area to access most services. Some services will be brought out into communities and delivered in GP surgeries, community hospitals or other local premises. Equally some services will be consolidated where clinical sustainability or quality of care is significantly improved by doing so. Joined up transport planning will enable us to support people in planning their travel arrangements where this is the case. We will involve the public in any decisions and provide the information needed to understand how and why things need to change.
…by the most appropriate person.	We need to create the capacity and resilience to enable GPs to be clinical navigators and senior clinical decision makers in the out of hospital care setting. This will be with a particular emphasis on people who are frail and those at risk of emergency admission. We will develop extended roles such as physician assistants and advanced practitioners in areas such as physiotherapy, dermatology and pharmacy and review the skill mix to free up the GP time needed to focus on patients with the most complex needs. Equally there are times when the demarcations in roles are too prohibitive and result in the need for additional roles that add more cost than value. This will change with alignment of pathways of care. Over time we have introduced a degree of complexity and cost that is not sustainable. The work we do to implement this plan will mean that people will be seen by the right person in the right place at the right time. This will mean change to the way in which services are delivered.

The essence of our Sustainability and Transformation Plan

Our health and care economy has become too dependent on reactive bed based care that results in reduced wellbeing, a poor patient experience and higher cost of services. There remains a public perception that being in hospital is the best place to be when people are unwell. This is despite there being considerable evidence to the contrary, particularly for people who are frail. The essence of our STP is to change this by keeping people well and enabling them to remain in their own homes. We will achieve this by focusing our efforts more on what happens in our communities, not just in hospitals. We will build our system around resilient and properly resourced general practice, that has community services wrapped around them. This will relieve pressure on our hospitals, which will be freed up to focus on efficiently dealing with complex elective and emergency care. Waiting times and outcomes for patients will be better. For the system it will enable us to live within the financial means available by the end of the 5 year period. To achieve this change we will require all partners to commit to this approach and to deliver this through their operational planning and delivery work. It will also require change from the population. We will need local residents and citizens to take more control of their own health and well being, to take more responsibility for supporting others in their communities. Building strong and resilient communities, through wider work around employment, housing and education, will be an essential foundation for this. As a result, people will no longer need the historic range and level of public services, and will be sensible consumers of the services we do need to provide.



A single page summary of the big priorities for this STP

Sustainable General Practice

- Prioritise investment to ensure delivery of the General Practice Forward View – developing primary care at scale "bottom-up" with practices , community pharmacy, third sector and health and care services.
- Redesign the primary care workforce, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity.
- Adopt an anticipatory model of provision – with proactive identification, case management and an MDT approach for those at risk of ill-health.
- Share information across practices and other providers to enable seamless care.
- Move to "big system management" – with real time data collection and analysis providing the intelligence to support continuous quality improvement and demand management.

Primary & Community Services

- During 2018/19, organise and provide services from locality based Multi-Speciality Community Providers (Worcestershire) and similarly formed alliance model (Herefordshire).
- Through the One Herefordshire Alliance and the Worcestershire Alliance Boards, develop population based integrated teams wrapped around general practice covering physical and mental health, wider primary and social care services and engage with the population to deliver services close to home.
- Support patients and carers to self-manage their own conditions, harnessing voluntary sector partners and communities to support independence and reduce loneliness.
- Develop plans which integrate specialist support, reducing the time taken to access specialist input and reducing the steps in the pathway. Initially focussed on supporting people living with frailty and end of life care, but adopting principles and learning quickly to a range of other priority pathways.

Prevention, self care and promoting independence

- Embed at scale delivery of evidence based prevention interventions across all providers of health and social care, achieving population behaviour change.
- Put long term life outcomes for children, young people and their families' needs at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future.
- Support people to manage their own health, linking them with social support systems in their communities and identify when a non-clinical intervention will produce the best experience and outcomes for patients.

MH & LD

- Deliver the requirements of the national taskforce.
- Work with NHS specialised services to increase local child mental health services to reduce demand for complex out of county services and enable repatriation of complex cases back to their local areas.
- With local authorities, develop joint outcomes and shared care for people with learning disabilities.

Urgent Care

- Reduce the number of individual physical access points to urgent care services across the two counties by 2020/21.
- Retain 3 units with an A&E function across the two counties. Explore the need for the number of MIUs and the Walk in Centre as we move to 7 day primary care services, and the opportunity for standardised opening hours for MIUs in Worcestershire.
- Shift to home based care – explore whether we should reduce the number of community based beds across the system and shift resources to primary and community services.

Maternity

- Implement the clinical model for maternity inpatient, new born and children's services within Future of Acute Services in Worcestershire programme.
- Develop a Local Maternity system across Herefordshire and Worcestershire delivering the Better Births strategy.
- Establish a single service with specialist teams working under a common management structure, delivered locally within both counties.

Elective Care

- Develop 4 key prevention programmes to reduce demand for surgery delivered at scale and improve the likelihood of positive clinical outcomes following surgery.
- Across Worcestershire undertake a greater proportion routine elective activity on "cold" sites to reduce the risk of cancellations and to improve clinical outcomes.
- Develop strategic partnerships with external partners to secure organised access to elective surge capacity in a planned and managed way.
- Expand pan STP working on cancer services and deliver the requirements of the national taskforce.

Infrastructure

- Explore the benefits from integration in pathology, radiology and pharmacy services across the two counties.
- Develop robotic pharmacy functions and maximise the use of technology.
- Develop a single strategy and implementation plan for a joined up place based back office across all local government and NHS partners.
- Develop a place based estates strategy and a place based transport strategy.

Our biggest challenges – health and well-being

Overall, health outcomes in Herefordshire and Worcestershire are good but we face significant challenges now and into the future. We recognise that radically scaling up prevention activities across all our health and care interactions with the population will be a vital element of securing improvements, we also recognise the need to work closely with wider system partners to ensure that a healthy place is created by all those who shape it, addressing the social, economic and environmental determinants of health. These partners will include police, fire and rescue, housing, and the VCS, as well as economic partners who can influence the overall wealth and inequality of our place.

The gap between life expectancy (LE) and healthy life expectancy (HLE)
There are large numbers of people living in poor health in our older population and this is one of the most significant gaps to reduce. In Herefordshire the gap at 65 years of age is 7.8 years for men and 9.4 years for women. In Worcestershire 7.1 and 9.1 years respectively. Closing these gaps is essential to improving the quality of life for the population.

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- **Premature mortality rates vary significantly between the two Counties** Worcestershire mortality rates are most concerning – the county ranks 55th out of 150 Authorities nationally (where 1st is best) for premature mortality rate per 100,000 population. Herefordshire ranks 21st out of 150. In comparison with its statistical neighbours, Worcs ranks 12th out of 15, with a premature death rate of 320 per 100,000, compared with 256 for the 1st ranked. This is equivalent to around 370 additional premature deaths a year. Herefordshire ranks best for its comparative group, with a premature death rate of only 287 per 100,000

- **There are some condition specific premature mortality concerns** - In Herefordshire, colorectal cancer, heart disease and stroke are slightly higher than expected (but not significantly), whereas in Worcestershire, premature mortality in some of these areas is amongst the worst or actually is the worst for its comparator group (for example colo-rectal cancers and heart disease)

Gap between life expectancy & healthy life expectancy

	Men	Women
Herefordshire	7.8 yrs	9.4 yrs
Worcestershire	7.1 yrs	9.1 yrs

Premature mortality rates compared to other areas (1 is best performing)

	England	Statistical Neighbours
Herefordshire	21st of 150	1st of 15
Worcestershire	55th of 150	12th of 15

Our biggest challenges – health and well-being

There is a gap in mortality rates between advantaged and disadvantaged communities, particularly in Worcestershire – Our health and well-being strategies identify approaches to tackle this gap, and these are reflected throughout the STP. The range of years of life expectancy across the social gradient at birth is 7.8 years in Worcs and 4.9 in Herefordshire. In our rural areas, health inequalities can be masked by sparsity of population but we know differences exist which need to be tackled, including issues of access.

Some outcomes for children and young people which are lower than expected:

- **School readiness** - In Herefordshire only 40% of Children receiving free school meals reach a good level of development at the end of the reception school year. In Worcestershire the figure is 46%. Both are worse than the England average of 51%
- **Neonatal mortality and stillbirth rates** – These are amongst the worst in the comparative groups for both counties. In Herefordshire it is 9.7 per 1,000 live births and Worcestershire 7.5 per 1,000
- **Obesity** – In Herefordshire 22% and in Worcestershire 23% of reception class children are obese or overweight
- **Alcohol admissions under 18s –** In Herefordshire the figure of 56 per 100,000 population and in Worcestershire 46.5 per 100,000 are both significantly higher than the England average of 40. This equates to an additional 30 admissions in Herefordshire and 37 in Worcestershire per annum
- **Breast-feeding initiation rates** are both below the national average (68% in Herefordshire and 70% in Worcestershire with a national figure of 74%).
- **Occurrence of low birth weight** in both counties is amongst the worst of their comparator groups
- **Teenage conceptions** - 24 per 1,000 in Herefordshire and 25 per 1,000 in Worcestershire are the highest rates amongst their comparator groups

Mortality variation between different social groups

Difference between less deprived and more deprived areas

Herefordshire	4.9 yrs
Worcestershire	7.8 yrs

Areas of concern regarding poor outcomes for children and young people across both counties

Older ---------- Younger

- **Neonatal mortality and still births**
- **Low birth weight**
- **Breastfeeding rates**
- **School readiness**
- **School age obesity**
- **Under 18 alcohol admissions**
- **Teenage conception rate**

Our biggest challenges – health and well-being

Mental health and well-being - This is a theme that cuts across and impacts on all the outcomes and is a priority in our health and well-being strategies**.** On average, men and women in contact with mental health services have a life expectancy 17.5 and 14 years less than the rest of the population of Herefordshire and Worcestershire, this is a highest figure compared to similar STP areas. On the Integrated Household Survey 21% of residents in Herefordshire and 18% in Worcestershire reported an anxiety score of over 5/10. In addition, we know that people suffering from mental health conditions suffer higher levels of health inequality and outcomes across an array of measures. We will focus on improving mental health and well-being which will in turn impact on individual behaviour change and physical health.

To narrow the gaps identified above, our plans for mental health will include improved access to early help as soon as problems start. we will also focus on living healthily, knowing that good physical health is inextricably linked to good mental health. We will focus on changing the lifestyle behaviours that increase risks of poor health outcomes**.** We want to reduce:

- **The numbers of people eating too many high fat, salt and sugar foods** - In Herefordshire 65.2% of adults are overweight or obese and in Worcestershire 66.6%
- **Alcohol consumption** - in both counties about 27% of the drinking population drink at increasing or higher risk levels
- **Smoking** - 14% of adults in Herefordshire and 17% in Worcestershire still smoke
- **Physical inactivity** - 22% of adults in Herefordshire and 25% in Worcestershire are inactive

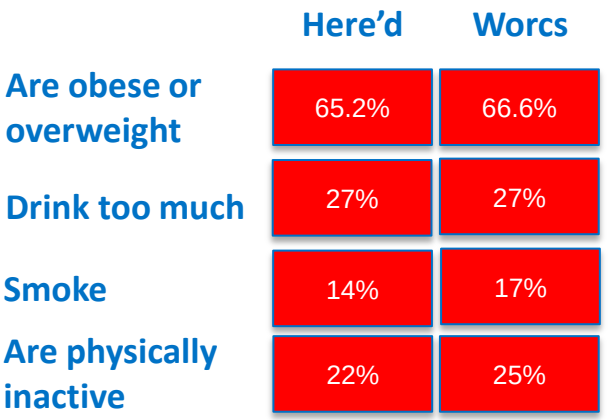
Although we are generally at national average in terms of these behaviours, the national figures themselves give rise for concern and average performance should not be allowed to provide false comfort. If unchecked, these issues will mean that the rising burden of avoidable disease will continue. Furthermore, there are marked differences between deprived and non-deprived areas which will require careful referral and targeting (for example smoking prevalence among routine and manual workers is 25% in Herefordshire and 32% in Worcestershire). The biggest single staff group across the two counties is employed by the NHS and local government. We will focus on implementing local strategies to support our own workforces to lead the way in changing behaviour for others.

Life expectancy for mental health service users compared to non-mental health service users

Gap in life expectancy in years

Unhealthy lifestyles

% of the population who:



Our biggest challenges – care and quality

In addition to our health and well being challenges, we also have a number of areas where our performance on care and quality can be significantly improved. We know there are significant workforce challenges in a number of areas leaving services too reliant and locums and agency staff to meet demand.

Our biggest challenges include:

- Lack of capacity and resilience in primary care and general practice.
- Social care provider capacity & quality (domiciliary and residential care capacity is stretched). The entirety of population growth in Herefordshire over the next 15 years is in the over-75s (with major implications for demand).
- One Trust in the CQC special measures regime and one that has recently emerged from it, having been re-categorised as "requires improvement".
- Poor Urgent Care performance on a number of measures including ambulance measures, 4 hour waits in A&E, long trolley waits and challenges around including stroke performance.
- Poor performance against elective care referral to treatment times (18 week waits) and access to mental health services such as psychological therapies.
- Poor performance of cancer waiting times.
- Low dementia diagnosis rates.
- Poor performance in parts of the STP area on a number of maternity indicators such as uptake of flu vaccinations, smoking at the time of delivery, low birth weight and breastfeeding initiation.

May 2017 Highest risk areas for key NHS Constitutional standards

Urgent Care	• 4 hour A&E standards across all sites • Poor patient flow resulting in 12 Hour Trolley breaches (WAHT) • Stroke TIA (WVT) • Ambulance Handovers
Planned Care	• Referral to treatment 18 week (WVT & WAHT) • Cancer 62 day wait • Cancer all 2 week wait referrals • Cancer 2 week wait – Breast Symptomatic • Cancelled operations (WAHT)
Mental Health	• Dementia Diagnosis • IAPT Access (Improved access to psychological therapies) • IAPT Recovery

Our biggest challenges – finance and efficiency

In October 2016 the STP developed a financial model that set out a 'do nothing' scenario for the health and care economy. The model was calculated showing the impact of increases in demography, inflation and other factors. The model also included those investments required to deliver the priority areas set out in the Five Year Forward View. The STP is in the process of refreshing its financial model, and the scale of the financial challenge is set out below. The Partnership Board has reiterated the importance of the investment in delivering the programmes set out in the General Practice Forward View. The financial model has been refreshed to include 2016/17 outturn, the 2017/19 contractual agreements and organisational control totals. The financial model will be continually refined as we move forward. The refreshed 'Do Nothing' base case for Herefordshire and Worcestershire split by sector is:

includes a £23.0m new requirement to deliver the NHS Five Year Forward View.

Area	Herefordshire	Worcestershire	Do nothing gap
NHS Commissioners	£34.4m	£99.6m	£311.1m*
NHS Providers	£74.8m	£102.3m	

In addition to this, the financial modelling shows that the two local authorities combined have a "do nothing" gap of circa £84m that are being addressed through local efficiency savings alongside the STP– taking the system gap to £395m.

NHS £311.1m gap by area	2020/21 'Do Nothing'	Population	Per head
Herefordshire *Including net import from Wales*	*-£109.2*	*225,000*	*£485*
	-£109.2m	185,000	£590
Worcestershire	-£201.9m	595,000	£339

We recognise the importance of addressing this position as quickly and effectively as possible. Based on published allocations for 2017/19 and advised inflationary uplifts spending allocations will increase from £1.168bn to £1.327bn (this includes NHS England priorities including MH Parity of Esteem). If the population continues to access services in the same way as now, and we continue to provide them in the same way, then our spending will be likely to increase by an additional £175m over and above this increase. When added to our opening gap and the social care gap, this results in the total financial challenge for the system by the end of 2020/21 of £395m.

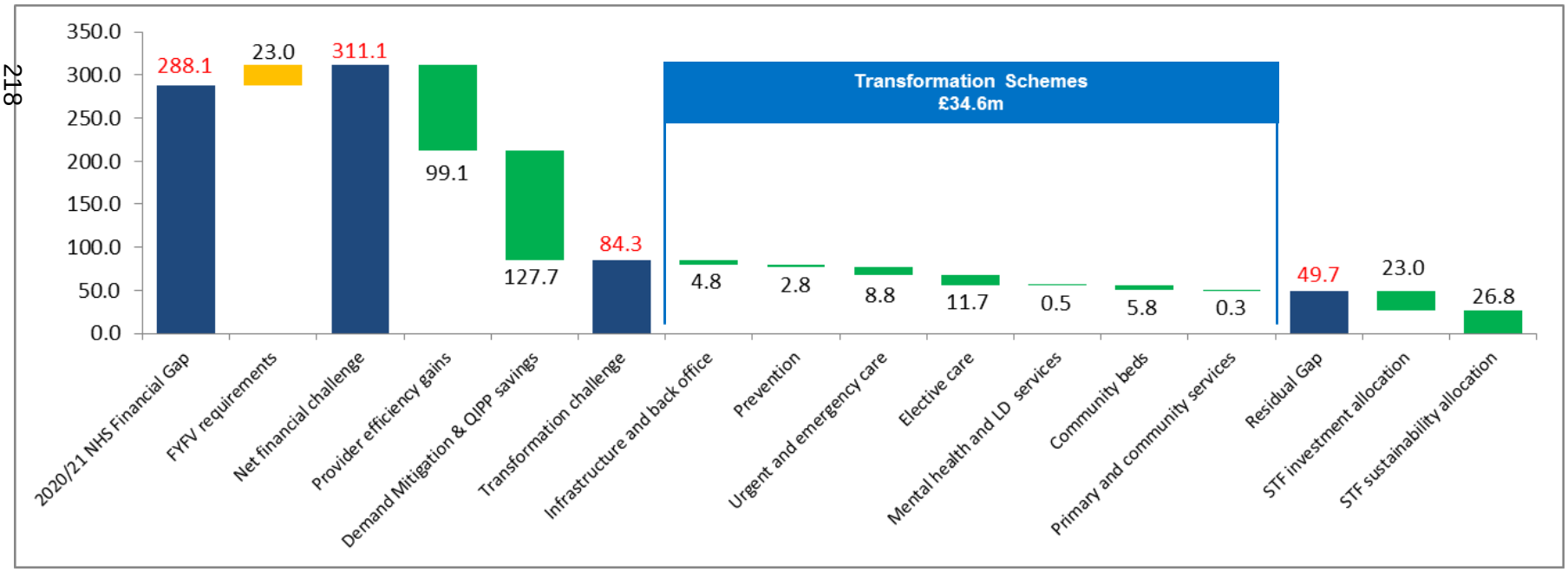
We are very conscious of the challenge between the need to live within individual control totals in the short term and the delivery of a balanced and sustainable system in the long term. In seeking to meet both challenges, we recognise the need to take radical steps, but equally will be careful not to compromise long term sustainability with rash steps towards short-term financial savings.

There is a significant disparity in the scale of the financial challenge across the two counties. The additional challenge in Herefordshire, in part, stems from the inherent additional costs resulting from serving a very dispersed rural population where there is limited access to the internet. These challenges are not fully reflected in the national funding formula. The current model assumes these financial challenges can be met through efficiency savings which are very challenging.

Our biggest challenges – finance and efficiency

Closing the NHS Gap by 2020/21

If we achieve the national planning assumptions of 1% demand mitigation and 2% provider efficiency gains, and deliver additional QIPP savings and efficiency gains, then our local modelling suggests that the financial challenge we will reduce to £84.3m (£311.1m - £226.8m demand management & efficiency gains) this is the gap before the transformation schemes and proposed use of the STF investments is allocated. We have currently identified transformational schemes totalling £34.6m that could begin to bridge the gap, leaving £26.8m to be covered by the STF money after covering the investment requirement from our STF allocation. Delivering this scale of transformation will be challenging without access to sufficient transformation resource to support change (see page 24 for plans). This is one of the key risks that the system will need to address as part of the next phase of development. In implementing any changes to services, all partners have agreed to the principle that we must not take decisions in one part of the system that have an adverse effect or shunt costs into another part of the system, without this being part of an agreed and organised approach. We are very conscious that there may be a tension between the need to live within the control totals of individual organisations in the short term and the delivery of a balanced and sustainable system in 2021. In seeking to meet both challenges, we are ready to take radical steps, but we will not be foolhardy, in taking rash steps towards short-term financial savings that undermine outcomes in the longer term.'



Opportunities identified using Right Care to support demand mitigation

In order to deliver our commissioner QIPP and provider CIP challenge we intend to apply the NHS Right Care approach and the wider efficiency work recommended by national reviews such as *Carter* . The CCG Right Care Commissioning for Value packs show that there are significant opportunities for demand mitigation compared to other areas in both elective and non-elective care. Other sources of analysis show opportunities in Continuing Healthcare and variation in GP prescribing. These savings opportunities are included with the CCG QIPP plans mainly within Acute Contracts for 2017/18 and 2018/19.

Elective Admissions

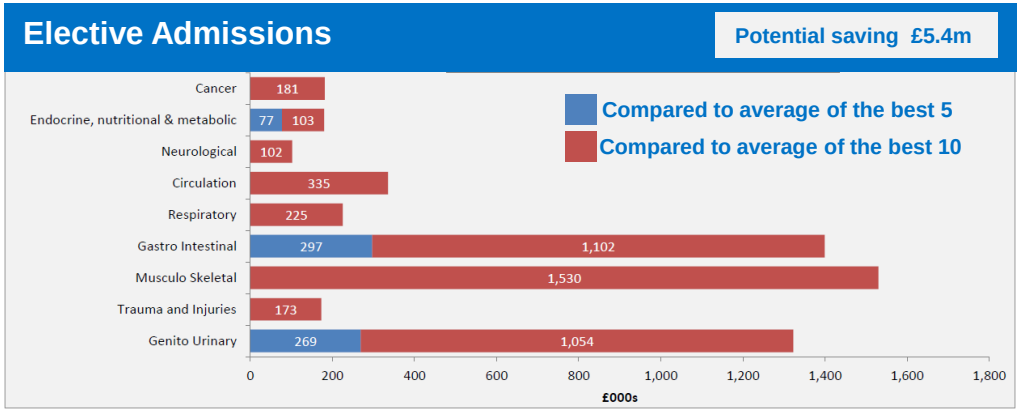
- There are significant opportunities to deliver efficiencies in this area, most notably in Gastro-Intestinal and Musco-skeletal
- Total saving opportunity =
  - £643k against the top 10 comparators
  - £5.4m against the top 5 comparators

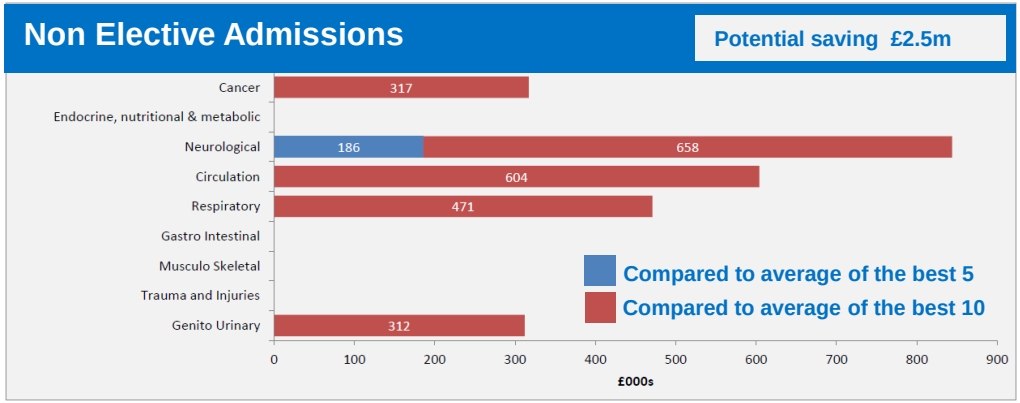
Non Elective Admissions

- There are also significant opportunities to be pursued in the non-elective admissions, but in a smaller number of areas. The most significant being Neurological.
- Total saving opportunity =
  - £186k against the top 10 comparators
  - £2.5m against the top 5 comparators

Other areas (not shown in charts)

- In addition to these areas CCGs have also identified CHC and GP Prescribing as areas to target for demand mitigation strategies with savings of £2.1m and £3.7m targeted.





In addition to existing schemes, jointly developed QIPP/CIP schemes will be developed through the operational planning process to support delivery of these savings, alongside the additional requirements to support control total compliant spend in 2017/18 and 2018/19.

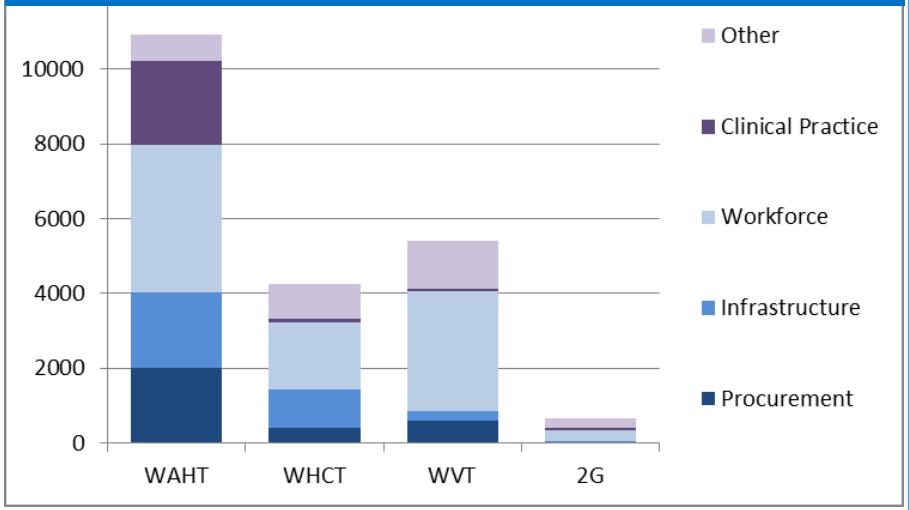
Identification of provider cost improvement plans – 2017/18 and 2018/19

Providers are developing plans to deliver the 2% cost improvement requirements outlined on page 18. These plans are consistent with the areas set out in the Carter review and include the following elements:

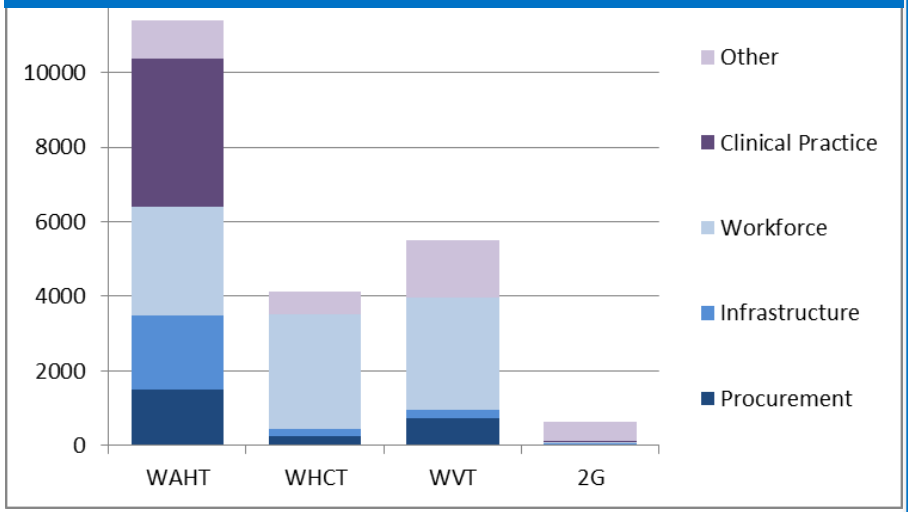
- **Procurement** – a total of £3.0m savings across the 4 providers in 2017/18 and a further £2.5m in 2018/19
- **Infrastructure** - £4.4m in 2017/18 and a further £2.5m in 2018/19. These savings are based on spend to save schemes, likely impairments and increased commercial income as part of an efficiency review linked to the Carter recommendations and other benchmarked opportunities such as estate management and PFI efficiencies.
- **Workforce** – this is the biggest area of focus in provider plans and is centred heavily on reducing spend on temporary staffing. Plans currently aim for £9.2m in 2017/18 and a further £9.0m in 2018/19.
- **Clinical Practice** – a reduction of £2.5m in 2017/18 and £4.0m in 2018/19. These savings include productivity and efficiency improvements in areas such as length of stay, day case rates, outpatient follow up rates, reducing non attenders and readmissions as well as more efficient prescribing practise and improved theatre utilisation.
- **Other** - £3.1m in 2017/18 and a further £3.7m in 2018/19. These savings include improved income recovery through better productivity, improved CQUIN performance and better contract management.

Note that, combined, these savings equate to £21.2m and £21.7m respectively for the next two years. However, in order to achieve control totals, additional savings across the providers or almost £27m will need to be identified in 2017/18. The plans need to be updated to reflect new areas and values being agreed.

2017/18



2018/19



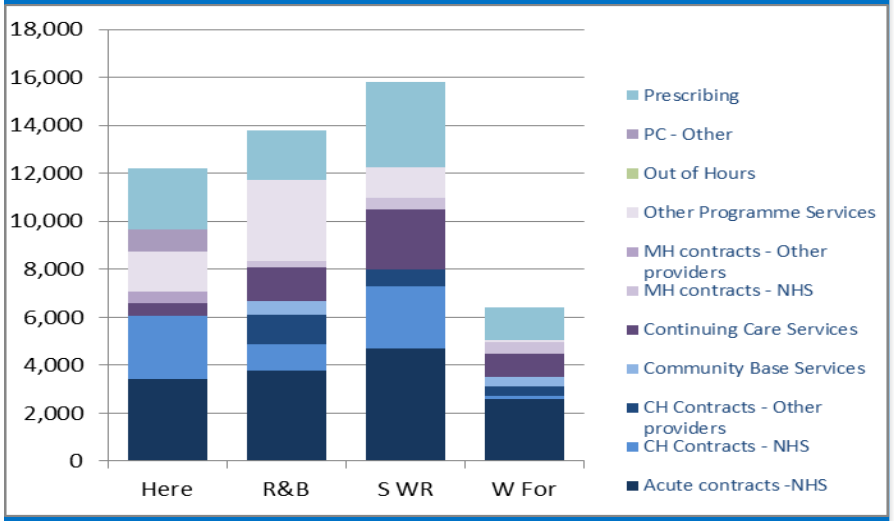
Identification of commissioner QIPP plans – 2017/18 and 2018/19

Commissioners are developing plans to deliver the 1% cost improvement requirements outlined on page 18. The QIPP detailed below is taken from the financial plans in March 2017. The plans cover the following areas:

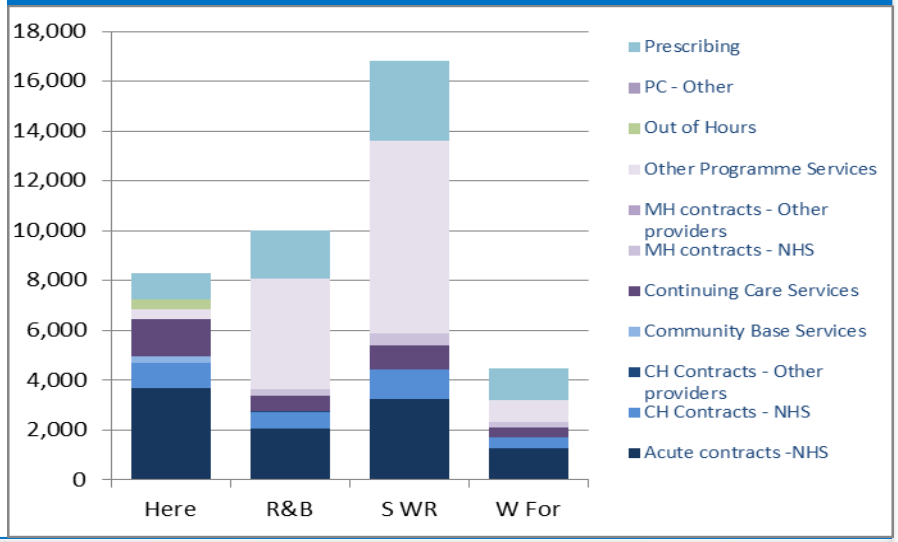
- **Prescribing** – £9.6m in 2017/18 with a further £7.4m in 2018/19. This will be delivered through a number so ways including reducing variation in drugs prescribed, repeat prescribing and review drugs available for prescription
- **Acute Contracts** – This is the largest area of focus with £14.4m in 2017/18 and £10.2m in 2018/19. As well as a 2% demand management requirement the other areas include follow up outpatient reductions, elective procedures being reviewed, procedures of limited clinical benefit and reductions in emergency admissions. All areas reviewed are subject to clinical agreement. This also includes the Right care opportunities as identified in the previous slide.
- **Continuing Care Services** - £5.4m in 2017/18 and a further £3.5m in 2018/19. This will focus on follow up reviews, 1:1 care packages, nursing care packages and ensuring full compliance with approved policies
- **Other Programme Services** - £6.4m in 201718 and £13.5m in 2018/19. For 2017/18 this covers a number of areas including a full forensic review of all CCG budgets. In 2018/19 this is mainly unallocated at this planning stage and will be allocated across programme areas once fully identified and agreed.
- **Other Health Contracts** - £8.8m in 2017/18 and £3.3m in 2018/19. This covers all community areas including Physiotherapy Therapy Service redesign, better care fund realignments and other technical savings

Note that, combined, these savings equate to £48m and £39m respectively for the next two years.

2017/18



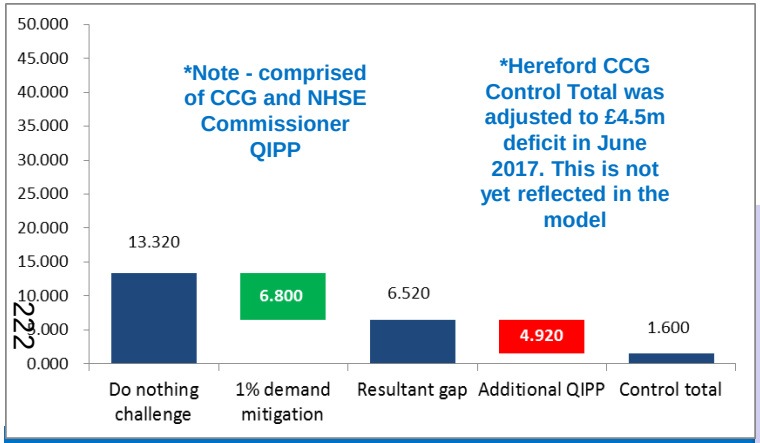
2018/19



Our biggest challenges – finance and efficiency

Information has been updated to reflect the latest financial projections for CCGSs and Acute Providers, although work continues, the model continues to be updated to finalise our modelling assumptions and **refresh** the solutions. The current model is not a final position. Our financial modelling shows that we can bring the system into financial balance by 2020/21 by using **£26.7m** of our STF allocation to support sustainability. However, we have a significant challenge in achieving the system control totals for 2017/18 and 2018/19. In order to achieve the 2017/18 control totals, the Herefordshire system would need to achieve combined savings of £23.1m in year. For Worcestershire this figure is £58.6m. In reality because a significant proportion of the commissioner challenge would be in spend areas with the provider, the provider challenge would be further magnified. Significantly for the two acute providers these programmes equate to circa 12.2% and 10.2% of income respectively.

Herefordshire Commissioner Bridge 2017/18

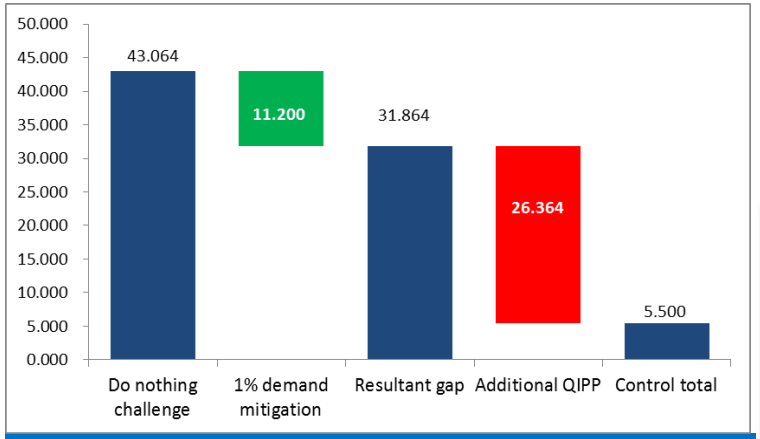


Herefordshire Challenge

£6.8m
£4.9m
£11.7m

£23.1m

Worcestershire Commissioner Bridge 2017/18

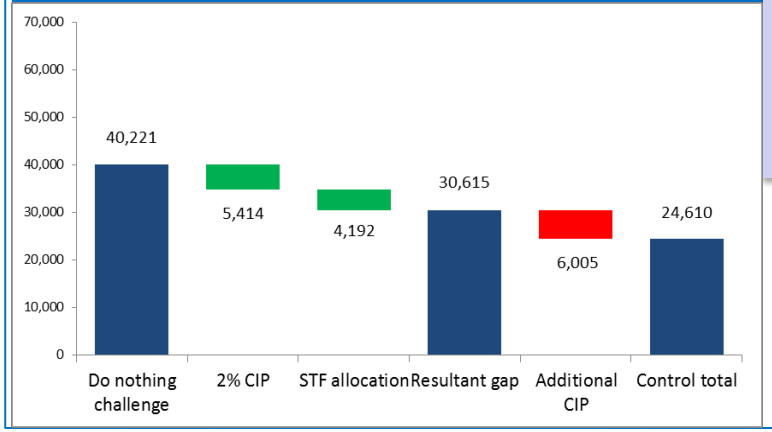


Worcestershire Challenge

£11.2m
£26.4m
£37.6m

£58.6m

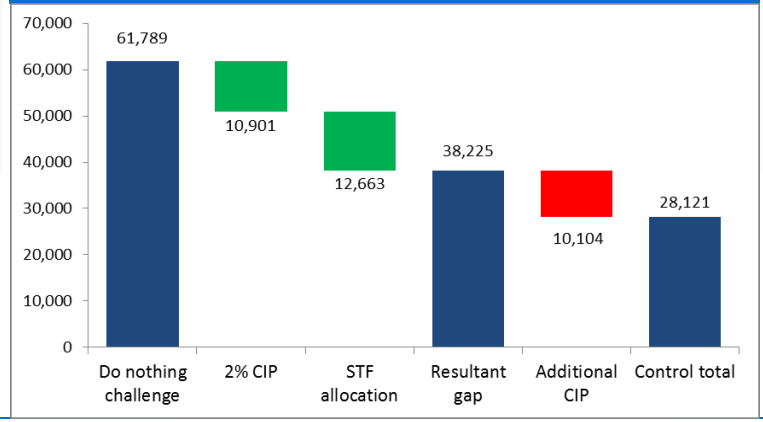
Wye Valley Finance Bridge – 2017/18



£5.4m
£6.0m
£11.4m

circa
12.2%
CIP (inc impact of commissioner QIPP)

Worcs Acute Finance Bridge – 2017/18



£10.9m
£10.1m
£21.0m

circa
10.2%
CIP (inc impact of commissioner QIPP)

Investing in change and transformation

An Allocative Approach to Budget Prioritisation

Partners on the programme board agreed to take a strategic approach to making investment and disinvestment decisions across the system budgets. A budget allocation exercise was facilitated by The Strategy Unit of the Midlands and Lancashire Commissioning Support Unit.

This process included partners reviewing national "asks", local performance and outcome information from the gap analysis and agreeing a strategic direction of travel for how we believed we could most efficiently optimise the use of resources to achieve the best outcomes for the population.

The core purpose was to enable rational allocation of any growth money that CCGs will receive in their allocations over the STP period and agree where the most significant efficiencies and service changes would need to be targeted in order to achieve this strategic intent. The intention is to use this process to support the strategic shift in resources over the lifetime of the STP.

However, it will be a significant challenge for the system to achieve this quickly using traditional methods of contracting. Any additional investment highlighted in the table is naturally reliant on the system's ability to disinvest equivalent amounts in the other areas. It is therefore a priority of the STP to move towards population based capitated allocations using more flexible contracts to enable commissioners and providers to ensure that resource is targeted to the right areas.

Through the joint operational planning process, CCGs and Providers are working together to develop joint schemes to support each other to deliver their respective financial positions.

Funding area	Indicative funding share	Real terms change*	Actual funding increase
Running costs	Reduce	-26%	-15%
Back office and infrastructure		-7%	
Urgent care and emergency admissions	Reduce	-6%	+7%
Maternity care	Increase	+1%	+15%
Mental health and learning disability services	Increase	+8%	+23%
Elective treatment – life threatening conditions (cancer, cardiac etc)	Increase	+7%	+22%
Elective treatment – non life threatening conditions	Reduce	-20%	-8%
Diagnostics and clinical support services	Reduce	-11%	+2%
Medicines optimisation	Reduce	-8%	+5%
Core primary care (GMS)	Apply national formula and GPFV requirements		
Extended primary and community services to support proactive out of hospital care	Increase	+17%	+33%
Total		**0.0%**	**+13.0%**

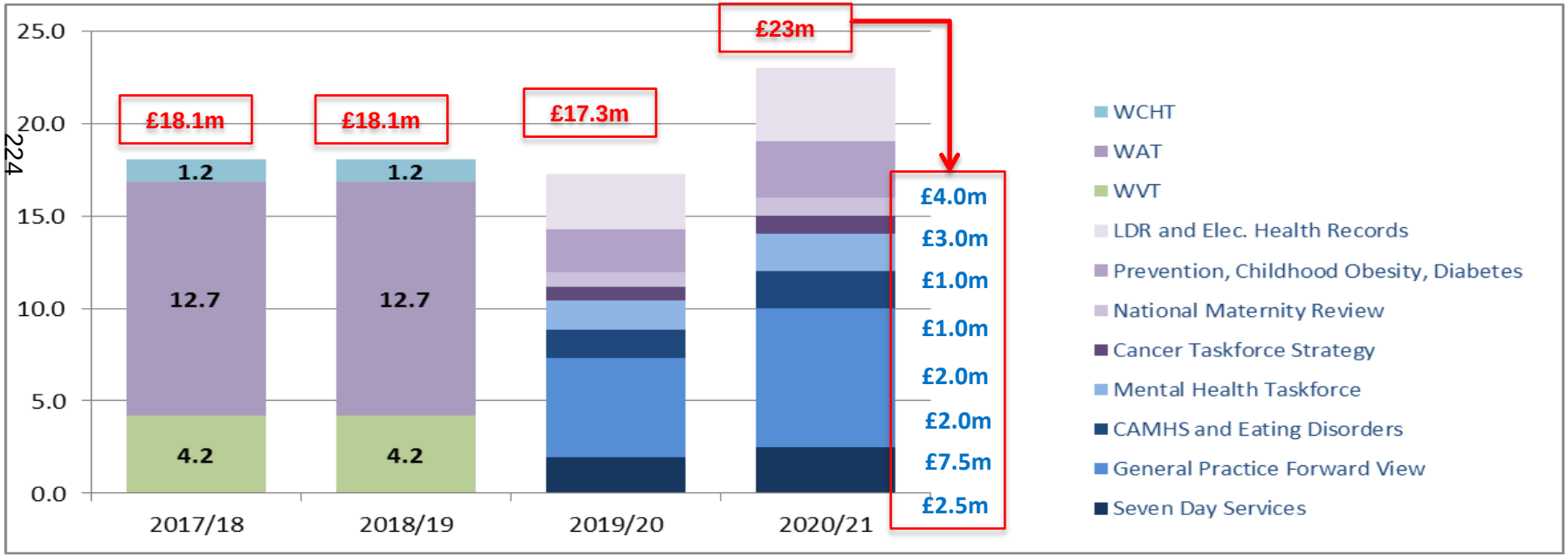
**Ambition for funding growth above inflationary increase*

Investing in change and transformation

Allocating the STF Money

The allocation exercise was also used to inform discussions and prioritisation for use of the transformation element of the STF. These investments will need to be made early in the planning cycle if they are to begin delivering the scale of transformation required to improve services and achieve financial balance. Any risk to our ability to make this investment will severely compromise our ability to deliver a balanced plan by the end of the period.

The chart below shows the initial proposed allocation of the STF transformation element. It shows the funding allocated to providers in 2017/18 and 2018/19 which is included within Provider Control Totals agreed with NHS Improvement. The model assumes £17.3m in 2019/20 to £23.0m in 2020/21 is invested in transformational solutions. It is important to note that this is the initial proposed allocation and may be subject to change as further work is conducted to develop the project delivery plans in each area.



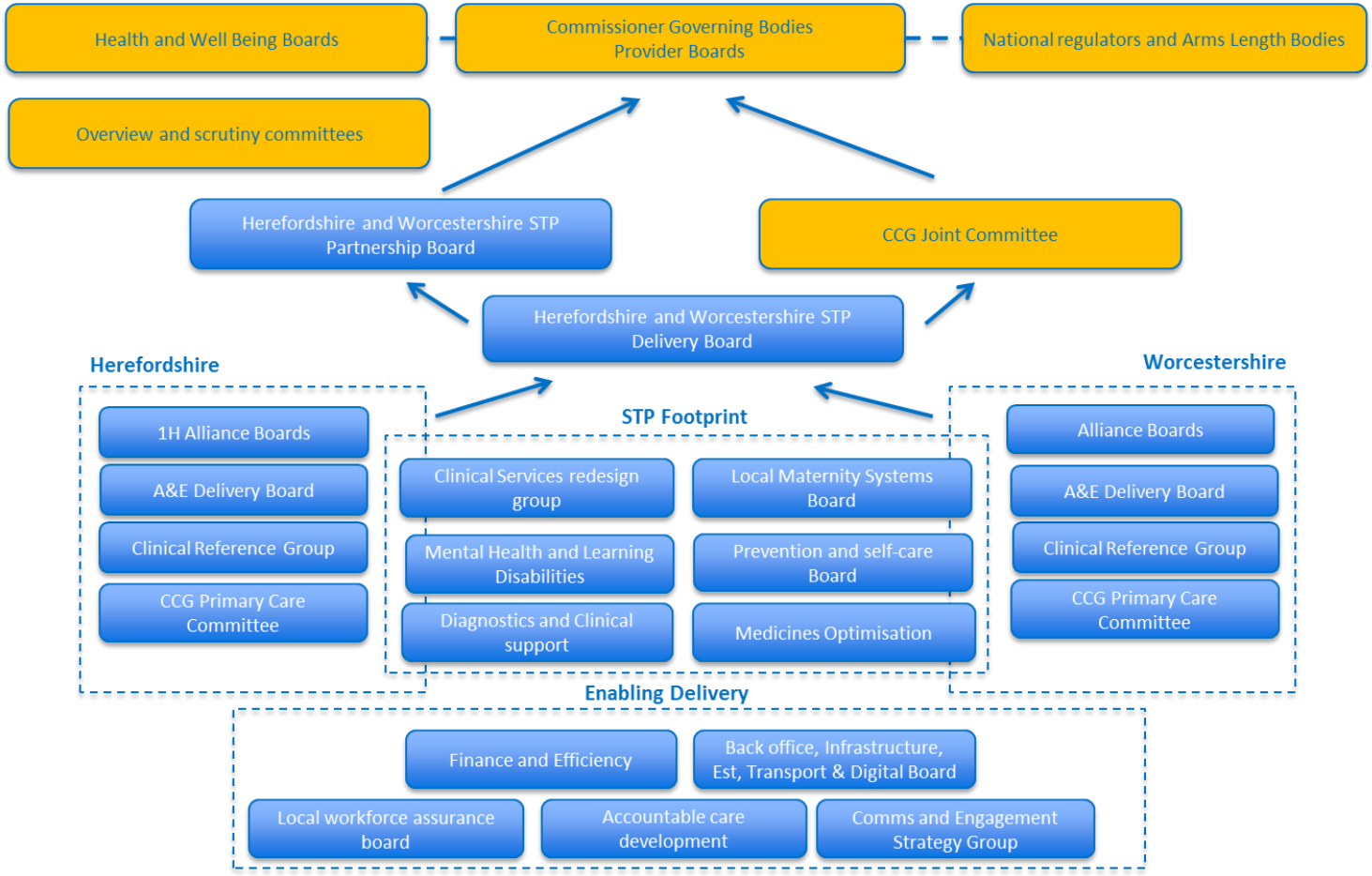
Within the use of this transformation resource there are specific primary care data sharing and governance issues that will need to be resolved.

Our priorities for transformation

Transformation Priorities	Delivery Programmes	Enablers
1 Maximise **efficiency and effectiveness** across clinical, service and support functions to improve experience and reduce cost, through minimising unnecessary avoidable contacts, reducing variation and improving outcomes.	• Maximising efficiency in infrastructure and back office services (annex 1a) • Transforming diagnostics and clinical support services (annex 1b) • Medicines optimisation and eradicating waste (annex 1c)	Develop **the right workforce and Organisational Development** within a sustainable service model that is deliverable on the ground within the availability of people and resource constraints we face. Invest in **digital and new technologies** to support self care and independence and to enable our workforce to provide, and patients to access, care in the most efficient and effective way, delivering the best outcomes. Engage with the **voluntary and community sector** to build vibrant and sustainable partnerships that harness innovation, further strengthen community resilience and place based solutions. Develop a **clear communications and engagement plan** to set out our strong commitment to involving key stakeholders in the shaping of our plan and describe the process and potential timelines associated with this.
2 Reshape our **approach to prevention**, to create an environment where people stay healthy and which supports resilient communities, where self-care is the norm, digitally enabled where possible, and staff include prevention in all that they do.	• Embedding prevention in everything we do and investing in 4 key at scale prevention programmes (annex 2a) • Supporting resilient communities and promoting self care and independence (annex 2b)	
3 Develop an improved **out of hospital care** model, by investing in sustainable primary care which integrates with community based physical and mental health teams, working alongside social care to reduce reliance on hospital and social care beds through emphasising "own bed instead".	• Investing in primary care to develop the infrastructure, IG requirements and a new workforce model that has capacity and capability as well as resilience (annex 3a) • Redesigning and investing in community based physical and mental health services to support care closer to home (annex 3b) • Redefining the role for community hospitals (annex 3 c)	
4 Establish **sustainable services** through development of the right networks and collaborations across and beyond the two counties to improve urgent care, cancer care, elective care, maternity services, specialist mental health and learning disability services.	• Investing in mental health and learning disability services (annex 4a) • Improving urgent Care (annex 4b) • Delivering improved maternity care (annex 4c) • Improving elective care and reducing variation (annex 4d & 4e)	

Arrangements for delivering the plan

Governance and delivery arrangements - A robust and inclusive framework has been developed to support the work undertaken to date on developing the STP. There is an independent chair of the programme board, which is comprised of all key organisational leads and stakeholders. Working to the programme board there is a programme management office (PMO) in place that will be enhanced as we move into the delivery phase. There is an STP wide communications and engagement strategy group and there are clinical references groups supporting both counties that will come together to agree on pan STP clinical issues. We will develop an STP wide transformation team to bring together transformation resources across the two counties to work in a more coordinated way. Where it makes sense to do so, programmes will be developed across the STP area, where there are local or geographic imperatives that require local solutions, these are and will continue to be managed within each county's tailored transformation programme structure.



Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

9 Must Dos		Delivery Programme
1. STP	• Implement agreed STP milestones, so that you are on track for full achievement by 2020/21. • Achieve agreed trajectories against the STP core metrics set for 2017-19.	STP Priorities 1,2,3 & 4
2. Finance 2227	• Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector and CCG Sector needs to be in financial balance in each of 2017/18 and 2018/19. • Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies. • Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes. • Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.	We have a significant challenge in achieving the system and provider control totals for 2017/18 and 2018/19. In order to achieve the 2017/18 control totals, Herefordshire would need to deliver a combined QIPP/CIP programme of £23.1m and Worcestershire £58.6m Through delivering our programmes of work we will; • Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market". • Improve access to diagnostics to promote ambulatory care. Streamline pathways and reduce waste in diagnostic services through reducing unnecessary requests. Improve efficiency through centralisation of supporting infrastructure and pooling of functions • Reduce variation in prescribing patterns and increase adherence to approved use of medicines, allowing allocation of additional resource available for new and proven treatments to support prevention and demand control • To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.
3. Primary Care	• Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support and the 10 high impact changes. • Ensure local investment meets or exceeds minimum required levels. • Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors, pharmacists working in general practice by 2020,the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems. • By no later than March 2019, extend and improve access in line with requirements for new national funding. • Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.	STP Priority 3	**Programme 3a: Developing sustainable primary care** • Work with patients to develop improved access to routine and urgent primary care appointments across 7 days a week through roll out of Prime Minister's Access Fund initiatives. • Local primary care working "at scale", developed through a "bottom-up" approach with practices working in partnership with patients, community pharmacy, third sector and public sector services as well as community and mental health services. • We will implement the "10 high impact areas for General Practice" within and across practices. • With increased capacity within primary care we will work with patient to adopt new ways of working: Moving to a proactive model of care, identifying and case managing through an MDT approach adopting early clinical assessment within a robust process to direct patients to the most appropriate clinician to achieve "right patient, right place, right time". This would ensure continuity of care for those with complex needs as opposed to those requiring same day episodic access.

Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

9 Must Dos		Delivery Programme
4. Urgent & Emergency Care	• Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan. • By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services. • Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each county, including a clinical hub that supports NHS 111, 999 and out-of-hours calls. • Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department. • Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.	STP Priority 4	**Programme 4b: Improving Urgent Care** • Improve urgent care pathways to improve access, performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements • Deliver the four priority standards for seven-day hospital services for all urgent network specialist services **Programme 4a: Improving mental health and learning disability care** • Access will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision. • Implement the crisis concordat action plan
5. RTT and elective care	Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT). • Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018. • Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups. • Implement the national maternity services review, Better Births, through local maternity systems.	STP Priority 3 & 4	**Programme 3c: The role of community hospitals** • More planned care will be available closer to home, e.g. outpatients and day case, reducing the need to travel for regular appointments **Programme 4c: Improving maternity care** • Citizens will have access to high quality, safe and sustainable, acute, women and neonatal and mental health services, localised where possible and centralised where necessary **Programme 4d: Elective Care** • Two aspects to improving elective care: 1. Effective commissioning policies and stricter treatment thresholds 2. Efficient organisation of services to meet demand, undertake more routine elective activity on a reduced number of "cold" sites
6. Cancer	• Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report. • Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards. • Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission. • Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types. • Ensure all elements of the Recovery Package are commissioned	STP Priority 4:	**Programme 4d: Elective Care** • We aim to achieve deliver world class cancer outcomes for our population by delivering the national cancer strategy. This will mean fewer people getting preventable cancers, more people surviving for longer after a diagnosis, more people having a positive experience of care and support; and more people having a better long-term quality of life. • We aim to be better at prevention and deliver faster access to diagnosis and treatment. We aim to achieve consistent access of all cancer treatment standards . • There will be fewer diagnoses made through emergency admission or unplanned care provision and better patient experience of cancer care received.

Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

9 Must Dos		Delivery Programme
7. Mental Health	• Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages; additional psychological therapies, more high quality Children and Young people services, treatment within 2 weeks for first episode of psychosis, increased access to individual placement support, community eating disorder teams and a reduction in suicides. • Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals. • Increase baseline spend on mental health to deliver the Mental Health Investment Standard. • Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support. • Eliminate out of area placements for non-specialist acute care by 2020/21.	STP Priority 4	**Programme 4a:Improving mental health and learning disability care** • The requirements of the National Mental Health Policy "No Health Without Mental Health" and the requirements of the National Mental Health Five Year Forward Vision will be embedded across our two counties – including crisis care, Mental Health liaison, transforming perinatal care and access standards . • Access to mental health and learning disability services will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision. • Improved access to CAMHs Tier 3.5 to reduce demand for Tier 4 • The services in place will be responding to the health and wellbeing gaps and health inequalities identified. • People who require more tertiary care/specialist support will have their care planned for via managed clinical networks.
8. Learning disabilities	• Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism. • Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population. • Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check. • Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.	STP Priority 4	**Programme 4a:Improving mental health and learning disability care** • Addressing Health Inequalities for people with LD – This is a priority for LD services its aim is to reduce barriers , promote inclusion and therefore increase access to health and social care services. • Transforming care - bringing people with LD and Autism back to their own communities from out of area placements and preventing admission to hospital, achieving safe discharge and robust community support. • Collaborating across Counties to provide Specialist services more efficiently/effectively.
9. Improving quality	• All organisations should implement plans to improve quality of care, particularly for organisations in special measures. • Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services. • Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.	Priorities 1,2,3 & 4	• There are currently two acute Trusts within STP area which are in special measures. A key component of our STP is to ensure care is delivered of a standard and quality which is acceptable for our population and to the CQC and is on a trajectory to GOOD and aspires to be OUTSTANDING. • An impact of achieving this will be delivering safe, sustainable and productive services through transformation in general practice, primary care, urgent, non-elective and elective care as described in the annexes of this plan.

Key risks and barriers to the delivery of our plan

	Key risk	Mitigation
Delivery	Insufficient redesign and transformation skills to transform the system and design care pathways across the health and care system	Learn from best practice elsewhere including successful individual organisational experience of transformation Core group identified and leading the STP Partnerships with external organisations (Provex, CSU to date , future plan being considered) Establish system transformation programme resource and central PMO
		Identify and maximise the transformation skills we have across the economy and ensure key people are focused on STP priorities
	Lack of sufficient capacity to focus on the change programme	Structure and commitment post 21st Oct submission being explored to transfer core STP work streams into operational plans, Programme Board are focused on capacity being identified
	Failure to maximise the potential for integration	Joint conversations and AO meetings to enable challenge to each other Significant relationship work has been undertaken to build trust
	Do not seize the opportunities presented by collaboration and continue to work in an isolated way	Joint conversations and AO meetings, Best Value challenge agreed at each point
	Programme does not deliver as insufficient focus and capacity agreed within the economy to deliver	Central PMO structure supported to 21st Oct submission but refresh of requirements moving forward currently underway
	Organisations do not commit to the changes and continue to look after self interests	Continued focus on local needs and the need to work differently as a system, national imperative OD plan moving forward to support more joined up working Develop a system risk share arrangement to incentivise system wide, not organisational thinking
	Planning process becomes overly health focused and as a consequence the role of social care, communities and the VCS sector is taken for granted and the associated costs not factored in	Engagement of wide range of partners on the STP Programme Board All SROs to consider this within workstream discussions Review of draft plans to strengthen this aspect Social care and the Voluntary and community sector are actively involved in programme board
	Inability to meet the requirements of the national strategies such as the mental health, maternity, and cancer strategies/taskforces within the resources that will be allocated	Establish clear agreement at STP board level over funding priorities Application of the strategic intent for resource allocation to operational plan development Develop alternative strategies where funding requirements cannot be fully met
Workforce	Insufficient staff are recruited or developed with the requisite skills to deliver the plan	Workstream focus on “World Class Worcestershire “ – making system wide roles attractive. Ongoing recruitment processes Ongoing training programmes and collaboration with Universities to shape training for the future
	Retention of staff deteriorates during the changes	Monitoring systems in place to identify deterioration Effective communication and engagement with staff about proposed changes
	Fragility of the domiciliary and residential care market	Local Authorities to review the sustainability of the private domiciliary & residential care market
	Insufficient primary care staff to deliver at the scale required for the future, (42% of West Mids GP workforce expect to retire or reduce hours in the next 5 years)	Primary care workforce strategy Consideration of new roles and extended roles to support a potentially smaller GP workforce in the future

Key risks and barriers to the delivery of our plan

	Key risk	Mitigation
Engagement	Inability to resolve fundamental barriers for primary care relating to indemnity and property liability that will compromise their ability to engage with partners in new models of care or contracting arrangements	Recognition of the significance of the challenge at STP Board Level Continue work to explore resolutions that could be achieved to reduce the risk to individual GP partners On-going discussions taking place nationally to reduce structural barriers
	Insufficient clinical engagement to own and deliver the plan	Clinical engagement to date through reference groups, internal briefings and input into specific workstream discussions Clinical engagement strategy for post Oct being developed
	Insufficient public engagement in the early stages of the plan may undermine support moving forward	Public and community engagement strategy in place. Comprehensive engagement milestones and approaches which recognise co production H&WBB briefed regularly
	Failure to maintain continued involvement and support of staff	Regular briefings / updates on progress to staff Engagement strategy in place
	Wider clinical engagement does not yield support for the plan	Identify and respond as part of the Engagement strategy
Political & Regulatory	Limited or no political support for the decisions	Regular updates to key forums, specific briefings to MPs National recognition of case for change
	Disagreement between regulatory bodies around the key proposals	Regular communication with Regulators about emerging themes
	The limited capacity of leaders could impact on delivery of the transformation required. Compounded by regulatory processes already in place distracting focus	Identify specific leaders for the transformation process who are not absorbed in delivery of regulator actions day to day
Financial	Inability to release the resources from the existing urgent care system to create the ability to invest in scaling up primary and community service investment	Workstreams in place to identify top priorities. Financial support to model impact with CEO oversight
	Savings opportunities identified may deliver less than planned	Continued rolling refresh programme to revise assumptions Governance processes in place to provide oversight and assurance
	In year financial positions deteriorate further	Organisational recovery plans in place
	Insufficient resources allocated to fund the cost of change – Including availability of capital to enable reconfiguration of services	Programme Board oversight of resource requirement at STP level AOs to review internal capacity and how individuals roles and priorities can be aligned to the change and identify where and external expertise will be required and enabled
	Inability to access sufficient transformation funding to drive the changes required to release the longer term benefits, including the investment required to deliver the national must do's	Implement a clear process for developing and assessing robust business cases for proposed changes
	Decisions made in isolation by partners have unintended knock on consequences to other parts of the system and result in cost shunting	Risks to quality will be identified early stage through existing arrangements incorporating quality impact assessments. Key risks around decisions made under the STP will be fully considered at STP board level so they are identified and decisions are taken. Explore new ways of aligning financial incentives and risk share arrangements

T&2

Next steps

There are a number of immediate next steps we need to take to move the STP forward:

- Refine the planning and financial assumptions based on the new control totals and STF funding allocations, with a particular focus on years 1 and 2.
- Identify the steps required to address the financial gaps related to the additional CIP and QIPP requirements identified on page 18.
- Develop our plan for stakeholder and public engagement plan to help us co-produce solutions to address the challenges set out in this document.
- Take immediate action and further development of the four key “at scale” prevention programmes.
- Take immediate action on the primary care sustainability workstream to increase resilience in core general practice and prepare for delivery of Primary Care at Scale.
- Continue to develop the new out of hospital integrated care models in each county.
- Participate in the West Midlands clinical review of the implementation of transforming urgent and emergency care services in the West Midlands.
- Seek NHSE support to review specific services and test proposals to address them which have a potential solution beyond the providers within Herefordshire and Worcestershire – eg. Stroke, mental health and cancer.
- Establish the benefits and delivery plan for those benefits of being a rural pathfinder for new ways of commissioning specialised services.
- Explore how we can unlock the benefits of the STP through different contracting models to incentivise delivery and develop partner risk share arrangements.
- Agree the revised governance structure to enable us to complete the planning process and transition into operational planning and contracting
- Commission support to help shape the refinements of specific issues to include :
    - An understanding of the clinical dependencies needed to support an acute service in Herefordshire and the resulting costs, reflecting the challenges of rurality.
    - Undertake further analysis of the bed modelling work and assess the potential for change alongside our ambition to deliver more care at or close to home.
- Continue to develop and implement delivery plans for the five year forward view next steps priorities; Urgent Care, Primary Care, Mental Health, Cancer and integrated care alongside local priorities.
- Put a functional delivery mechanism in place to ensure that the work programmes within the STP are developed and implemented.

Detailed Plans

Name of footprint	Herefordshire and Worcestershire
Region	Midlands and East
Nominated Lead	Sarah Dugan, Chief Executive Worcestershire Health and Care NHS Trust
Contact Email	whcnhs.yourconversationhw@nhs.net

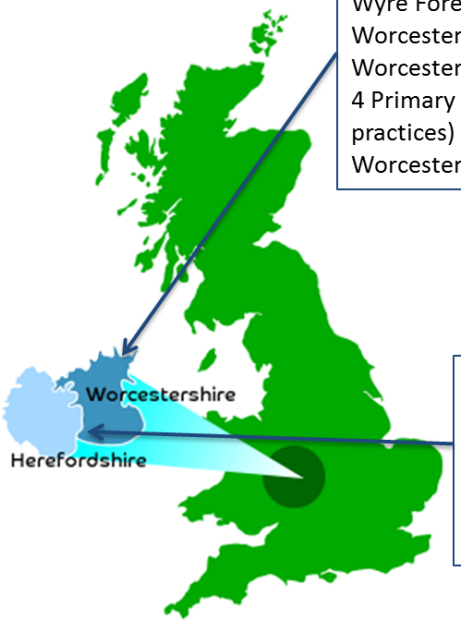
Partners involved	
GP Practices	90
CCGs	4
Acute Trusts	1
Combined Acute and Community Trusts	1
Combined Community and Mental Health Trusts	1
Mental Health Trusts	1
HealthWatch bodies	2
District and Borough Councils	6
Councils with Health & Well Being Boards	2

Key Statistics	
Population	780,000
Area	1,500sq miles
Annual NHS Allocation – 2016/17	£1.168bn
Annual NHS Allocation – 2020/21	£1.327bn
STF allocation in 2020/21	£50m
NHS "Do Nothing" financial gap to 2020/21	£288.1m
NHS Residual Gap after applying national planning assumptions	£61.3m

Herefordshire and Worcestershire

Sustainability and Transformation Plan

5th July 2017



Redditch and Bromsgrove CCG (R&BCCG)
South Worcestershire CCG (SWCCG)
Wyre Forest CCG (WFCCG)
Worcestershire Acute Hospitals NHS Trust (WAHT)
Worcestershire Health and Care NHS Trust (WHCT)
4 Primary Care Collaborations (covering 66 practices)
Worcestershire County Council (WCC)

Herefordshire CCG (HCCG)
Wye Valley NHS Trust (WVT
2gether NHS Foundation Trust (2G)
Taurus GP Federation (representing 24 practices)
Herefordshire Council (HC)

Contents

Priority 1 – Maximise efficiency and effectiveness

Programme 1a	INFASTRUCTURE AND BACK OFFICE	SRO	Michelle McKay, CEO Worcestershire Acute Hospitals NHS Trust
Overall aim	Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market".		

What will be different between now and 2020/21

We intend to move to a place based model for commissioning support services, infrastructure and back office which results in the best value
The Back Office and Infrastructure Programme will both deliver improvements in service delivery and savings but will also enable the delivery of other STP work streams.

The key components are:

- **Single Procurement Strategy** - New contracting arrangements over longer time periods and single procurement framework for common services and products across all STP partners where beneficial.
- **Single Place Based Estates Strategy** – enabling co-location and service integration and the release of unwanted property and land. Careful consideration will be needed to see how the primary care estate can be included in this work given the different nature of ownership, financing and liability arrangements in place.
- **Single Transactional Services** – With end to end business processes and administration with joined up support services, commissioned and designed to meet the efficiency and STP programme agenda . – particularly in relation to consolidated approaches with an initial focus on:
  - Finance
  - Payroll
  - Procurement support services through making best use of NHS Shared Services or other competitive provider
- **"Virtual" Single Strategic Estates function** – making best use of collective resources, consistent with the "One Public Estate" ethos (and inclusive of wider partners eg. Police, Fire and DWP). To include considering the extension of Place Partnership Ltd in local NHS Property Management. Specific areas to be explored in wave 1:
  - Hospital Catering
  - EBME (Medical Device Management and servicing)
  - Courier & Taxi Services
  - Hard Maintenance
  - Help Desk
  - Waste Management
- **Joined up Digital Strategy** – with modern integrated technology ensuring 100% Digital Access, and paperless care by 2020 (ensuring all are digitally included and patients are empowered through technology) with a connected infrastructure and joined up access channels, including telephony. Overarching digital strategy which brings together the two Local Digital Roadmaps and future-proofs developments around five key areas: connected infrastructure, improving integration, empowering citizens, working collaboratively, enhancing our understanding.
- **Joined up Transport Strategy** – for patients and service users that ensures transport provision is optimised and a reduction in the number of vehicles on the road.

Priority 1 – Maximise efficiency and effectiveness

Programme 1a	INFASTRUCTURE AND BACK OFFICE	SRO	Michelle McKay, CEO Worcestershire Acute Hospitals NHS Trust

Overall aim	Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market".

How will this be better for residents and patients in Herefordshire and Worcestershire

Before reviewing the provision of front line services within the STP we recognise the importance of maximising the value and impact, whilst reducing costs of our business support functions.

Through this programme, we aim to:

- **Reduce spend** across back office functions by more than 20% through more efficient infrastructure, organisation and reduced transaction costs. This will include fundamentally changing the way in which local NHS bodies contract with each other, by moving towards population based capitated budgets rather than having an internal market.
- **Co-locate and integrate services** with shared platforms and administration leading to the optimisation of resources across organisational boundaries and reducing unnecessary contacts and journeys.
- Achieve **intelligent estate planning** across the whole "one public estate" to reduce wasted space, enable the sale of surplus land and property and make better use of existing local facilities to support care delivery.
- **Standardise technology applications** to enable a one stop shop approach across all partners , including things like a single Help Desk.
- **Co-ordinate procurement**, bringing efficiency and standard approaches to maximise purchasing power and operational efficiency.
- **Integrate digital care records** to improve clinical management of patients and result in fewer handovers between services and organisations.
- **Coordinate existing transport** provision more effectively to Improve patient access and customer journeys and **Reduce vehicles** on the road and the associated environmental impact
- **Create a common digital infrastructure** with better digital links across organisations bringing enhanced understanding through new ways of data use, leading to earlier intervention and improved outcomes with enhanced and joined up access channels for customers.
- **Joined up channel and telephony** with integrated and effective channels for improved patient access and customer journey resulting in fewer handovers between services and organisations.

All of these programmes of work will provide the opportunity to explore joint working between a range of public sector partners including fire and police

Priority 1 – Maximise efficiency and effectiveness

Programme 1b	DIAGNOSTICS AND CLINICAL SUPPORT	SRO	Michelle McKay, CEO Worcestershire Acute Hospitals NHS Trust

Overall aim	Improve access to diagnostics to promote ambulatory care. Streamline pathways and reduce waste in diagnostic services through reducing unnecessary requests. Improve efficiency through centralisation of supporting infrastructure and pooling of functions

What will be different between now and 2020/21

There are critical changes to be pursued within the STP. (1) **Amalgamation of pathology laboratory** services across the two counties and beyond and greater functional sharing and consolidation of infrastructure in other clinical support services such as radiology and pharmacy. (2) **Development of agreed system demand management strategies** and delivery mechanisms, with the aim of eliminating unnecessary requests and reducing overall requested activity.

Pathology:

- Early exploration of a consolidated service across both counties.
- Longer term plan to join forces with a larger regional provider or to explore the option of developing a private sector partnership model.

Radiology:

- Development of appropriate direct access initiatives to support ambulatory care outside of acute hospital settings.
- Shared arrangements for out of hours cover and diagnostic reporting.
- Centralisation of specialised services to align with emergency and elective centres.

Pharmacy:

- Development of a single stores, distribution and procurement function across the STP patch
- Options appraisal into medicines supply outsourcing at Worcestershire Acute.
- Other functional service consolidation such as medicines information.

How will this be better for residents and patients in Herefordshire and Worcestershire

- There will be fewer unnecessary requests for diagnostic imaging and laboratory testing, resulting in a reduction in unnecessary exposure to radiation and other harm.
- Workforce and processing of pathology samples will be centralised across a much wider area releasing costs, creating economies of scale and increasing purchasing power. These savings will offset pressures in other front line service areas.
- Patients will be able to access diagnostic services more local to them in their communities for less complex procedures and greater direct access will result in reduced need for unnecessary hospital stays.
- Some more specialised diagnostic services will be centralised in fewer emergency / major elective centres to ensure quality and sustainability of clinical skills.

Priority 1 – Maximise efficiency and effectiveness

Programme 1c	MEDICINES OPTIMISATION	SRO	Simon Trickett, Accountable Officer, RBCCG and WFCCG

Overall aim	To ensure medicines optimisation is integrated across all services to provide safe, cost effective medicines use, reducing variation in prescribing and patient outcomes to secure best value from finite NHS resources.

What will be different between now and 2020/21

- Standardised Care pathways to rationalise choice and place in therapy of medicines used.
- Redesign and recommission services to ensure appropriate prescribing/supply of medicines to address issues identified in the pharmaceutical needs assessment and to optimise outcomes and reduce waste.
- Greater use of IM&T to support appropriate use of medicines at every stage of care.
- Reduced variation in prescribing spend between practices.
- Virtual elimination of spend on low priority treatments.
- Enhancing pharmaceutical skill mix to optimise medicines use across all pathways.
- Improving patient reported outcomes that demonstrate effective medicine use.
- Investment into clinical capacity to implement change and deliver new service models, extending into community services.
- Robust and co-ordinated public engagement and communication strategy to support change messages.
- Significantly enhanced role for community pharmacies, including a review of dispensing practices in light of local population access and the most recent guidance and legislation.

How will this be better for residents and patients in Herefordshire and Worcestershire

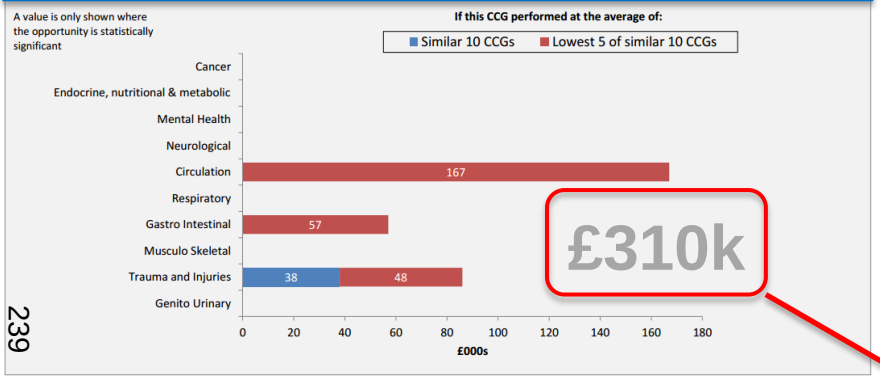
- Transformed access to medicines through service redesign, e.g. off- prescription supply models
- Greater integration and seamless care between all providers.
- Increased reporting of medication reviews across multiple care settings

Priority 1 – Maximise efficiency and effectiveness

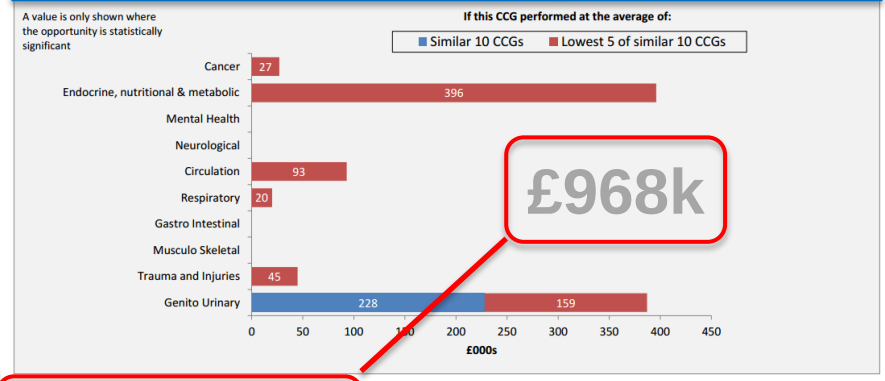
Programme 1c	MEDICINES OPTIMISATION	SRO	Simon Trickett, Accountable Officer, RBCCG and WFCCG

Overall aim	To ensure medicines optimisation is integrated across all services to provide safe, cost effective medicines use, reducing variation in prescribing and patient outcomes to secure best value from finite NHS resources.

Herefordshire



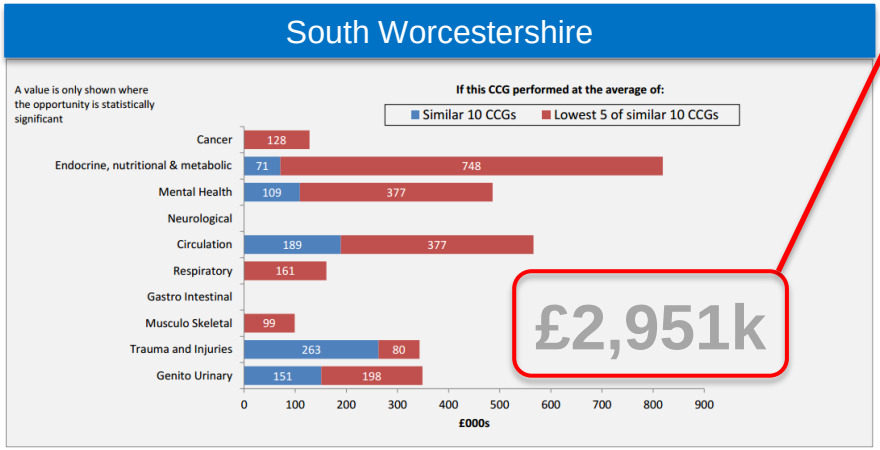
Redditch and Bromsgrove



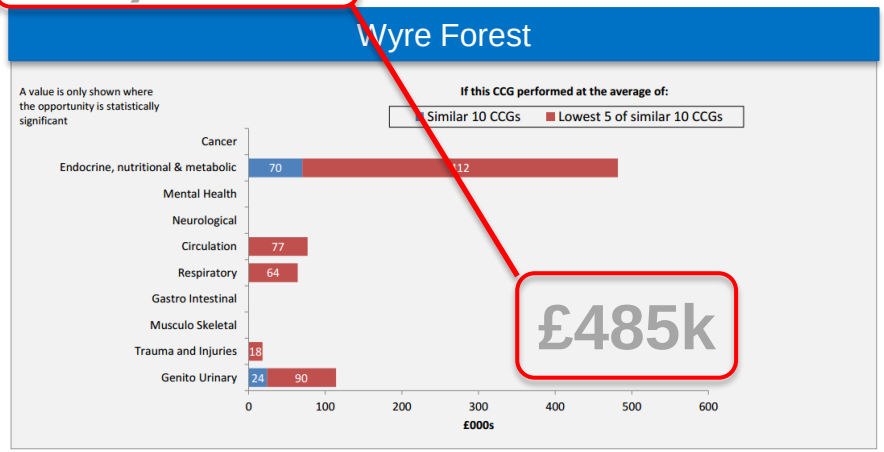
System total opportunity through achieving RightCare prescribing performance of comparable CCGs is a total **of £4.714m**

£4,714k

South Worcestershire

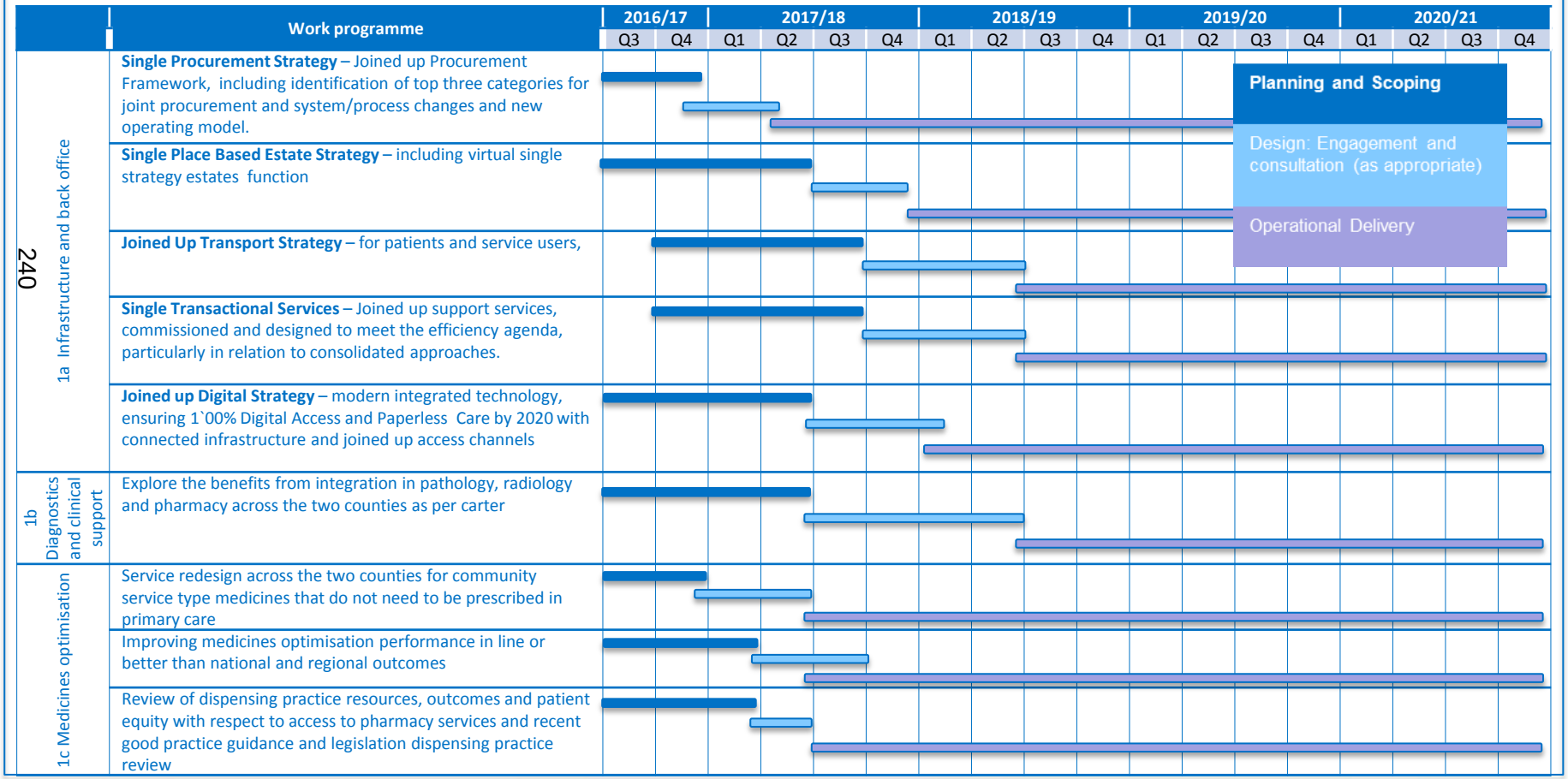


Wyre Forest



Delivery Plan – Priority 1: Maximise Efficiency and effectiveness

Infrastructure and Back Office SRO	**Michelle McKay -** CEO Worcestershire Acute Hospitals NHS Trust	**Programme Lead**	**Pauline Harris -** Programme Manager Worcestershire County Council
Diagnostics and Clinical Support SRO	**Michelle McKay -** CEO Worcestershire Acute Hospitals NHS Trust	**Programme Lead**	**Richard Cattell** – Director Medicines Optimisation & Pharmacy Worcestershire Acute Hospitals NHS Trust
Medicines and Prescribing SRO	**Simon Trickett** Accountable Officer – RBCCG and WFCCG	**Programme Lead**	**Jane Freeguard** Head of Medicines Commissioning WCCG's



Priority 2 – Our approach to prevention, self care and promoting independence

Programme 2a	PREVENTION	Owner	Simon Hairsnape, Accountable Officer, HCCG
Overall aim	To embed at scale delivery of evidence based prevention interventions across the health and social care system, achieving population behaviour change , and improving health outcomes		

What will be different between now and 2020/21

Ensure evidence based prevention is delivered at scale across health and social care , working with partners to ensure that prevention is everybody's business.

- We will use the approach to prevention set out in our health and well-being strategies, working with partners to address the causes of ill-health as well as to deal with problems well as soon as they arise
- 4 prevention delivery platforms embedded across all health and social care services:
  - **Social prescribing** - Reducing escalation of conditions, supporting recovery and reducing dependence on services
  - **Making Every Contact Count (MECC) and 'a better conversation' health coaching approach** - Staff work in partnership with patients having a different type of conversation that guides and prompts individuals to be more active participants in their care and behaviour change to achieve goals and outcomes that are important to them
  - **Digital inclusion** - Preventing social isolation and supporting self care and recovery
  - **Lifestyle change programmes** - Focusing on obesity (diet and physical activity) smoking and alcohol harm reduction. National Diabetes Prevention programme rolled out across the two counties, as part of an integrated obesity strategy
- System wide approach to tackling key local issues - Uptake of flu vaccinations in vulnerable groups and carers as well as both systematic and opportunistic immunisation by staff across all service groups, Building resilience in parents and children – Redesigned health visiting, school nursing and family support services. Prevention of Cancer and related Screening - Reducing both the incidence/prevalence of cancer and earlier diagnosis. Prevention of serious injury from falls - contributing to ageing well. Extended healthy life expectancy, and narrowing the health inequalities gap - Elimination of variation between practices
- Developing 'asset rich communities' where local people thrive in a network of families, neighbours and communities, getting involved in activities and organisations for the benefit of all, and where front line staff across the systems are able to link clients to their local assets easily and constructively. Dementia friendly communities – integrating with dementia services to provide dementia friends training and support for Dementia Alliances

How will this be better for residents and patients in Herefordshire and Worcestershire

- Staff are confident in undertaking motivational conversations about lifestyle and able to deliver brief intervention and signposting
- Population behaviour change prevents ill-health - at population level and for individuals
- Reduced levels of preventable disease – in particular those caused by misuse of alcohol, smoking, inactivity and obesity, reducing demand for both elective and non elective services
- Improved self care by patients and their carers – reducing demand for non-elective services and improving patient experience
- Reduced levels of social isolation – reducing demand for services, improving mental well-being and prolonging independence
- Improved community support of individuals and their carers – reducing demand for services and improving well-being

Priority 2 – Our approach to prevention, self care and promoting independence

Programme 2a	PREVENTION	Owner	Simon Hairsnape, Accountable Officer, HCCG

Overall aim

Promoting better long term life outcomes for children, young people and their families' needs to be at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future. It is important to remember that 'Later interventions are considerably less effective if they have not had good foundations' (Marmot Review 2010)

What will be different between now and 2020/21

Best start in life - Focus on full implementation and adequate resourcing of the Healthy Child Programme (HCP) and broader early childhood services offer including;

- Effective early help - to improve the early identification and response to critical issues affecting children and young people's development as well as supporting parenting and socialisation
- 0 to 5 early years in Herefordshire – to improve the health, well-being, developmental and educational outcomes of children aged 0-5 years . Herefordshire is also currently developing and integrated 0-19 service model.
- Through the redesign of the Integrated Public Health Nursing 0-19 Service in Worcestershire, all children, young people and their families on their Starting Well journey will have access to the Healthy Child Programme delivered by skilled community Public Health teams at key development points
- Implement Connecting Families across Worcestershire taking a whole system response in overcoming challenges that prevent and/or delay positive outcomes for children, families and vulnerable individuals
- Vulnerable Groups - focus on vulnerable children and young people across the two counties who are more likely to experience difficulties in their lives and may need support to help overcome them. More can and should be done to address these health concerns through improving the quality of the workforce and range of interventions
- Mental Health - Focus on improving the emotional well being and mental health of children and young people
- Strengthening relationships with the education and skills sector as a key stakeholder in improving outcomes

How will this be better for residents and patients in Herefordshire and Worcestershire

In the short term:

- Improve information and support for children and families to enable self- management and independence
- Increase personalised care planning in partnership with children, young people and their families
- Strengthen information sharing across the system to enable a joined up approach and end to end care pathways
- Increase competency and confidence of staff across all sectors to manage children and young families needs in partnership with their parents
- Improve our 19-25 provision improving access to education for all (including recovery college)

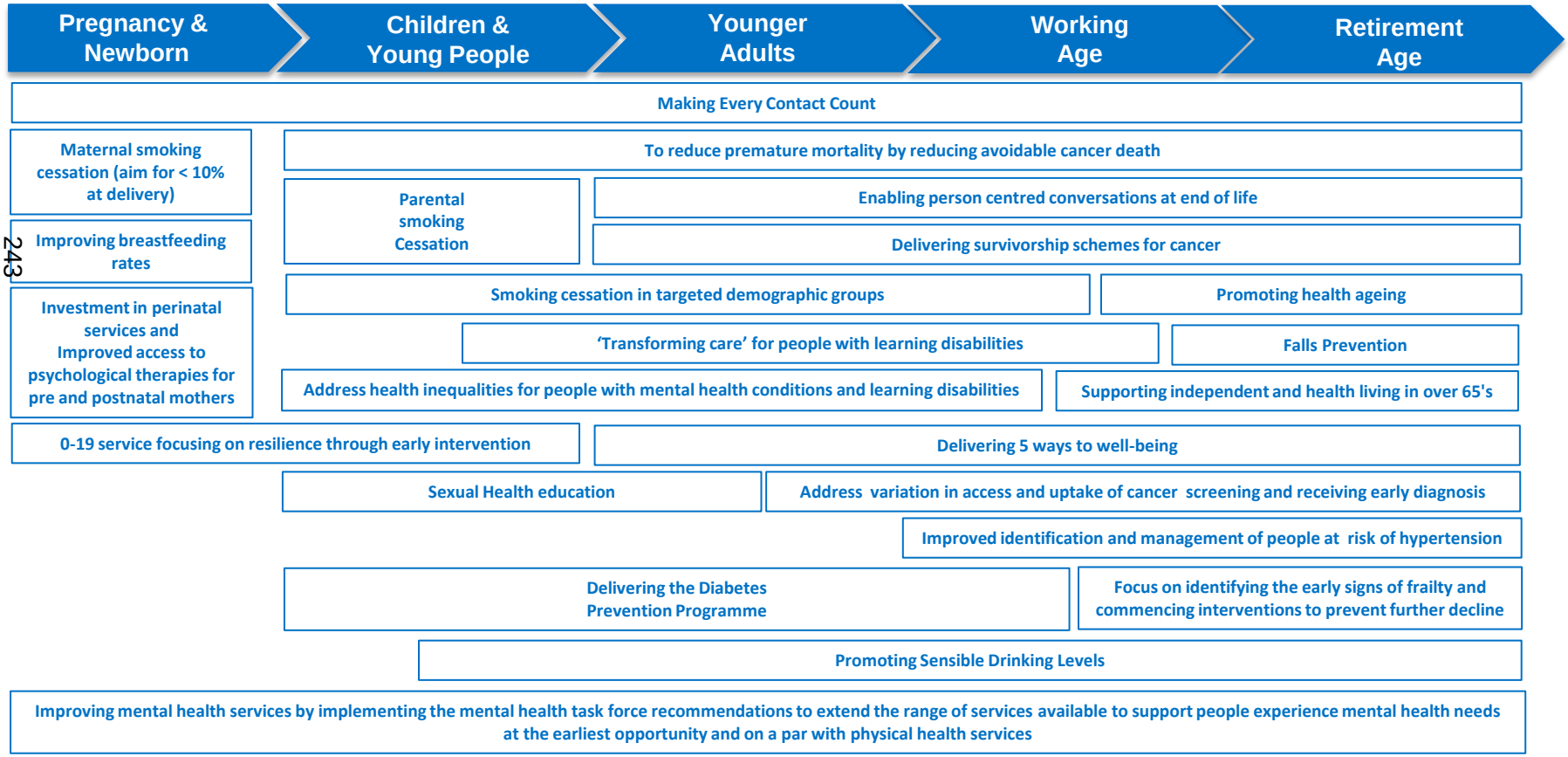
In the medium term:

- Increased choice and control through increased uptake of personal budgets
- Reduced referrals to specialist services
- Reduced out of county placements
- Reduced numbers of looked after children
- Improved educational achievement for vulnerable children and young people including those with SEND
- Reduced NEET and increased young people in education/training
- Improved wellbeing for children, young people and families

Priority 2 – Our approach to prevention, self care and promoting independence

Reshape our approach to prevention, to create an environment where people stay healthy and which supports resilient communities, where self care is the norm, digitally enabled where possible, and staff include prevention in all that they do.

Driving prevention through everything we do; The following diagram demonstrates how we are ensuring that a focus on prevention is inherent across our STP for all age groups and all work streams, delivering an improvement in health and well-being.



Priority 2 – Our approach to prevention, self care and promoting independence

Programme 2b	SELF CARE and PROMOTING INDEPENDENCE	Owner	Simon Hairsnape, Accountable Officer, HCCG

Overall aim	To support people to manage their own health and live independently, linking them with social support systems in their communities and identifying when a non-clinical intervention will produce the best experience and outcomes for patients. This approach should be led by communities with Health, Social Care and the Voluntary Sector working together to support.

What will be different between now and 2020/21

Building on the success of existing self care initiatives will continue to be regarded as a high priority area within the prevention agenda, helping people to stay well. Greater benefits will be realised for local people and staff as the following key interventions are expanded and further innovation applied:

- More individuals will utilise the range of solutions available to manage their condition including information, peer support, informal and formal education, digital approaches (e.g. Map My Diabetes, Patient Management Programme)
- Care planning and self-management will be hardwired into how care is delivered. Care plans will be digital and shared between care settings, owned by and useful for patients, their families and carers (e.g. iCompass)
- People already at high risk of ill health will be identified and offered behaviour change support (e.g. Pre Diabetes Project, Living Well service)
- Social prescribing schemes will be systematic, connecting individuals to non-medical and community support services (e.g. care navigators based in primary care to signpost and link people to social prescribing support).
- Extension of the roll out of national screening tools used to assess an individual's motivation to self care - thus tailoring the needs of the intervention (e.g. Patient Activation Measure)
- Early prevention will be embedded within each service that the person comes in contact with thus proactively supporting self care programmes, reducing social isolation and improving social integration [e.g. Health Checks, Falls Prevention, Strength and Balance classes, Reconnections] tailoring and focussing services on those who have the greatest need.
- We will be working more closely with front line services such as police, the Fire Service and housing agencies to deliver the prevention agenda.

How will this be better for residents and patients in Herefordshire and Worcestershire

Individuals will be increasingly independent, self-sufficient and resourceful to confidently manage their needs, thus reducing dependency on the health and social care system and improve their well-being and lifestyle. Ultimately individuals will:

- Increase their sense of control in their lives
- Feel confident to assess and address their health and well-being needs
- Better symptom management, including a reduction in pain, anxiety, depression and tiredness, reduced stress
- Experience improved health and quality of life
- Are able to live well with any health condition
- Are able to problem solve, make changes and manage their thinking, moods and behaviours positively
- Live as active participants in their communities
- Reduce their use of key services, with fewer primary care consultations, reduction in visits to out-patents and A&E, and decrease in use of hospital resources
- Increase their healthy life expectancy
- Live independently for longer

Every contact with a patient in primary, community and secondary care will be used as an opportunity to improve patient's knowledge of involvement in their care on an individual basis.

Delivery Plan – Priority 2: Our approach to prevention, self care and promoting independence

2 Prevention , Self care and promoting independence SRO	**Simon Hairsnape** Accountable Officer – Herefordshire CCG	**Programme Leads**	**Frances Howie** – Director of Public Health, Worcestershire **Rod Thomson** –Director of Public Health, Herefordshire **Menna Wyn-Wright** - Transformation Programme Lead - Worcs CCGs **Jacinta Meighan-Davies** - Clinical Programme Manager HCCG

2 Prevention, Self Care and Promoting Independence

Work programme	2016/17		2017/18				2018/19				2019/20				2020/21			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
SOCIAL PRESCRIBING SCHEMES will be systematic, connecting individuals to non-medical and community support services [e.g. care navigators based in primary care to signpost and link with social prescribing support] and will align to social work practice models which are developing a strengths and community based asset approach.																		
LIFESTYLE BEHAVIOUR CHANGE - More individuals will utilise the range of solutions available to manage their condition including information, peer support, informal and formal education, digital approaches. These will include a strong offer on behaviour change linked to the NHS health checks programme.																		
MAKING EVERY CONTACT COUNT - Front-line staff across the system will be trained with accredited materials to enable them to have motivational conversations with patients and public about lifestyle choice and healthy behaviours , guiding individuals to achieve goals and outcomes that are important to them. Whilst delivering brief interventions and signposting to further support.																		
DIGITAL INCLUSION/INFORMATION – A range of measures will be delivered to increase digital inclusion, so that everyone who wants to is enabled to get on-line and benefit from the digitalisation of services. Care plans will be digital and shared between care settings, owned by and useful for patients, their families and carers. Digital aids and tele-health will be utilised where appropriate.																		
EMBEDDING PREVENTION - Early prevention will be embedded within each service that the person comes in contact. STP clinical work streams will include a specific set of prevention actions thus prevention is core in all that we do. Whilst proactively supporting self care programmes, reducing social isolation and improving social integration, tailoring and focussing services on those who have the greatest need.																		
SYSTEM WORKING – All partners within the system will work together to contribute to identifying problems early and intervening early to stop them from getting worse. This will include partners in fire and rescue, voluntary organisations, and local government including housing providers.																		

Planning and Scoping

Design: Engagement and consultation (as appropriate)

Operational Delivery

Priority 3 – Developing out of hospital care

Programme 3	INTEGRATED PRIMARY & COMMUNITY SERVICES	Owner	Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust
Overall aim	To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.		

What will be different between now and 2020/21

Care will be developed and enhanced through the implementation of new models of care, which we will deliver through alliance working as we develop our Accountable Care Systems. We will use the "Primary Care Home" approach, recognising that no one model will work for the range of communities that we serve across Herefordshire and Worcestershire.

In line with the Primary Care Home approach the following has been agreed by primary and community care leaders;

Localities representing General Practice across the STP have come together and agreed to develop a new model of care based on the principles of the emerging vanguards. The local arrangements will be built around natural localities that either already exist or which are rapidly coming together. These localities will range in size from around 35k to potentially more than 150k population. There is widespread agreement about the scope and focus of these localities in bringing together primary, community, mental health and social care services as well as some aspects of acute services that could be more effectively delivered from a community base.

There is agreement that there will need to be some form of infrastructure organisation to enable these localities to operate at the required scale to enable integration with county wide partners, to manage risk as well as to provide economies of scale around back office functions. It is agreed that the localities will have a central role in setting local strategy and priorities, but there is widespread recognition that planning and service delivery will need to be layered – with some consistent county or STP wide pathways operating alongside some very local pathways built around smaller groups of practices.

Priority 3 – Developing out of hospital care

Programme 3a	**DEVELOPING SUSTAINABLE PRIMARY CARE**	**Owner**	Graeme Cleland, Managing Director Taurus
Overall aim	Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services		

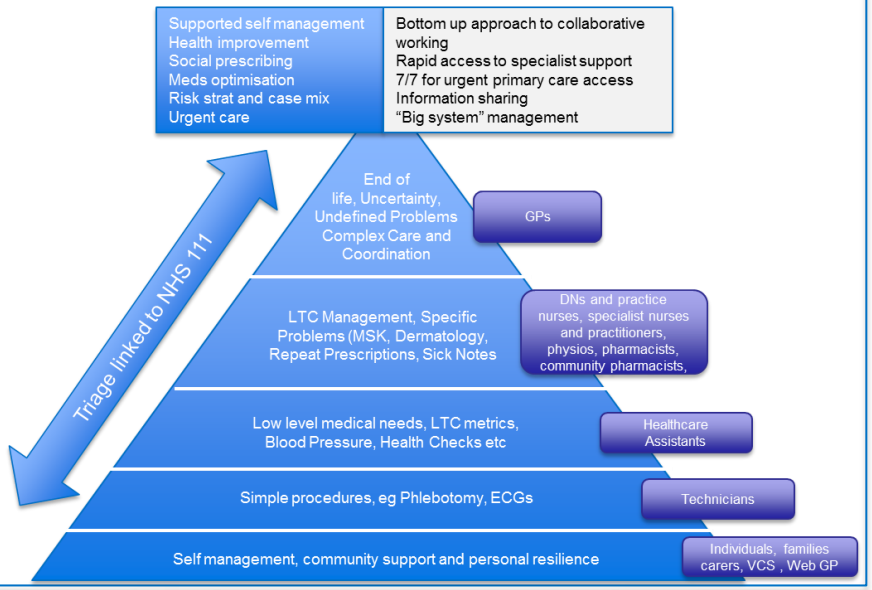
There are a number of fundamental challenges that need to be resolved to support primary care sustainability. Amongst the most significant of these are clinical indemnity, information governance and property liability. Successful delivery of the STP will be dependent on these issues being resolved in a way that enables full engagement of general practice in the new ways of working.

Implementing the GP forward view - Our system has long benefitted from strong primary care which has enabled us to adapt to change. We have a range of federations, including one of the most well developed federations in the country in Taurus. In Herefordshire and South Worcestershire there are already 7 day services delivered to the population. However the ability of primary care to continue to meet the changing needs of our population is at risk. Our approach will include investment from the transformation fund to ensure primary care remains sustainable and at the heart of delivery.

Our out of hospital care models will be based around the GP lists for local populations and this will support a shift of resource to enable out of hospital care to be a reality.

The models will recognise the differing needs across the "continuity of care spectrum" from those patients who absolutely need continuity of care to manage their conditions effectively and efficiently, to those with an episodic need where quick and convenient access is the priority. We will work with localities and practices to identify the "care functions" needed to provide holistic care across the spectrum.

The models will build on what is already working well and will embed social prescribing, health improvement and self-management, utilising digital solutions where possible to provide these at scale and support demand management in primary care. The model will seek to extend 7 day access to high quality primary and community care where needed. It will also deliver proactive anticipatory care, through risk stratification, case finding, case management and an MDT approach. The models are predicated on the sharing of resources and specialist primary care expertise across practices. We will work with localities and groups of practices to develop and implement these using a "bottom up" approach to identify what they will deliver (and be accountable for) at practice level, at locality level or at county level and beyond.



Priority 3 – Developing out of hospital care

Programme 3a	DEVELOPING SUSTAINABLE PRIMARY CARE	Owner	Graeme Cleland, Managing Director Taurus
Overall aim	Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services		

90% of all NHS contacts happen in primary care and it is widely accepted that if primary care fails then the whole health and social care system would be at risk. Therefore developing capacity and resilience in primary care, and particularly in general practice, is a priority for our STP. Resilient primary care with sufficient capacity and capability is also critical to our ability to improve health outcomes and to manage people closer to their own home/in community settings. It is a core building block to the development of our new model of care strategy

What will be different between now and 2020/21

- We will deliver this through local primary care working "at scale", developed through a "bottom-up" approach with practices working in partnership with community pharmacy, third sector and public sector services as well as community and mental health services.
- Through our GP 5YFV work we will implement the "10 high impact areas for General Practice" within and across practices. This will include:
  - Embedding prevention and health improvement to "Make Every Contact Count"
  - Embedding social prescribing, to connect patients and their carers with community support
  - Training and educating our staff to be able to support self care by patients and carers
  - Utilising digital solutions to enable social prescribing and self-management, as well as new consultation types such as skype consultations and these at scale
- We will encourage all staff to recognise when the end of life is approaching and to have frank and honest conversations with patients and their loved ones and carers. This will lead to development of shared expectations and clear guidance with a view to helping patients take control.
- Through "big system management" we will use real time data collection and analysis to support continuous quality improvement and demand management
- Through primary care at scale we will redesign the primary care workforce to support comprehensive skills and capacity across primary care. Through our alliance working we will deliver this in partnership with acute and community providers through a delivery model that:
  - Enables seamless working across health/mental health community teams, social care and acute services to provide seamless out of hospital care
  - Enables sharing of resources (clinicians and managers) across organisational boundaries
  - Supports professional accountability, clinical governance, line management, education and development across organisational boundaries

Priority 3 – Developing out of hospital care

Programme 3a	DEVELOPING SUSTAINABLE PRIMARY CARE	Owner	Graeme Cleland, Managing Director Taurus
Overall aim	Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services		

What will be different between now and 2020/21

- With increased capacity within primary care we will adopt new ways of working:
  - Moving to a proactive model of care, identifying and case managing through an MDT approach those at risk of ill-health and/or emergency admission
  - Adopting early clinical assessment within a robust process to direct patients to the most appropriate clinician to achieve "right patient, right place, right time". This would ensure continuity of care for those with complex needs as opposed to those requiring same day episodic access).
- We will build upon the success of our "Prime Ministers Access Fund" pilots to provide 7 day primary care services, including 7 day access to Urgent Care.
- There will be a statute and regulatory compliant data-sharing model initially developed and delivered across Primary Care that will manage the risk of data breach. This will learn from existing service leading models and will need to be formally approved by the regulatory bodies and legal advisors. This will go on to form the foundation of the "Big Data" workstream ultimately sharing appropriate live data, throughout the Health and Social Care organisations in real time based on the point of individual need and express consent.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Improved access to primary care – for example in Herefordshire in 2016/17 an additional 24,106 appointments by the end of 2016/17 through the Prime Minsters Access Fund.
- Confidence that primary care can support their healthcare needs in a timely manner.
- Capacity and capability within primary care to meet their needs.
- Improved experience, and outcomes through support to prevent ill-health and self manage their own conditions.
- Continuity of care provided through consistent access to patient information.
- High quality care at every consultation, with reduced variation within and across practices.
- Resilient primary care, with the capacity to undertake proactive anticipatory care to prevent people becoming unwell.
- Continuity of care for those with complex needs
- Improved access to specialist opinion in primary care settings
- Patients consistently able to access the most appropriate help and support over 7 days, for both elective, urgent care needs and end of life care.

Priority 3 – Developing out of hospital care

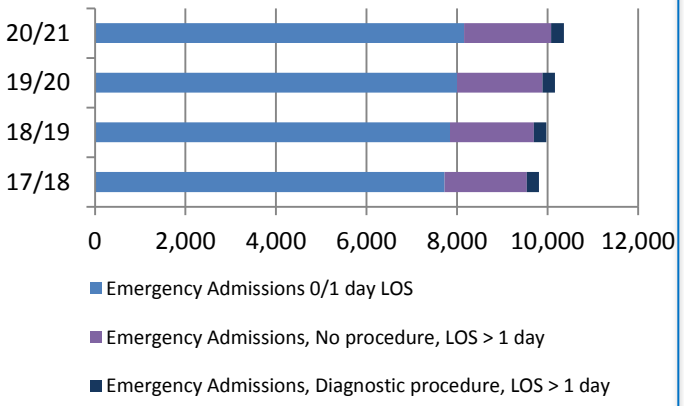
Programme 3b	INTEGRATED PRIMARY & COMMUNITY SERVICES	Owner	Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust
Overall aim	To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.		

What will be different between now and 2020/21

- By April 2019 we will have used the Primary Care Home approach to deliver integrated primary and community services through our Accountable Care Systems.
- Our workforce will promote the wellbeing at every opportunity to reduce the impact of long term conditions. There will be a core focus on priorities such as immunisation programmes and falls prevention.
- Traditional organisational and professional boundaries will be removed, and a place-based model of care will be in place.
- The focus of the system will shift to an "own bed is best" model of care, using a proactive approach, optimising opportunities for independence and reducing reliance on bed based care.
- Care will be delivered by an integrated workforce, spanning primary, community, secondary and social care, organised around natural neighbourhoods.
- Local hubs will be developed from existing community sites as part of a coherent and effective local network of urgent care across 7 days, providing a comprehensive rapid response within communities and neighbourhoods – this includes a number of General Practices working collaboratively at scale, releasing GP capacity to care for patients with more complex needs.
- Specialist support will be available nearer to patients, reducing the time taken to access specialist input and reducing steps in the pathway.
- Robust information about patients, carers and their circumstances will be available digitally to all professionals involved in delivering care
- Personalisation of care will be prioritised , supporting self management and improvements in population health, working proactively with wider place based partners around the determinants of health (e.g. housing, leisure , education, employment, community engagement).
- An integrated frailty pathway will be in place which ensures people living with frailty are at the centre of services, enabling them to live well with their condition, age well and supporting them until the end of life. There will be a shift in focus on to what a person can do rather than what they can't do.
- Individual care and support plans will include carer support and encompass emotional as well as physical needs.

The chart below shows the activity that would be removed from the acute sector as a result **of full implementation of an integrated frailty pathway and other admission avoidance schemes** as , By 2020/21 there would be **10,359 fewer** hospital admissions within Worcestershire.

Admissions that will be avoided as a result of the new integrated frailty pathway and other admission avoidance schemes



The chart above shows that the most significant reduction in emergency admissions will be for those where the length of stay is one day or less.

Priority 3 – Developing out of hospital care

Programme 3b	INTEGRATED PRIMARY & COMMUNITY SERVICES	Owner	Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust
Overall aim	To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce.		

How will this be better for residents and patients in Herefordshire and Worcestershire

- Patients and their carers will be fully involved in the assessment of their needs, and integrated community teams will enable and support them to meet these needs whether they are health or social needs.
- Care plans will be person centred, and reflect specific needs and wishes. The plans should ensure that systems are in place to get help at an early stage to avoid a crisis.
- There will be continuity of care and support, patients will be able to build relationships with staff over time. Care will be delivered in an efficient and timely manner – things happen when they are supposed to and patients will know what to expect, and when.
- With patients permission, information from assessment and care planning is entered on to a digital record, and is shared with everyone involved including the patient. The professionals involved in care talk to each other and work as one team. Everyone has timely digital access to any updated assessments or changes to the care plans.
- Consistent information, is provided to patients and their carers at the right time, and in a format that is easily understood. Patients will have a consistent point of contact if they wish to discuss any concerns.
- Patients will be supported to be independent – our workforce are trained in coaching to enable patients to become more active in managing their own health, wellbeing and care. Staff have time to allow patients to continue to do what they can, make good choices and offer practical support where necessary rather than intervening because its is quicker. Clinicians work in partnership with patients to encourage lifestyle change, support self-management, increase medication compliance and aid complex decision making. This will be measured through Patient Activation Measures (PAMs)
- Patients are empowered to self manage their long term conditions using technology to achieve goals and outcomes that are important to them
- Patients at the end of life will be supported to have conversations about their choices, outcomes of the conversations will be shared and patients will be able to receive their care at home as long as it is safe to do so
- Patients will have one first point of contact in a crisis. It will be clear to the patients who to contact day and night and care will be seamless.
- Teams involved in care will have a comprehensive understanding of the range of formal and informal support available, so that they can offer alternative support where appropriate including from voluntary and 3rd sector agencies who will be part of the community teams.
- Carer's needs are considered – the needs and preferences of my family and other informal carers are taken into account, and they are able to access support to continue to care for as long as they wish.
- Where an admission to hospital is necessary, community teams familiar to the patient will in-reach and manage the discharge into the community and provide holistic support tailored to their needs.

Priority 3 – Developing out of hospital care

Programme 3c	THE ROLE OF COMMUNITY HOSPITALS	Owner	Simon Hairsnape, Accountable Officer, HCCG
Overall aim	To develop community hospitals as local delivery facilities for an increased range of activity including outpatients, day case and support services and also to develop the potential of some sites becoming specialist centres for frailty, stroke care etc		

What will be different between now and 2020/21

- We are engaging with patients, the public, local clinicians and other stakeholders to understand how we can make better use of our community bedded resources to support care closer to home in line with the principle "own bed is best", in line with what the public has told us. A range of activities could be provided from these facilities such as outpatient services and/or elective surgical procedures to support improved local access. Some sites might therefore become specialist centres or be points for new pathways of care (e.g. frailty assessment and specialist stroke rehabilitation).
- Some community hospitals may be able to operate as bedless, e.g. as a "locality hub" for domiciliary based community services integrated with primary care. This may include the co-location and integrated delivery of community teams with primary care based services and/or 24/7 primary care.
- Some community hospitals may be able to operate with a defined role in the system of care, as part of an integrated care pathway and some may need to reduce the number of beds as services are provided in new ways such as domiciliary based care.

How will this be better for residents and patients in Herefordshire and Worcestershire

Our ambition is that any of the benefits of a new role for community hospitals are consistent with those for community services. In addition, our ambition is that:

- The model of care will move from a reliance on bed based care to care in peoples own homes/their usual place of residence, reducing crisis admissions, onward deterioration and poor outcomes at the point of discharge.
- More planned care will be available closer to home (outpatients and day care for example) reducing the need to travel for regular appointments.
- People will experience more of a "one stop shop" in their Locality Hub as their locality teams (including community, primary and social care staff) will all be co-located.
- People who are frail will experience a wrap around response designed to treat and stabilise so people do not have to go into an acute hospital.

We are undertaking this on the principle of co-production with patients, the public and wider stakeholders to ensure we meet the needs of local populations. We will also work with local clinicians to ensure services are integrated and work seamlessly across 7 days.

Priority 3 – Developing out of hospital care

Improving integration between health and social care

In order to transform our services it is essential that we find more effective ways of organising services to respond to the increasingly complex and chronic health and social care needs of our population. This is to reduce duplication as well as to deliver improved outcomes for people and their carers. The evidence indicates that integration results in improved clinical outcomes and a better patient experience (Ref: Stepping up to the Place, NHS Confed and ADASS, 2016). This is supported by our engagement with local people who live with long term conditions and/or multiple needs, which highlights that people want more joined up care. In particular they tell us that the divide between health and social care often impacts on the effectiveness and the efficacy of the support they receive.

We are committed to continue developing services that work in a more integrated way; wrapping the necessary skills and competencies around people and their carers to enable them to live as independently at home for as long as possible. We believe that redesigning services around the needs of individuals in a locality / place presents the best opportunity to improve health and well-being and reduce health inequalities whilst also helping to bring about financial sustainability.

We will use our integrated care plans (Better Care Fund) to drive this integrated front line service delivery, developing and sharing skills and competencies across organisations at locality level, and at larger levels where it makes sense to do so. This includes working with organisations outside the NHS, including public sector partners and the VCS, to meet the totality of peoples needs.

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o deliver this we will:

- Improve early and consistent provision of advice and information to individuals, their carers and families, to enable proactive decision making that supports and enables independence and self care
- Offer more choice and control for individuals and their carers, including the wider adoption of Direct Payments/Integrated Personalised Budgets as appropriate
- Embed personalised care planning, in partnership with individuals and their carers, as the central tenet to our ways of working. We will ask' "what matters to you", as well as "what's the matter with you."
- Ensure joined up working across disciplines through the MDT approach, supported by shared information
- Develop a multi skilled workforce that can work across organisational and professional boundaries, whilst identifying tasks which can be shared across professional domains to reduce duplication and improve efficiency
- Work with local communities and the voluntary/community sector, to understand where and how partnership working can support individuals and carers to manage their own health and care needs
- Successful delivery will require us to nurture leadership across our workforces, to drive change in both culture and ways of working across personal and professional boundaries.

Delivery Plan – Priority 3: Developing out of hospital care

Primary Care SRO	**Graeme Cleland** Managing Director - Taurus Healthcare	**Programme Lead**	**Lynda Dando –** Director of Primary Care , Worcestershire CCG's **Lesley Woakes -** Director of Primary Care, Herefordshire CCG
Integrated Care SRO	**Sarah Dugan** CEO Worcs Health and Care NHS Trust	**Programme Leads**	**Sue Harris –** Director of Strategy Worcs Health and Care Trust **Matt Stringer –** Strategic lead new models of care WHCT **Alison Talbot-Smith –** Director of Transformation for One H **Nisha Sankey –** Associate Director of Transformation WCCGs
Community Hospitals SRO	**Simon Hairsnape** Accountable Officer – Herefordshire CCG		

	Work programme	2017/18				2018/19				2019/20				2020/21			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3a Developing sustainable primary care	Prioritise investment to ensure delivery of the General Practice Forward View – develop primary care at scale 'bottom up' and enhancing the role of wider primary care, including community pharmacy, ensuring stability in the longer term																
	Create an environment that enables sharing of resources, focused on 'Out of Hospital Care' (clinicians & managers) across organisational boundaries																
	Moving to a proactive model of care, identifying & case managing, potentially through an MDT approach, those at risk of ill health and/or emergency admission																
	We will, where required, create 'legally compliant' information across the Primary Care Community. This will include practices & other providers (where statutory compliance is achieved), to enable seamless care wherever patients enter the system																
	Through 'big system management' type activities, we will use real time data collection & analysis to support continuous quality improvement and demand management focusing on the future																
	Delivery of improved access to routine & urgent primary care appointments across 7 days a week through roll our of Prime Minister's Access Fund Initiatives																
	We will implement the '10 High Outcome Areas for General Practice' within and across practices																
	Adopting and deploying a contractual model (MCP/ACO) pan STP that will promote early clinical assessment within a robust framework directing patients to the most appropriate clinician underpinned by the 'Six Rights'																
3b Integrated primary & community services	Through the Worcs Alliance Boards, develop population based integrated teams																
	Through the One Herefordshire Alliance, develop population based integrated teams																
	Embed the integrated out of hospital care model into the development of our ACOs																
	Develop integrated frailty pathways in both counties																
3c Community Hospitals	Co-design options for change with patients, the public, local clinicians and other stakeholders to support care closer to home, based on the principle that "own bed is best".																
	Implement any resulting changes to inpatient beds, community based "hubs" and increased in planned care in community hospitals																

Planning and Scoping

Design: Engagement and consultation (as appropriate)

Operational Delivery

Priority 4 – Establish clinically and financially sustainable services

Programme 4a	IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE	Owner	Shaun Clee, Chief Executive, 2gether NHS FT

Overall aim	To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities.

What will be different between now and 2020/21

We aspire to meet the requirements of the National Mental Health Policy "No Health Without Mental Health" and the requirements of the National Mental Health Five Year Forward Vision across the two counties. In order to achieve this aspiration, as partners across the system, we have agreed to prioritise investment in mental health services where financial circumstances permit.

We will work on the following priorities:

- A specific focus on Perinatal care as it delivers immediate benefits and evidence-based Mental ill-Health prevention.
- Increased access to psychological therapies for a range of common mental health disorders and the management of 'Medically unexplained symptoms' to reduce demand within acute and primary care.
- Strengthened management of people with dementia in acute urgent care systems and primary care at scale.
- Increased visibility, awareness and acceptability of mental health through a high profile Mental Health Cabinet focused on delivering integration rather than isolation.
- Collaboration to deliver a range of care more locally at an STP/STP Plus level i.e. Improved access to CAMHs Tier 3.5 to reduce demand for Tier 4 CAMHS, Locked Rehabilitation, Complex Dementia services, eating disorder and personality disorder services.
- Moving mental health care from Good to Outstanding with immediate priorities for delivery focused on talking therapies (IAPT) and Early Intervention Services (EIS).
- We will conduct coordinated work on reducing stigma through campaigns and communications.

Through delivering these priorities:

- There will be better access to mental health and learning disability services at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision.
- Services will be responding to the health and wellbeing gaps and health inequalities identified within the Herefordshire and Worcestershire JSNA's and resultant Health and Wellbeing Strategies.
- Through *Transforming Care* - we will be bringing people with LD and Autism back to their own communities from out of area placements and preventing admission to hospital, achieving safe discharge and robust community support.
- People who require more tertiary care/specialist support will have their care planned for and provided across the STP and in partnership with neighbouring STPs via managed clinical networks.
- We will reduce expenditure in other programme areas, such as urgent care and complex care (ie CHC and social care packages) from the increased investment in mental health and learning disability services.

Priority 4 – Establish clinically and financially sustainable services

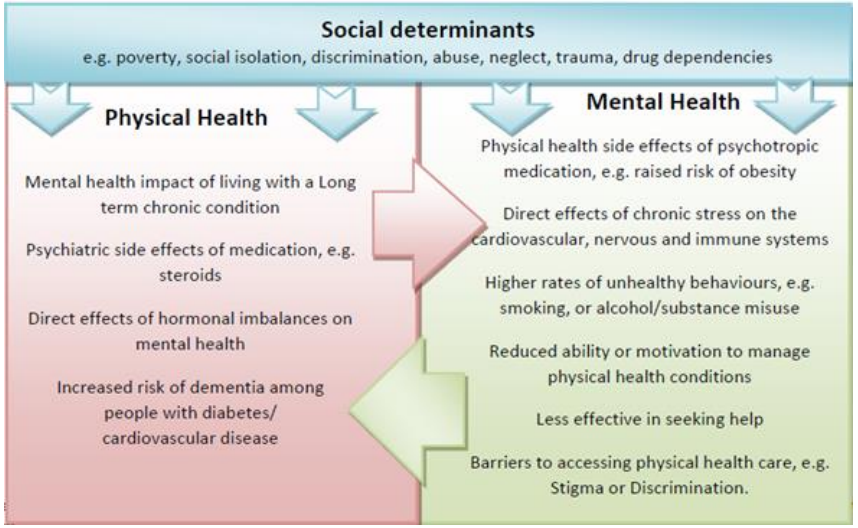
Programme 4a	IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE	Owner	Shaun Clee, Chief Executive, 2gether NHS FT

Overall aim	To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Citizens will have better access to information that promotes and supports positive mental wellbeing – social prescribing, MECC, digital inclusion and lifestyle change programmes – can all impact in the short to medium term. Longer term, tackling social deprivation through economic regeneration and the creation of healthy jobs has a significant role in improving population mental health and well being.
- The population's attitudes to individuals experiencing both common and more complex mental health difficulties will be better informed, more supportive and less stigmatised. This in turn will support earlier access to wellbeing services, diagnostics, treatment and better support and opportunities for recovery.
- Individuals who experience physical and mental health co-morbidities will experience well coordinated, education based packages of care that promote and enable self care and minimise the complications associated with comorbidities.
- Fewer people will need to access specialist services outside of the two counties.
- Improved rates of access to or sustained education, training and or employment consistent with local rates of whole population attainment.
- Improved access to and sustained stable accommodation consistent with local rates of whole population attainment.

Relationships between Social Determinants, Physical health and Mental health Adapted from "No health without mental health" by Prince et al in 2007



Priority 4 – Establish clinically and financially sustainable services

Programme 4a	IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE	Owner	Shaun Clee, Chief Executive, 2gether NHS FT

Overall aim	To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities.

Risks to delivery

There are a number of delivery risks to be addressed in order for us to deliver our shared ambition to make parity of esteem a living reality for the people of Herefordshire and Worcestershire. Predominantly we have to be able to address our immediate financial challenges and create the headroom to invest in improved services in line with the MHFYFV priorities. This will be challenging in the early years of the STP but we will continue to pursue the aspiration to prioritise investment in future planning cycles. To start this process off, we are commissioning a specialist review to examine existing expenditure patterns in order to explore opportunities to reprioritise current resources. This will include:

- Developing a plan that identified how to deliver core 24 standards in crisis care and MH liaison.
- Redesign early intervention services to extend age range and skills profile
- Review peri-natal pathways and opportunities to deliver STP wide service
- Develop a personality disorder service
- Develop more local CAMHS tier 3.5 and 4 service
- Develop a complex dementia service

Many of our services are rated highly by regulators and service users alike, and we are committed to maintaining and improving quality and supporting people to live healthy and fulfilling lives. As with other service areas, the ability to recruit and retain the right number and calibre of staff has a significant impact on the sustainability and development of services, and so our workforce development plans are therefore a key priority.

We are committed to adopting the early recommendations from the Kings Fund Evaluation of the New Models of Care, namely that mental health is a core component of all of our STP workstreams, especially in the design of Neighbourhood Teams and embedding of prevention initiatives. Therefore we will seek to involve patients, service users and carers early in the design process to develop mental health metrics that reflect outcomes, activity and quality of provision. Across our STP developments we will look to strengthen mental health capabilities in the primary and community health workforce by improving the confidence, competence and skills of GPs, integrated care teams and others and ensure that professionals involved in new models of care have protected time to provide an educational function to other members of staff, in order to share learning between health professionals working in physical and mental health.

Delivery Plan – Priority 4:Establish clinically and financially sustainable services

Mental Health & Learning Disabilities SRO	**Shaun Clee** - Chief Executive 2gether NHS Foundation Trust	**Programme Lead MH** **Programme Lead LD**	**Colin Merker** – Director of Service Delivery, 2gether NHS Foundation Trust **Liz Staples** – Deputy Director of Nursing ,Worcestershire Health and Care NHS Trust

4a Improving mental health and learning disability care

Work programme	2016/17		2017/18				2018/19				2019/20				2020/21			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Independent review of Mental Health spend and scoping of opportunities for re-prioritisation																		
Increasing visibility, awareness and acceptability of mental health through a high profile Mental Health Cabinet																		
Collaboration to deliver a range of care more locally at an STP/STP Plus Level																		
Increasing access and availability of psychological therapy to 25% Worcestershire:																		
Increasing access and availability of psychological therapy to 25% Herefordshire:																		
Develop early intervention services in line with national proposals Worcestershire:																		
Develop early intervention services in line with national proposals Herefordshire:																		
Development of CAMHs community eating disorder services Worcestershire:																		
Development of CAMHs community eating disorder services Herefordshire:																		
Development of perinatal mental health services Worcestershire:																		

Independent review of investment

Planning and scoping

Design, Engagement and Consultation (As appropriate)

Operational Delivery

Delivery Plan – Priority 4:Establish clinically and financially sustainable services

Mental Health & Learning Disabilities SRO	**Shaun Clee** - Chief Executive 2gether NHS Foundation Trust	**Programme Lead MH** **Programme Lead LD**	**Colin Merker** – Director of Service delivery 2gether NHS Foundation Trust **Liz Staples** – Deputy director of nursing Worcestershire Health and Care NHS Trust

4a Improving mental health and learning disability care

Work programme	2016/17		2017/18				2018/19				2019/20				2020/21			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Development of perinatal mental health services Herefordshire: *(To be agreed following independent review of investment)*																		
Development of crisis care and National Standards for Core 24/7 mental health urgent care services. (NB: small extended hours service currently in place) Worcestershire:																		
Development of crisis care and National Standards for Core 24/7 mental health urgent care services. (NB: small extended hours service currently in place)Herefordshire: *(To be agreed following independent review of investment)*																		
Development of CAMHS emergency, urgent and routine pathways																		
Development of dementia services – with a focus on early intervention, strengthened VCS links and interface with frailty pathway																		
Development of acute mental health care – reduce the need for admissions out of area and the number of re-admissions																		
Development of integrated mental health and physical health care pathways in line with alliance developments																		
Development of personality disorder services Worcestershire:																		
Development of personality disorder services Herefordshire:																		

Independent review of investment

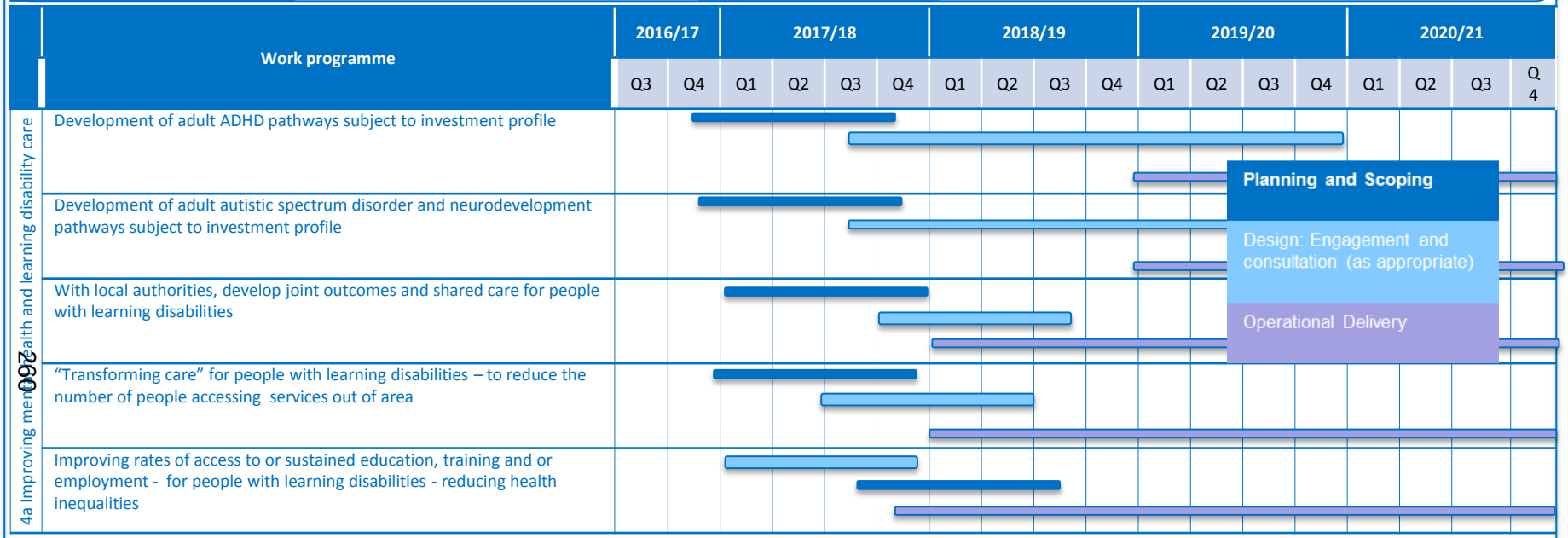
Planning and scoping

Design, Engagement and Consultation (As appropriate)

Operational Delivery

Delivery Plan – Priority 4:Establish clinically and financially sustainable services

Mental Health & Learning Disabilities SRO	**Shaun Clee** - Chief Executive 2gether NHS Foundation Trust	**Programme Lead MH** **Programme Lead LD**	**Colin Merker** – Director of Service delivery 2gether NHS Foundation Trust **Liz Staples** – Deputy director of nursing Worcestershire Health and Care NHS Trust



Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access, performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Introduction

Delivery of high quality accessible urgent care services is a high priority for the populations in both Herefordshire and Worcestershire in terms of speedy access to the most appropriate services and of the experience of individuals entering the urgent care system. There are a number of key challenges that need to be tackled over the life of the STP, the most pressing challenge across both counties is to address the poor performance in terms of meeting the four hour emergency access standard. Acknowledging recent national guidance i.e. NHSE Urgent and Emergency Care delivery plan 2017, both Herefordshire and Worcestershire have reviewed and enhanced its local plan with actions to improve the emergency access standard. For the STP this reinforces the need to develop more effective streaming of patients to the most appropriate urgent care access point and to continue to improve lean patient flow through the system.

How will this be better for the residents and patients of Herefordshire and Worcestershire

- Communities will be able to access more convenient alternatives to hospital based urgent care services, such as community pharmacies which are closer to home
- People will have better access to primary care support and advice for their urgent care needs, 7 days a week (see priority 3A)
- Investment in public education to help communities navigate the new services, making it easier to get the right care, first time by the right person
- Patients who are at heightened risk of emergency admission will have their care more coordinated to reduce the likelihood of a crisis occurring
- Less patients will be admitted to acute hospitals, meaning they can receive care closer to home and remain in more familiar surroundings
- Patients who require emergency care from acute and/or mental health specialists will be quickly assessed and streamed into the most appropriate management, with fewer delays
- Patients receive supported discharge from hospital into an appropriate community environment, once the acute phase of their care is over
- Waiting time performance for access to key services – such as response to 999 calls and 4 hour waits in A&E will be significantly improved

There are many important aspects to our STP strategy for achieving this, namely:

- Integrated Urgent Care - Review of urgent care physical access points
- Development of seven day services
- Improving flow within hospitals
- West Midlands Urgent and Emergency Care network review
- Improving stroke services
- Designing an urgent care workforce fit for 2020/21

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

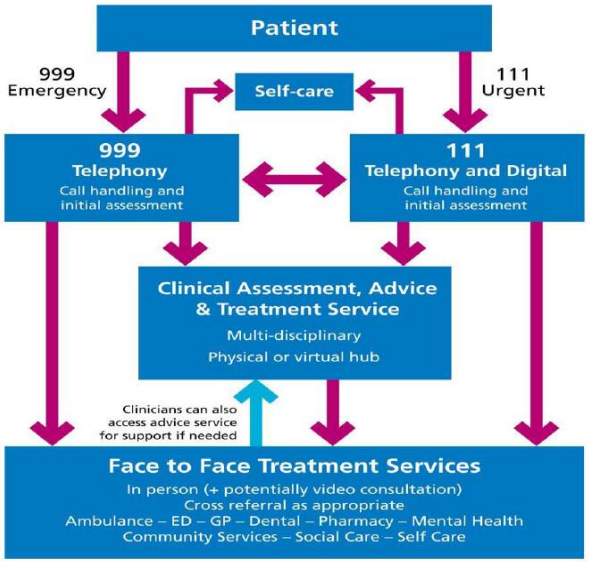
Introduction

Integrated Urgent Care - Urgent Care systems across both counties already provide 24/7 access for patients that need it. There are three 24/7 Accident and Emergency Departments, two 24/7 Minor Injury Units, 24/7 support and referral mechanisms through NHS111 and of course, accessible ambulance services through 999. In addition to this, although not operational 24/7, there are GPs working in one A&E in Worcestershire 8 hours a day on weekdays and 12 hours a day on weekends and GPs working with the ambulance service 12 hours a day on weekends and bank holidays. All of these services combine to provide a comprehensive urgent care offering. However, we recognise that we can do more to integrate services more effectively.

CCGs in both counties now have a newly commissioned Integrated Urgent Care Service, as part of the West Midlands service that went live on 8th November 2016. This new model provides a single point of access and clear onward referral arrangements to improve patient experience and to try and alleviate pressures across the health and social care systems. The model includes earlier clinical assessment and advice through the introduction of a clinical hub and supports closer working with the wider range of existing urgent care providers. The next phase of the development is looking at the expansion of the clinical hub; a number of pilots across the region including a Care Home HCP Support Line and the introduction of a Paramedic Support Desk by September 2017.

Within Worcestershire Care UK was selected to deliver both the NHS111 (for the WM Region) and the Out of Hours service (locally), ensuring that the opportunities for integration are maximised. Within Herefordshire, whilst different providers were selected for the two services, both are required to operate to a service specification that is built around effective integration between the two services under an Alliance Agreement.

The New Integrated Urgent Care Model
From November 2016 onwards



Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Review of urgent care physical access points - Alongside the new integrated urgent care model, we need to review physical access to urgent care services and the provision of specialist facilities – including the number of hospital beds required to support the demand. Changes to physical access is required because the system simply contains too many options, too much duplication; is too confusing for patients and the population and professionals to navigate effectively:

The complex array of ways to access urgent and emergency care across Herefordshire and Worcestershire

Current Provision	Herefordshire	Worcestershire
Telephone access	**NHS 111 and 999**	**NHS 111 and 999**
Main A&E departments	**Hereford**	**Worcester and Redditch**
Minor Injury Units	**Ledbury** (7 days / 24 hours a day) **Kington** (7 days - *8am to 8pm)* **Leominster and Ross on Wye** (5 days, 8:30 to 5:30)	**Kidderminster** (7 days / 24 hours a day) **Evesham, Malvern and Tenbury** (7 days, *9am to 9pm)* **Bromsgrove** (*Mon-Fri – 8am to 8pm, Weekends – 12pm to 8pm)*
Walk In Centres	**Hereford** (*7 days a week – 8am to 8pm)*	**None** (*Worcester's was closed in 2014)*
GP Out of hours hubs (dial NHS 111)	**Hereford, Leominster and Ross on Wye** *Weekdays - 6:30pm to 8:00am,* *Weekends – 24 hours a day*	**Evesham, Malvern, Kidderminster, Redditch, Worcester** *Weekdays - 6:30pm to 8:00am,* *Weekends – 24 hours a day*
Prime Minister's Access Fund/ single points of access for patient flow	**Primary Care Access Hubs in Across Hereford, Leominster and Ross on Wye** *Mon-Fri 6.30pm to 8pm, Weekends 8am to 8pm*	**Clinical Contact Centre in South Worcestershire (Telephone and face to face)** *Mon-Fri 8am to 8pm, Weekends 8am to 12 noon* **Patient Flow Centre to navigate professionals to the correct discharge to assess pathway**
GP Practices	**24 Practices** *Mon-Fri 8:00am to 18:30pm*	**67 Practices** *Mon-Fri 8:00am to 18:30pm*

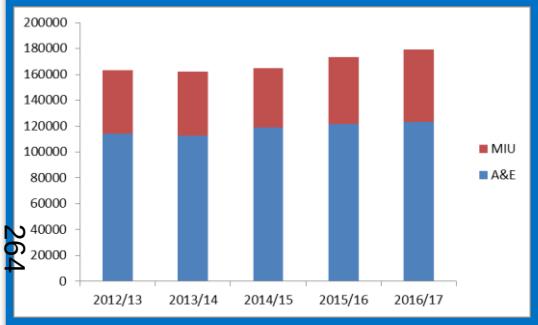
Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Review of urgent care physical access points– A&E and MIU Attendances during the last five years

A&E and MIU Attendance Trends - Worcestershire



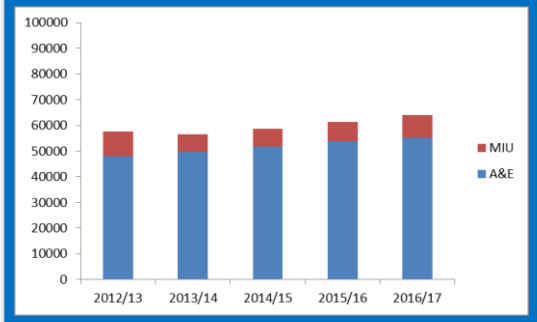
Trend over 5 yrs

A&E = +7.8%

MIU = +14.1%

Amb conveyed patients to A&E +26.5%

A&E and MIU Attendance Trends - Herefordshire



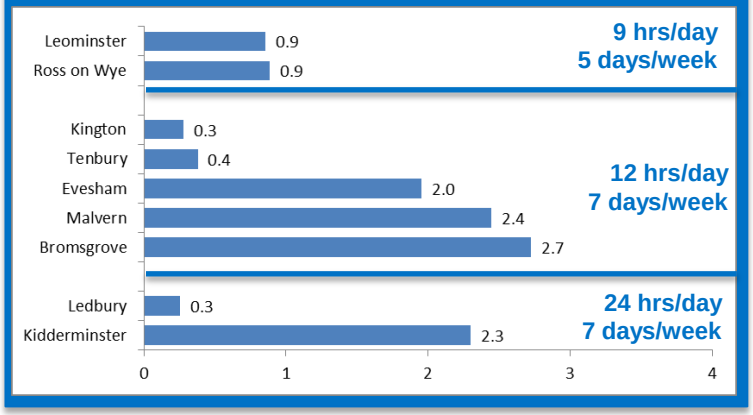
Trend over 5 yrs

A&E = +12.2%

MIU = +15%*

From 2013/14 otherwise opening hours not comparable

Average number of MIU attendances per hour open



- Activity in urgent care facilities has increased over the past five years across both counties. In Herefordshire the growth has been higher in the main A&E department than it has been in Worcestershire.
- Usage of MIUs varies significantly across the two counties, with not surprisingly, the busier units being based in larger population centres.
- There is a clear need to review the demand and capacity match and specification across all MIU sites to ensure that best use of resources is obtained from the facilities that are provided.
- Through implementation of the integrated urgent care model we expect to see this recent annual increase in demand mitigated initially before seeing actual reductions in later years of the STP as the service becomes embedded.

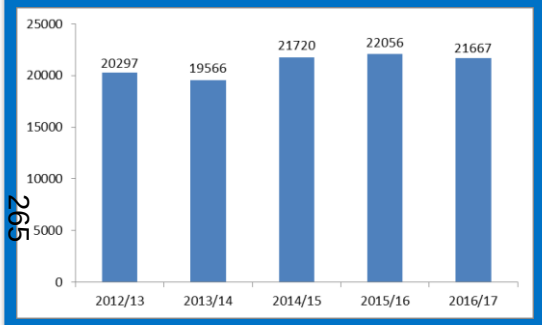
Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

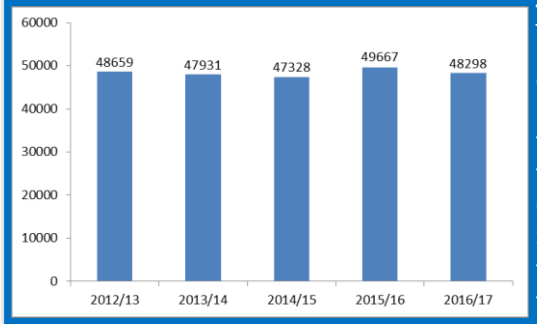
Review of urgent care physical access points – Emergency Admissions during the last five years

Emergency Admission Trend - Herefordshire



Trend over 5 yrs
Emergency admissions have increased by 6.7% over the last 5 yrs, but have steadied this year

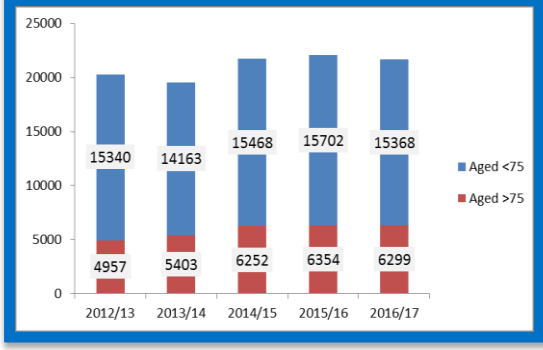
Emergency Admission Trend - Worcestershire



Trend over 5 yrs
Emergency admission have been flat over the period, but there has been a 6.8% increase in >75 admissions this yr compared to last yr.

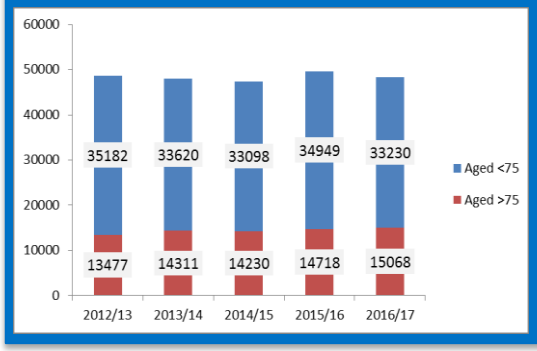
Successful delivery of our strategy to improve out of hospital care will relieve pressure on main A&E departments and the need for emergency admissions.

Emergency Admission Trend – Herefordshire Age Group



Trend over 5 yrs
>75 admissions have increased by 27% over the period and now represent 29% of all emergency admissions

Emergency Admission Trend – Worcestershire Age Group



Trend over 5 yrs
>75 admissions have increased by 12% over the period and now represent 31% of all emergency admissions

2016/17 extrapolated from first 6 months and previous annual profiles

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Implementing the seven day service standards

We intend to achieve roll out of the 4 priority clinical standards during 2017/18:

Standard	Our Baseline	Our Plan
2 - Time to consultant review Demonstrate evidence there is a clinical patient assessment by a suitable consultant and a first consultant review within 14hrs,7 days a week.	Target Compliance – 100% Current Compliance – 43.9% (Worcs), 40% weekdays and 70% weekends (Hfds)	All patients admitted through emergency portals will be reviewed by a consultant within 6 hours, supported by AEC and OPAL services.
5 - Access to diagnostics Access to diagnostic services 7 days a week for x-ray, ultrasound, CT and MRI, echocardiography, endoscopy, bronchoscopy and pathology.	Currently mainly 'day time' access to a number of these services x-ray available to Emergency Departments 24/7. Target Compliance – 100% Critical Care Current Compliance Within one hour – 100% Urgent Care Compliance Within 12 hours – <50%	95% of all patients requiring access to diagnostics will receive this within 12 hours Direct access to a range of diagnostics will be available for GPs to support admission avoidance
6 - Access to consultant-directed interventions Hospital inpatients have timely 24 hour access, 7 days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements.	Currently quite a traditional model of consultant availability prevails with ad-hoc GP to consultant telephone consultancy. Target Compliance – 100% Current Compliance – 33%	To utilise consultant telephone support for urgent care within agreed pathways to AEC, OPAL, hot clinics , direct diagnostics. 24/7 service for cardiac pacing across Herefordshire and Worcestershire to be developed.
8 - On-going review Patients on the AMU, SAU, ICU and other high dependency areas are seen and reviewed by a consultant twice daily. General ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours.	Target Compliance – 100% Twice daily ward rounds Current Compliance – 29% (Worcs.), 90% compliance (Hfds)	By March 2018 twice daily ward rounds will be undertaken on MAU, SCDU and ICU with 90% compliance 7 days a week.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

What will be different between now and 2020/21

As part of the West Midland Urgent and Emergency Care Network we expect to participate in a fundamental re-organisation of our existing urgent care system. In line with national guidance we aim to secure, for all patients with urgent care needs, a highly responsive service that provides care as close to home as possible and for those patients with more serious or life threatening conditions we will ensure they are treated in centres with the right expertise, processes and facilities to maximise their chances of survival and a good recovery. Key aspects will be:

- Working collaboratively with all system partners to further develop our A&E delivery board plan, clearly defining 'what good looks like', with clear mapping & matching of demand and system capacity and clearly understood outcome measures. Refresh to be undertaken beginning of November
- As part of this strategy we will include the further development of seven day services, including a comprehensive workforce plan to support urgent and patient flow.
- Building on the digital infrastructure across Herefordshire and Worcestershire, we will ensure all urgent, emergency, physical and mental health partners are connected and that effective and prompt communication underpins and facilitates excellence in urgent care and end of life care.
- Reducing hospital admissions through the local adoption of well proven methodologies; e.g. reducing care home admissions, remote monitoring
- Improving flow in hospitals through streaming at the front door and more timely access to speciality medicine
- Influencing the regional ambulance commissioning strategy to ensure the provision of an 'urgent care' model of ambulance provision with ambulance clinicians increasing their use of hear and treat and see & treat, making better use of alternatives to ED and therefore reducing ED activity and emergency admissions
- Continuing to progress current improvement initiatives
  - Urgent Care Connect
  - Review of ED GP support/streaming at the front door of A&E
  - Implementation of frailty pathways that maximise independence
  - NHS 111 - Increased referral to clinical advisors and defined links to care homes to promote alternate pathways
  - Improving patient flow; further defining the capacity required for D2A pathways and Trusted assessor models
  - Reviewing and updating escalation and de-escalation plans, focusing on cross system escalation and rapid de-escalations actions.
  - Exploring benefits of further integration of access points into one single point of access for professionals within Worcestershire

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

What will be different between now and 2020/21

Given our STP geography and system challenges, there are different but related review areas that we will need to explore locally to address our immediate pressures. These will need to be explored as part of the next phase of redesign and it is important, at this early stage, to identify their potential impact:

- **Review area 1** – Better use of telephone review (NHS 111 or local streaming through clinical contact centres), web based services and clinical navigation in providers to ensure people can either self- direct or are directed to the most appropriate facility. This action is core to our strategy and will be supported through the implementation of the new Integrated Urgent Care Pathway

- **Review area 2** – Review of existing access points and with the potential consolidation onto fewer individual sites. This would enable the scarce staffing to be co-located, resulting in a significantly reduced demand for expensive agency resources and simpler access routes . The sites that would need to be considered as part of this option in Herefordshire are the existing minor injury units, the out of hours GP hubs, and the Herefordshire Walk in Centre, in the context of the development of 7 day access to primary care . This option would have an impact on improving performance, better clinical outcomes through more specialisation and reducing cost through more effective use of existing resources. Within Worcestershire FOASHW plans to alter the provision of A&E services for certain conditions. The next stage will be to review the Worcestershire Urgent Care Strategy, taking into account national guidance, and the requirement for Urgent Treatment Centres (UTC's), determining the most appropriate location and capacity to meet the demand of the specification. We are planning for the provision of an 'urgent care' model of ambulance provision, in line with 'Clinical Models for Ambulance Services' with ambulance clinicians making better use of alternatives to ED, the new UTC's would strengthen this approach, further reducing conveyances to ED.

- **Review area 3** – This would explore the establishment of a single **Emergency Centre with Specialist Services** (ECSS) for Herefordshire and Worcestershire, alongside two **Emergency Centres (providing A&E functions)** (EC-A&E). This will be determined in conjunction with the regional network for urgent care. Based on current configurations, capability and geography, the ECSS) would need to be in Worcester, with EC-A&Es in Hereford and Redditch. This would enable more integrated working, mutual support and improved links to regional centres.

It is important to emphasise that any work to explore alternative options to the current model of provision would be subject to a full public consultation process.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements

What will be different between now and 2020/21

The number of hospital beds required to support the system

Whichever model is pursued, there will need to be access to the right number of hospital beds to support patient care needs. Detailed modelling has been undertaken by an independent organisation (Strategic Healthcare Planning) to help identify the bed requirements for Herefordshire and Worcestershire over the life of the STP. This has identified that if partners can achieve the transformational changes that are sought in out of hospital and social care provision, caring for more patients with integrated primary and community services provided 24/7 to support patients within their own homes, there could be a significantly lower number of hospital beds required than there are now. The modelling, which is based on the agreed system assumptions shows the following:

- **Herefordshire** - The need for a **+15%** increase the number of acute beds in Herefordshire, but the potential for a reduction of up to **-62%** in the number of community hospital beds.
- **Worcestershire** – There is potential for a small reduction in the number of acute beds and a **-30%** reduction in the number of community hospital and resource centre beds. In terms of acute beds, the main issue to address is location, with more beds required in Worcester but less required in Redditch. This is likely to result in a rebalance of some low level acute services across the acute area. There is also scope to reduce the number of NHS commissioned beds from the private care home sector from 86 in the base year to 9 in 2020/21.

	Herefordshire		Worcestershire	
	Base yr	2020/21	Base yr	2020/21
Acute Beds	226	260	743	740*
Community Beds	97	37	260* (Jun 17)	182
Total Beds	323	297	1,003	922
		- 26		-81

**FoASHW pre-consultation business case projection for 2018/19, all other numbers from the STP strategic model for 2020/21. # There have been planned bed reductions since the last STP submission*

In order to facilitate this scale of reduction in beds overall, the out of hospital care offering needs to be optimized. We are taking this forward through our alliance working and in Herefordshire our upcoming public engagement, to develop integrated primary and community services that can support people in their own homes 24/7. This will build upon previous engagement across the two counties for example evolving the coproduced outcomes for integrated care in Wyre Forest. Work is also underway to analyse what additional capacity and skill sets would be required in primary and community care services to enact any further reduction in community beds that will lead to more care being provided in home based settings, leading to better clinical outcomes and improved independence. It is acknowledged this aspirational transformation needs to be tested for deliverability, would be incremental and services would need to be in place before any changes are made.

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

What will be different between now and 2020/21

An urgent care workforce for the future

Key to the delivery of the local A&E delivery board plan to improve the emergency access standard and to delivery of the vision for the STP is an enhanced workforce in the most appropriate setting with a range of urgent care skills. Whilst there are national and local challenges with the recruitment of clinical workforce the urgent care systems working within Herefordshire and Worcestershire will design, agree and implement new roles to support these improvements.

These roles will be a mixture of qualified and non qualified practitioners that support reduced duplicate assessments and focus on early assessments and streaming to the most appropriate urgent care setting and will be aligned to the pathways for urgent care that will be developed.

Herefordshire and Worcestershire will learn from each other related to the innovation and design of the workforce and will use the STP workforce planning process to support this.

Routes to workforce change

Priority 4 – Establish clinically and financially sustainable services

Programme 4b	IMPROVING URGENT CARE	Owner	A&E Delivery Board Chair

Overall aim	Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements.

Stroke Services - The aim is to deliver high quality, sustainable stroke services across the two counties to ensure delivery of 7 day services and improved patient outcomes. A full options appraisal will be undertaken on the configuration of stroke services, specifically hyper acute and acute stroke services, to identify a sustainable solution that will deliver key clinical and performance standards in these areas (access to specialist consultant review, 24/7 thrombolysis and 4 hour admission to HASU) and which also delivers 7-day TIA services, high quality rehabilitation services including early supported discharge and a robust primary prevention strategy. Worcestershire is currently rated as Band D under the Sentinel Stroke National Audit Programme (SSNAP) and Herefordshire at Band B. The plans we are taking forward should achieve B (Good) across both counties once fully implemented.

What will be different between now and 2020/21

- High quality, timely and sustainable stroke services across Herefordshire and Worcestershire
- Telemedicine service across the two counties and networked with other Trusts to provide a service for Herefordshire, Worcestershire and mid-Powys.
- Collaboration across the two counties, to deliver a sustainable rota and seven-day TIA service.
- Highly skilled and competent workforce in place across Herefordshire and Worcestershire to ensure delivery of high quality stroke services and all key clinical and performance standards associated with delivery of stroke services;
- Robust clinical pathways to ensure optimum outcomes for patients throughout the stroke pathway

Specific short term goals for Worcestershire:

- Development of workforce plan that crosses organisational boundaries and optimises skills and expertise across the stroke pathway to build a robust and sustainable workforce going forward;
- Development of a 'Straight to Scanner' pathway;
- Development of nurse led TIA services;
- Establishment of an Early Supported Discharge service to facilitate timely discharge;

Specific short term goals for Herefordshire:

- Access to TIA clinics for those at risk of Stroke across seven days
- 24/7 thrombolysis treatment
- 24/7 access to specialist inpatient care advice
- Consistent access to therapists whilst an inpatient
- Consistent access to step-down community services

How will this be better for residents and patients in Herefordshire and Worcestershire

- Patients will receive best practice stoke services across the stroke pathway
- Improved outcomes for patients through access to timely and high quality stroke services
- Access to 7 day services
- Access to highly skilled stroke specialists as all stages of the pathway
- Improved primary prevention of stroke
- Increased levels of long term care at home
- Access to third sector services to support patients long term
- Care as close to home as possible

Priority 4 – Establish clinically and financially sustainable services

Programme 4c	IMPROVING MATERNITY CARE	Owner	Michelle McKay – CEO Worcestershire Acute Hospitals NHS Trust

Overall aim	Our vision is that our citizens have access to high quality, safe and sustainable, acute, women and newborn/neonatal and mental health services, localised where possible and centralised where necessary.

What will be different between now and 2020/21

Within Worcestershire maternity services are temporarily suspended on the Redditch site and re-provided on the Worcester site due to the Trust not being able to recruit sufficient staff to provide clinically sustainable services across two sites. The Future of Acute Services at Hospitals in Worcestershire (FOASHW) has completed public consultation on the permanent centralisation of these services on the Worcestershire Royal Site. This is a critical component of the clinical and financial sustainability of the Worcestershire service.

Beyond this **we plan to develop a Local Maternity System[LMS]to deliver Better Births , Saving Babies Lives and Maternal & Newborn Health safety Collaborative** locally across both counties. This will result in:

- The removal of traditional county boundaries with sharing of community and hospital based resources across a wider area. This is not expected to result in a change to the provision of obstetric services in Herefordshire.
- A joint maternity care offer with common clinical pathways that guide women to the most clinically appropriate place of birth.
- Review maternity specifications to reflect the requirements of a local maternity system.
- Integrated specialist/clinical teams (such as Antenatal Screening team, Governance team etc) to increase skills and ensure adequate access for women.
- Development of community hubs for maternity care.
- Integrated neonatal pathways between Hereford and Worcester.
- We will focus on the Secretary of States objectives of reducing still birth , perinatal mortality maternal death and brain injury by 20% by 2020 and 50% by 2030 based on 2010 data .
- We will focus on the implementation of Saving Babies lives bundle by reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movements , effective fetal monitoring during labour.
- Working with the national Safety Collaborative to develop clinical leadership in the delivery suit , human factors training and enhanced training in developing a safety culture
- We will implement the national system to systematically review still birth and perinatal death –SCOR [standardised computerised objective review]
- Shared approach for perinatal mental health offer for families.
- Shared end to end electronic maternity information system.
- IT links between the hospitals services .

Priority 4 – Establish clinically and financially sustainable services

Programme 4c	IMPROVING MATERNITY CARE	Owner	Michelle Mckay. Chief Executive, Worcestershire Acute Hospital NHS Trust

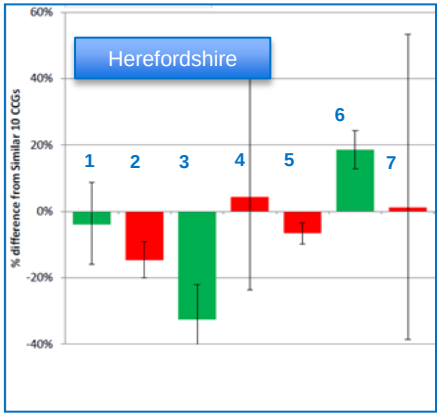
Overall aim	Our vision is that our citizens have access to high quality, safe and sustainable, acute, Women and newborn/neonatal and mental health services, localised where possible and centralised where necessary.

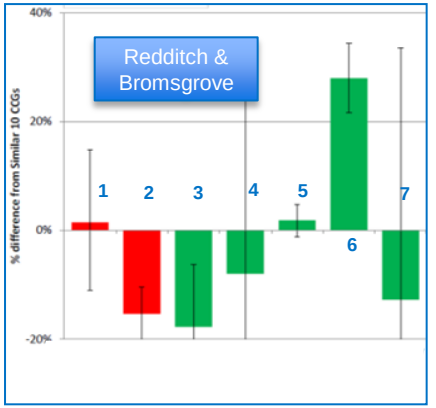
How will this be better for residents and patients in Herefordshire and Worcestershire

The overriding benefit to the local population will be a higher quality, more sustainable service that achieves improved health and well being outcomes for babies and young children. This will be achieved through:

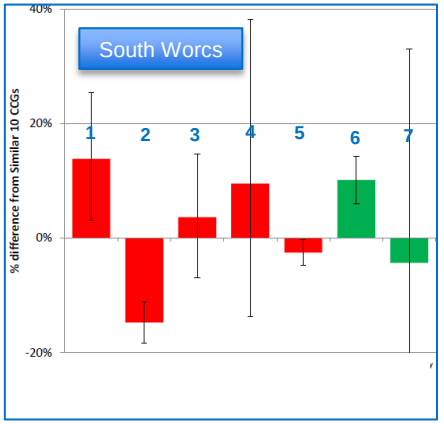
- Increased midwife led care and home birth numbers
- Improve women's access to birth in the most appropriate birth setting
- Reduce out of area neonatal transfers for sick and premature infants
- Increased specialist community based Perinatal Mental Health care
- Improved availability of access to specialist teams across both counties for women and babies
- Retaining local services for women and families within the counties
- Raised profile for maternity and newborn services across the West Midlands
- Reduction in Perinatal mortality rates
- Achieving national caesarean section rate
- Improved learning from strengthened governance will lead to a greater safety culture.
- Shared learning and development opportunities to increase and maintain knowledge and skills.

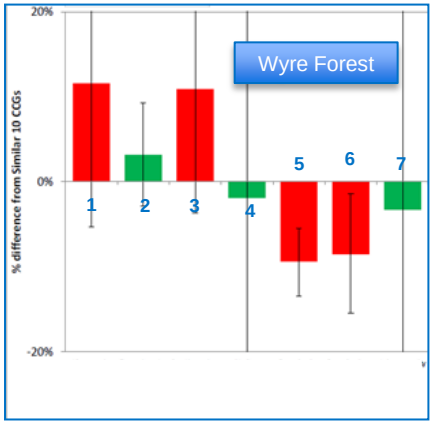
The charts of this page show where indicators are better (green) or worse (red) than comparable 10 areas nationally. Therefore the charts cannot be compared against each other.





1 < 18 Conception rates	2 Flu vaccine take-up by pregnant women	3 Smoking at time of delivery	4 % of low birthweight babies (<2500g)	5 Breast-feeding initiation (first 48 hrs)	6 Breastfeeding at age 6-8 weeks	7 Infant mortality rate





Priority 4 – Establish clinically and financially sustainable services

Programme 4d	ELECTIVE CARE	Owner	Carl Ellson, Accountable Officer, SWCCG

Overall aim

Non – life threatening conditions - Reduce clinical variation in referral and treatment, reduce the number of procedures performed where there is a limited clinical benefit or enhanced risk of harm and work with patients to improve their overall well being by seeking lifestyle improvement as part of the elective pathway.

What will be different between now and 2020/21

There are two key aspects to improving elective care – in terms of clinical effectiveness, achievement of performance standards and financial sustainability.

- **Effective commissioning policies** and stricter treatment thresholds
- **Efficient organisation of services** to meet demand.

During the allocative programme budgeting work, the STP partnership board recognised that significantly tightening commissioning policies and treatment thresholds for elective care would be required to support financial balance with the STP. In order to progress this, there were two distinct categories of elective care identified – treatment for life threatening conditions such as cancer, cardiac and renal services and treatment for non-life threatening conditions. The programme board agreed to prioritise investment in the former, in order to do this the following has been agreed:

- Develop a system wide (commissioner and provider across both counties) policy and treatment threshold on procedures that:
  - Are probably linked to an aesthetic benefit
  - Probably have a lower cost alternative
  - Have a relatively limited impact
  - Are perceived to have a close ratio of benefit to harm.
- Develop a policy to support lifestyle improvement by providing prevention interventions and alternatives such as social prescribing with regard to healthy weight (where possible), smoking and alcohol consumption to improve the likelihood of positive clinical outcomes following surgery.

Potential savings from achieving top decile rates

Elective procedures for non-life threatening conditions

CCG	Probably Aesthetic	Probably lower cost alternative	Limited Effect	Close Benefit to Harm Ratio
HCCG	£64k	£521k	£26k	£439k
RBCCG	£14k	£362k	£0k	£546k
SWCCG	£133k	£784k	£0k	£1,025k
WFCCG	£149k	£397k	£48k	£271k
Total	**£4,779k**			

Elective procedures that are likely to be wholly attributable to

CCG	Alcohol	Obesity	Smoking
HCCG	£0k	£28k	£72k
RBCCG	£124k	£57k	£153k
SWCCG	£599k	£59k	£478k
WFCCG	£279k	£50k	£199k
Total	**£2,098k**		

- Achieving top decile performance in these areas against comparator CCGs will release **£6.8m** worth of expenditure.

Priority 4 – Establish clinically and financially sustainable services

Programme 4d	**ELECTIVE CARE**	**Owner**	Carl Ellson, Accountable Officer, SWCCG
Programme 4e	**CANCER CARE**		
Overall aim	**Life threatening conditions (cancer and others)** -Increase funding to meet demographic pressures and increasing illness burden. Improve efficiency and reduce waste and waits across pathways and for all critical complex elective care, for clinical sustainability and quality outcomes, we will concentrate provision in centres of excellence		

What will be different between now and 2020/21

- Our Clinical Reference Group will focus initially on Breast Screening, Renal and Cardiology services a with a view to improving clinical outcomes, deliverability and sustainability of services in the best interest of patients.
- We will have implemented the key changes required from the national cancer strategy
- There will be much greater alignment between prevention strategies and treatment, but adopting a more integrated approach, where driving the prevention and healthy lifestyles message is the responsibility of all partners in the system.
- Far greater uptake of screening programmes across the population, where local performance is currently poor (see overleaf)
- We will ensure that we maximise the use of the diabetes prevention programme pilot currently being implemented across the STP and use the learning from this for other possibilities for using risk identification to target intensive lifestyle interventions.
- Revised pathways with increased pan-STP working, particularly with UHCW and Gloucestershire to enhance clinical sustainability and specialism to improve outcomes.
- Reviewing opportunities for repatriating activity and referring out of area to achieve the best use of resources and outcomes for patients.
- Joint staffing appointments to specialist roles across the STP or wider STP area (for example interventional radiology).
- Concentration of specialist complex surgery on fewer sites to secure clinical sustainability and improve outcomes.
- As part of the Specialised Services Rural Pathfinder we expect to redefine existing pathways to be locally commissioned, repatriate some current pathways including renal, some cancers and cardiac care, working closely with regional specialised providers.
- Implement alternative models for cancer survivorship through remote monitoring and supporting patients in out of hospital environments.

How will this be better for residents and patients in Herefordshire and Worcestershire

- Local services will be better placed to deliver world class outcomes for cancer care.
- The system will achieve consistent access of all cancer treatment standards.
- Earlier recognition and faster diagnosis of cancers and other life threatening conditions.
- Faster treatments times and improved survival rates.
- Reduced diagnosis through emergency admission or unplanned care provision.
- Better patient experience of cancer care received (which is currently poor – see pages 77-79)

Delivery Plan – Priority 4: Establish clinically and financially sustainable Services

Urgent Care SRO	**A&E Delivery Board Chairs**	**Programme Leads**	**Stuart Ide –** Urgent Care Lead – Worcestershire CCGs **Hazel Braund –** Operations Director – Herefordshire CCG
Maternity Care SRO	**Michelle McKay** Chief Executive – Worcs Acute Hospitals Trust	**Programme Lead**	**Fay Baillie –** Deputy Director Nursing and Midwifery Worcs Acute Hospitals NHS Trust
Elective Care SRO	**Carl Ellson** Accountable Officer - SWCCG	**Programme Leads**	**Sarah Smith –** Worcestershire Acute Hospitals NHS Trust **Simon Gartland -** Deputy Director of commissioning WCCGs

	Work Programmes	2016/17		2017/18				2018/19				2019/20				2020/21			
		Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
4b Improving urgent care	Complete review of emergency care provision, exploring reductions to the number of MIUs and the Walk in Centre in Herefordshire and standardised opening hours and enhanced specification for MIUs in Worcestershire.																		
	Shift to home based care – identify the requirements to increase home based care to deliver proposed bed reductions and test deliverability																		
	Design and agree a model for stroke services across two counties that meets the stroke standards and seven day working requirements																		
	Agree and implement a workforce plan for urgent care and patient flow across the health and social care within the two counties																		
4c Improving maternity care	Implement the clinical model for maternity inpatient, new born and children's services within Future of Acute Services in Worcestershire programme.																		
	Develop a Local Maternity System across Herefordshire and Worcestershire																		
	Establish a single service with specialist teams working under a common management structure, delivered locally.																		
	Deliver the FoASW objectives for gynaecology																		
4d Elective Care	Develop a system wide policy and treatment threshold on procedures of limited clinical value																		
	Develop a policy to support lifestyle prevention interventions and alternatives to improve health prior to surgery, thus improving outcomes																		
	Across Worcestershire undertake a greater proportion of routine elective activity on "cold" sites to reduce the risk of cancellations and to improve clinical outcomes																		
	Revised pathways with increased pan STP working, reviewing opportunities for repatriating activity and referring out of area to achieve the best use of resources and outcomes for patients																		
4E Cancer	Expand pan STP working on cancer services and deliver the requirements of the national taskforce.																		

Planning and Scoping

Design: Engagement and consultation (as appropriate)

Operational Delivery

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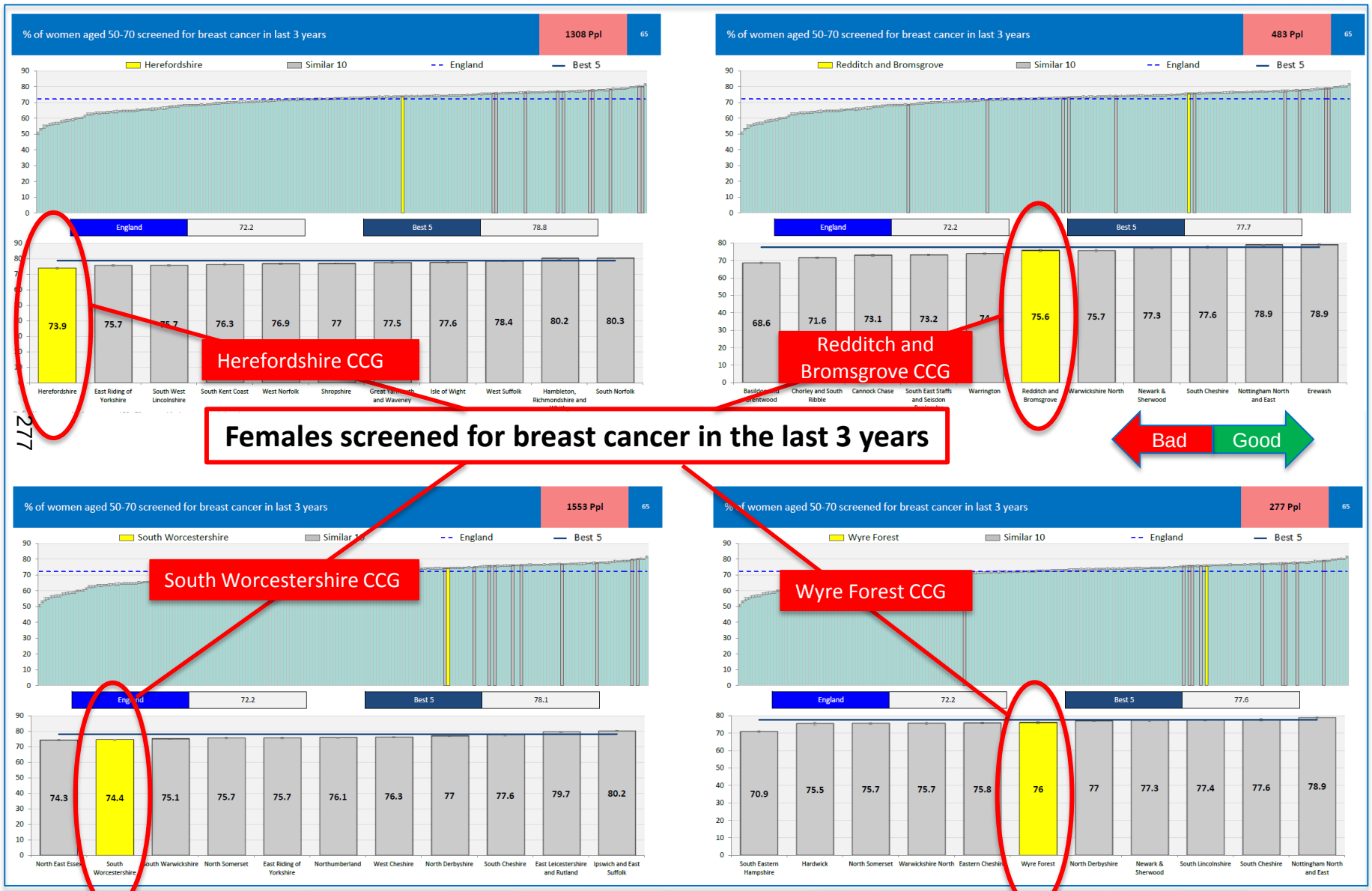
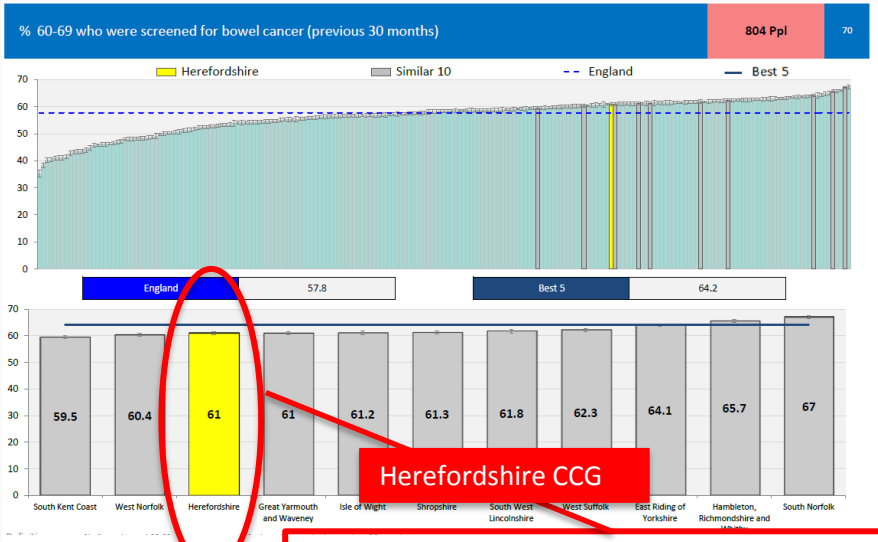
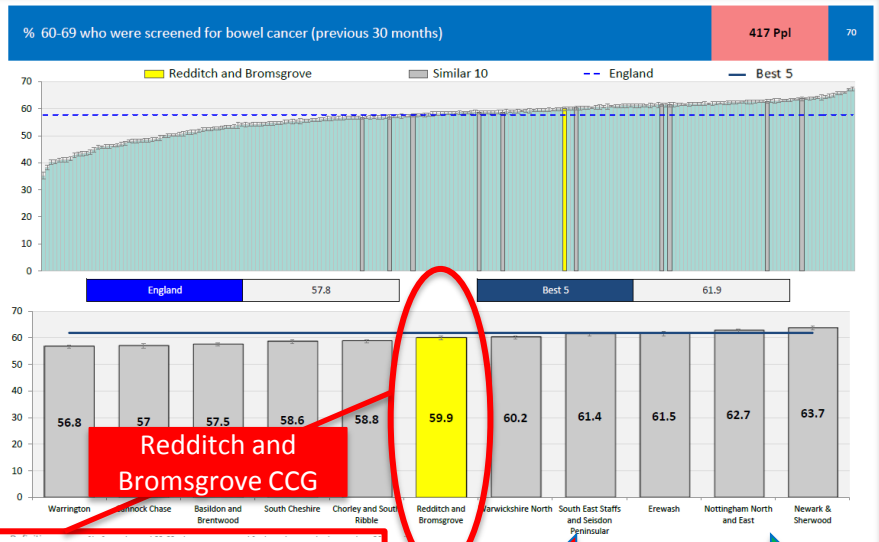
Breast cancer screening



Bowel cancer screening





Herefordshire CCG

Redditch and Bromsgrove CCG

Population screened for bowel cancer in the last 3 years

Bad Good

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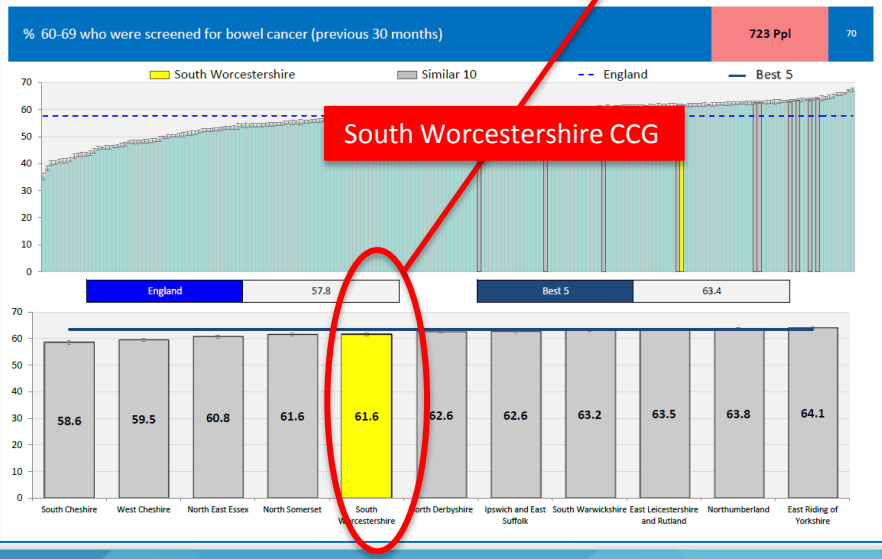
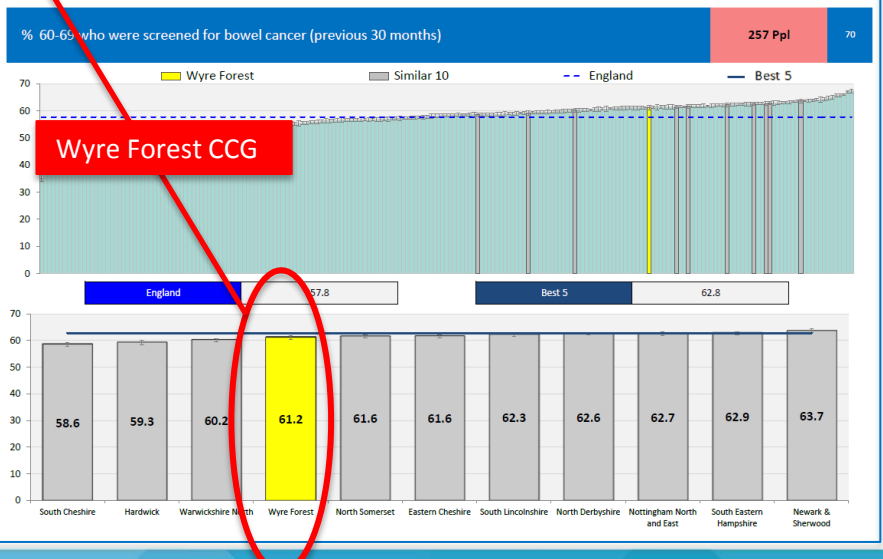
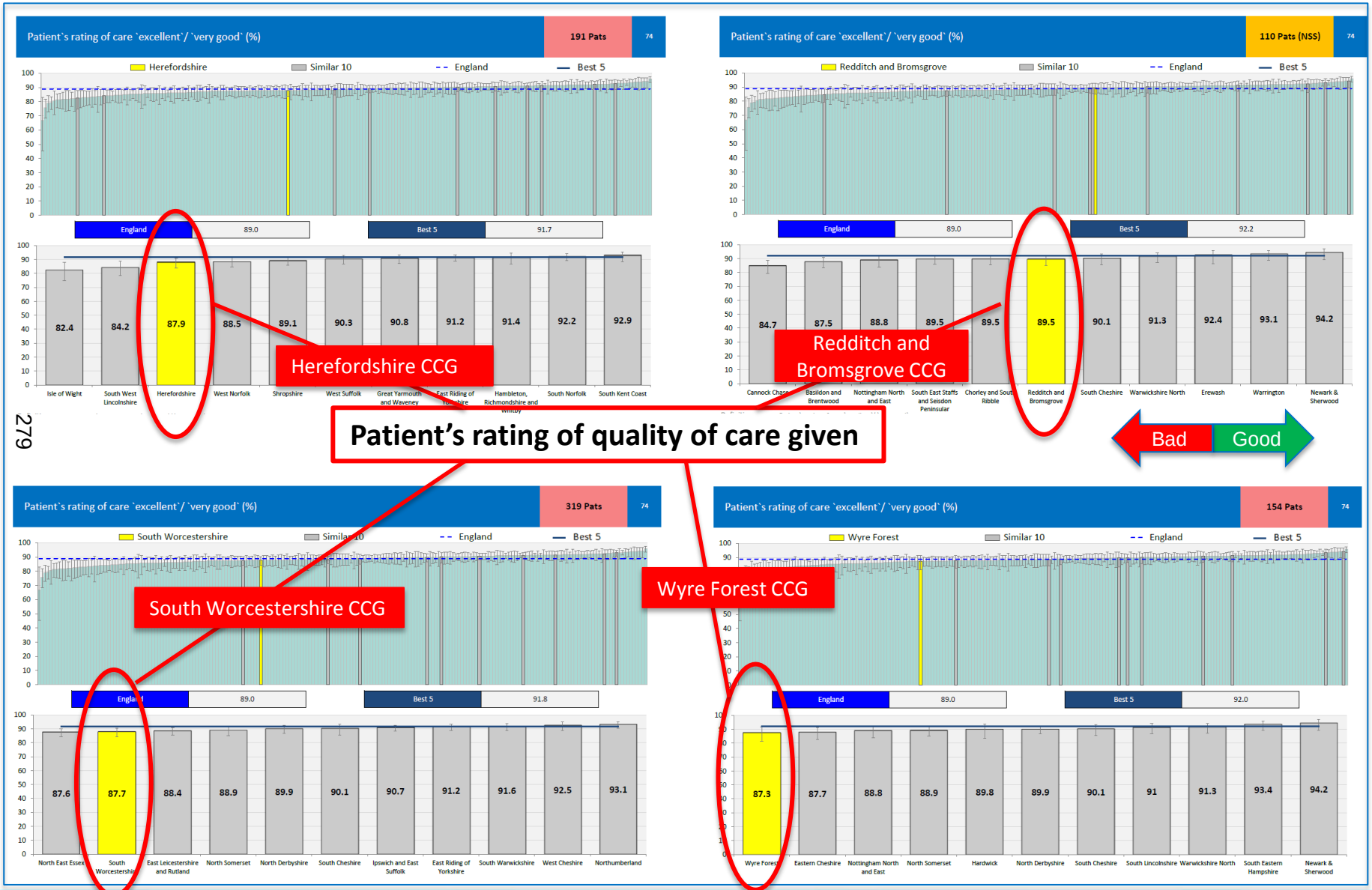


South Worcestershire CCG



Wyre Forest CCG

Patient experience of cancer care



Enabling change and transformation

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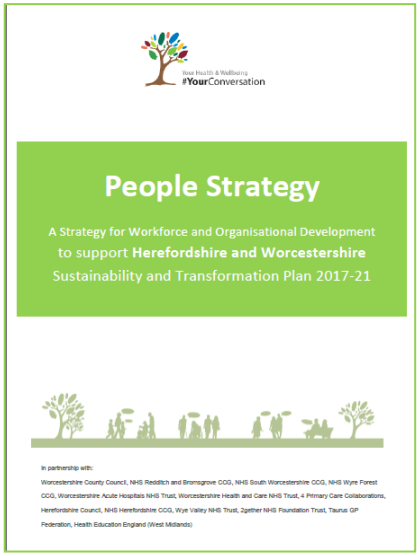
Workforce and OD

Enabler 1	WORKFORCE AND ORGANISATION DEVELOPMENT	Owner	Shaun Clee, Chief Executive, 2gether NHS Foundation Trust

Overall aim

Develop the right workforce and Organisational Development within a sustainable service model that is deliverable on the ground within the availability of people and resource constraints we face.

During 2016/17 the Workforce and Organisational Development strand has engaged with stakeholders across the STP to develop a People Strategy and Delivery Plan. The Strategy builds on the STP vision and priorities identified in the STP submission.



What will be different between now and 2020/21 - Update

- Erosion of traditional boundaries to **'teams without walls',** supported by a multi-disciplinary learning environment **Minimum standards for a multi-disciplinary system-wide Preceptorship programme have been drafted for consultation**
- Increased **investment** in the **mental health and learning disability** workforce
- **Less** reliance on **agency and temporary staffing HR Directors have agreed to lead on an STP-level piece of work during 2017**
- **Integrated multi-disciplinary teams** based around the person, supported by access to specialist advice and support
- Increased use of apprenticeship levy to ensure **appropriate training** for existing staff and 'new' roles, alongside work experience and **career pathways** to build the **future workforce University of Worcester has agreed to work with employers to develop an STP-level apprenticeship 'hub' during 2017**
- A **more diverse skill mix**, with 'new' roles embedded within teams offering greater flexibly and the potential to **work across traditional boundaries** and systems.
  Nursing Associates 'fast follower' training programme started across the STP in April 2017
- A shift to a workforce **culture focused on prevention , self-care and independence**, utilising, health coaching conversations across the workforce, improved signposting and better links to public health
- Flexible employment contracts, annualised hours, portfolio careers, and **incentives to retain and recruit staff** across the system
- **GPs** will have more time to focus on patient care **Primary Care workforce, workflow, capacity/demand work commenced as part of delivery of GPFV.**
- A more significant role for the voluntary and community sector, the public sector and the unpaid workforce (family, neighbours, carers, volunteers) **working together to deliver better outcomes for local people.**

How will this be better for residents and patients

- "**Tell my story once**" with fewer 'hand-offs' between clinicians and other practitioners
- **More care will be provided out of hospital**, with greater continuity of care and care wrapped around the person
- Health coaching conversations will **enable healthy behaviours and increased self- management of care**
- People will co-produce and **'own' individual care and support plans**
- People with on-going conditions will have more control over their lives and receive **more care provided closer to home**
- Improved access to **specialist care and expertise will be available when people need it**
- **Education and development for carers**

Digital and Technology

Enabler 2	DIGITAL	Owner	Michelle McKay, CEO Worcestershire Acute Trust
Overall aim	Invest in digital and new technologies to enable our workforce to provide, and patients to access care in the most efficient and effective way, delivering the best outcomes		

What will be different between now and 2020/21

- **We have two aligned Digital Road Maps within the two counties,** successful delivery of our digital roadmaps for Herefordshire & Worcestershire will be critical to improving access, increasing productivity and changing clinician /practitioner behaviour. One example is Worcestershire Health and Care NHS Trust being selected as a Global Digital Exemplar for Mental Health.
- **Creating a connected Infrastructure** e.g. modern and connected infrastructure enabling practitioners and linking services; e.g. better use of telemedicine and increasing use of e-consultations to improve access to specialist services
- **Improving integration** e.g. Integrated Digital Care Records for patient's and citizens across health and care - providing integrated records that have the ability to be interlinked care settings across the two counties; establishing a consent and information sharing model and robust data standards, security and quality.
- **Empowering residents and citizens through technology** e.g. creating a consistent user and patient experience – including common, digital front doors to our services, complementing traditional interactions. Enabling increased public and patient control and empowerment (i.e better use of apps, wearables and assistive technologies), moving away from a paternalistic culture of care; and supporting self-care and increasing levels of patient activation. A key enabler is consistent local access to broadband / digital options.
- **Enhancing our understanding**: New insights using health & care intelligence - Using data in new ways to lead to earlier intervention and enabling improved outcomes and wellbeing for people and the population
- **Working collaboratively** – ensuring we are reading as a system to work together and to deliver technological changes for the benefits of residents and patients, including using resources smartly and sharing good practice

How will this be better for residents and patients in Herefordshire and Worcestershire

- **Patient data access and information sharing**, care planning and transitions plans available across providers meaning patients will only have to tell their story once
- Patients access to own care records, giving a **better understanding of care received**
- Improved access to specialist services via telehealth and tele/video conferencing across acute and community, providing **faster access to specialist care**
- Use of tele/video conferencing in GP practices & nursing homes enabling **joined up care**
- Interoperability of systems across the two counties allowing **patient choice**
- Use of apps and wearables to support empowerment of patient and residents and **increase levels of patient activation**
- Better sharing of information
- Seamless care for patients
- Patients more engaged and self-sufficient
- Better use of pharmacies and review of medications

Engaging communities and the voluntary sector

Enabler 3	HEALTHY COMMUNITIES AND THE VCS	Owner	Martin Samuels, Herefordshire Council

- We recognise the importance of reengineering our system so that health and care services work alongside thriving communities to realise the value of individuals, their informal networks and wider communities. Being able to respond to the new landscape ahead requires the vision and commitment of all and embracing different partners into a new way of working. In particular this includes listening and responding to different solutions that are presented by the VCS, who often have effective methods, if not the means, to support those facing multiple disadvantage
- We will use the principles of co-production in our work with the VCS so that a common approach to the challenges we face is developed
- The adoption of 'a better conversation' approach across the wider system; including volunteers and community champions to develop a lay coaching model to focus on what is important to the individual in living with a health condition
- We recognise the depth of understanding that the sector can bring and the significant benefits of prevention. There are numerous asset based activities already implemented across our STP, creating social capital across our communities and we want to scale up this approach to promote and strengthen the factors that support good health and well-being, protect against poor health and foster positive communities and networks
- The VCS has a vital role in reducing demand on formal services such as unplanned hospital admissions for example through care navigation/bridging roles, peer support and group activities . The sector also helps to address health inequalities by contributing to wider social outcomes such as employment and school attendance
- Therefore, we need to find ways to tap into the energy, enthusiasm and innovation of the VCS in a coordinated manner, including a simplification of the commissioning process to enhance the contribution that the VCS can make, particularly those grassroots community organisations who struggle with complex commissioning arrangements. We will also strengthen how we support volunteering, recognising the assets and capacity of the workforce in our wider system planning

Healthwatch Perspectives

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Engaging communities and the voluntary sector

The Chairs of Herefordshire Healthwatch and Worcestershire Healthwatch are members of the programme board and asked for the following content to be included in the STP submission:

healthwatch Herefordshire

Healthwatch Herefordshire (HWH) would wish to place on record its thanks to all involved in the production of the Herefordshire and Worcestershire Sustainability and Transformation Plan (2016 - 2021).

Healthwatch Herefordshire welcome the opportunity that STP presents in bringing all parties across health & social care together through the STP process to look at sustainability and importantly transformation of services. We hope that STP will lead to improved simplified patient pathways and increase access to services for the residents of Herefordshire and Worcestershire.

HWH wishes it to be noted that Herefordshire remains the most sparsely populated area of England. NHS England will need to address a number of key issues in relation to the needs of the population of Herefordshire and the future provision of the County's health and social care services. In HWH's view the sensitive issue of funding and the particular special case of rurality and rural sparsity is something which NHS England should take into account when it considers overall budget provisions.

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HWH would like ensure that the plan recognises and addresses; issues which arise from the budget reductions to Herefordshire Council social care services and the projected increase in demand for services from the public in the future.

It is clear from proposed future models of service delivery in health and care across the STP footprint that greater involvement and assistance will be put on the voluntary and community sector to assist in maintaining peoples wellbeing . The STP needs to make sure that this is resourced and supported adequately, involving the public, communities and voluntary sector organisations in the plans and implementation.

As STP moves into the implementation phase HWH will continue to be actively involved and will ensure that the voice of the public is fully taken into account. The public need to see transparency and honesty throughout the STP process and a genuine opportunity for involvement

HWH has assisted in engagement and involvement of putting the public's views into this planning process from Autumn 2016- spring 2017 and we will be monitoring that the inclusion of those views are at the heart of the process and that the STP continues to inform the public abut the process going forward.

HWH would like to see that the focus of the STP is directed at how H&SC professionals and VCS organisations work across organisational, and where of benefit geographical, boundaries for shared outcomes for people's wellbeing, rather than being diverted into being concerned about structures. HWH makes a special a plea to NHS England to minimise the levels of bureaucracy in relation to the overall plan.

Engaging communities and the voluntary sector

healthwatch Worcestershire

Healthwatch Worcestershire [HWW] has been engaged in the process to develop the Sustainability and Transformation Plan for the Herefordshire and Worcestershire footprint since January 2016. HWW's contribution has included membership of the former Programme Board since the Board was set up and more recently the Partnership Board. It has been represented on both Boards by its Chair, who has significant experience of working at a strategic leadership level in health and care matters across both Worcestershire and Herefordshire. HWW was also an attendee at the communications and engagement group in which HWW has provided advice, guidance and support to the NHS and Local Government stakeholders.

HWW recognises the inclusive approach the STP leadership team has taken to engaging with Local Healthwatch as the voice of patients and the public in developing STP proposals, given the constraints we understand were initially placed on engagement by NHS England, and the extensive programme of public/patient involvement that has taken place since the publication of the STP plan in November 2016. HWW welcomes the positive response the STP team have made to HWW's comments during the process and to the public's feedback during the engagement programme.

HWW therefore welcomes the opportunity to make the following comments on the July 2016 version of the plan :

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HWW recognises the need for change and has a track record of arguing for safe, sustainable and integrated health and care service provision in Worcestershire which, for example has enabled HWW to support the recommendations for the future delivery of acute hospital services in Worcestershire and the developments in primary care such as 'care at home' and new models of care. HWW therefore welcomes the incorporation of these and associated initiatives into the STP, building on Worcestershire's 'Well Connected Programme' as a pioneer and the review of future Acute Hospital Services in Worcestershire, with a view to delivering the necessary improvements in health care.

- HWW is principally concerned with championing the interests of those who use health and care services in Worcestershire. In that context, from the outset HWW has been concerned about the potential implication for Worcestershire's patients and public of 'pooling' the funding allocations to the Worcestershire CCGs with the allocation to the Herefordshire CCG.

In response to HWW concerns the 2020 financial position as between Herefordshire and Worcestershire has been detailed in the STP submissions, which reflects that Herefordshire's potential gap will be £468 per head as opposed to Worcestershire's gap of £279 per head.

Engaging communities and the voluntary sector

healthwatch Worcestershire

HWW welcomes the recognition from STP stakeholders that achieving financial balance across the STP footprint would result in significant subsidy to Herefordshire from Worcestershire, with a consequent impact on service provision for patients and the public in Worcestershire.

- HWW believes the patients and public in Worcestershire expect the NHS to make efficiency savings in the 'back office' and in the delivery of support services as a pre requisite to making savings in patient services. This should include consideration as to the number of commissioners and providers operating in Worcestershire, as well as the STP footprint.

- HWW recognises the STP proposals include significant reductions in 'elective care' and expects the CCGs to properly involve patients and the public in these proposals as they are developed.

- HWW is concerned that NHS plans to deliver care at home could place additional burdens on social care services and have raised an issue about domiciliary care based on its knowledge of the review of the existing care market in Worcestershire.

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- HWW endorses the concerns that were widely expressed during the public engagement programme including the potential requirement that will be placed on patients to travel to access services, the implications of the planned reduction of beds across the community hospitals and the impact of the proposals on carers. In particular HWW is concerned about how the proposals will affect the vulnerable and those who live with health inequalities. HWW will expect work-streams in the STP to specifically address this issue.

- HWW recognises that the proposals relating to Self-Care and Prevention require significant behavioural change by the population at large and within the NHS, and considers that this is unlikely to be achieved without a national communications/engagement exercise because of the resources that will be required.