Herefordshire Council

Agenda

Health and wellbeing board

Date:	**Monday 10 February 2020**
Time:	**2.30 pm**
Place:	**Council Chamber, 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:

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Agenda for the Meeting of the Health and wellbeing board

Membership

Chairperson	Councillor Pauline Crockett	Herefordshire Council
Vice-Chairperson	Dr Ian Tait	NHS Herefordshire Clinical Commissioning Group
	Hayley Allison / Julie Grant	NHS England
	Chris Baird	Director for children and families
	Ingrid Barker	Gloucestershire Health and Care NHS Foundation Trust
	Russell Hardy	Wye Valley NHS Trust
	Councillor David Hitchiner	Herefordshire Council
	Councillor Felicity Norman	Herefordshire Council
	Ian Stead	Healthwatch Herefordshire
	Simon Trickett	NHS Herefordshire Clinical Commissioning Group
	Stephen Vickers	Director for adults and communities
	Karen Wright	Director of public health

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES

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

3. DECLARATIONS OF INTEREST

To receive any declarations of interests of interest in respect of schedule 1, schedule 2 or other interests from members of the board in respect of items on the agenda.

4. MINUTES 7 - 14

To approve and sign the minutes of the meeting held on 14 October 2019.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.

For details of how to ask a question at a public meeting, please see:

www.herefordshire.gov.uk/getinvolved

The deadline for the receipt of a question from a member of the public is Tuesday 4 February 2020 at 5.00 pm.

To submit a question, please email councillorservices@herefordshire.gov.uk

6. QUESTIONS FROM COUNCILLORS

To receive any written questions from councillors.

The deadline for the receipt of a question from a councillor is Tuesday 4 February 2020 at 5.00 pm.

To submit a question, please email councillorservices@herefordshire.gov.uk

7. HEALTH AND WELLBEING BOARD REVIEW AND FUTURE WORKING 15 - 28

To ratify the outcomes of the health and wellbeing board review, agree the board format and make recommendations for the future working arrangements including membership, the vision, priorities and cross-cutting themes.

8. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 29 - 58

To present the 2019 director of public health annual report and to seek the support of the board in implementing the recommendations.

9. BETTER CARE FUND QUARTER 2 AND QUARTER 3 REPORT 2019/20 59 - 90

As part of the statutory function of the board the purpose is to review the better care fund quarter two and three performance reports and recommend any future improvements.

10. DATES OF FUTURE MEETINGS

The next scheduled board meeting in public is Monday 20 April 2020, 2.30 pm.

The following provisional meeting dates are suggested:

Monday 6 July 2020, 2.30 pm

Monday 7 September 2020, 2.30 pm

Monday 7 December 2020, 10.00 am

Monday 8 March 2021, 2.30 pm

Monday 7 June 2021, 2.30 pm

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- Inspect minutes of the council and all committees and sub-committees and written statements of decisions taken by the cabinet or individual cabinet members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting (a list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
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- Have access to a list specifying those powers on which the council have delegated decision making to their officers identifying the officers concerned by title. The council's constitution is available at www.herefordshire.gov.uk/constitution
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The chairperson or an attendee at the meeting must take the signing in sheet so it can be checked when everyone is at the fire assembly point.

Minutes of the meeting of Health and wellbeing board held at Committee Room 1, Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Monday 14 October 2019 at 2.30 pm

Members	Councillor Pauline Crockett (Chairperson)	Cabinet member - Health and Adult Wellbeing	Herefordshire Council
	Councillor David Hitchiner	Leader of the Council	Herefordshire Council
	Councillor Felicity Norman	Cabinet Member - Children and Families and Deputy Leader	Herefordshire Council
	Ian Stead	Chair and Director	Healthwatch Herefordshire
	Duncan Sutherland	Non-Executive Director	Gloucestershire Health and Care NHS Foundation Trust
	Dr Ian Tait (Vice-chairperson)	Chair and Clinical Lead	NHS Herefordshire Clinical Commissioning Group
	Karen Wright	Director of public health	Herefordshire Council

In attendance	Ben Baugh	Democratic services officer	Herefordshire Council
	John Coleman	Democratic services manager and statutory scrutiny manager	Herefordshire Council
	Dr Mike Hearne	Managing Director	Taurus Healthcare Ltd
	Jane Ives	Managing Director	Wye Valley NHS Trust
	Jacinta Meighan-Davies	Clinical Programme Manager	NHS Herefordshire Clinical Commissioning Group
	Colin Merker	Deputy Chief Executive and Managing Director for Herefordshire	Gloucestershire Health and Care NHS Foundation Trust
	Alistair Neill	Chief executive	Herefordshire Council
	Amy Pitt	Head of partnerships and integration	Herefordshire Council
	Paul Smith	Assistant director all ages commissioning	Adults and Communities
	Dr Alison Talbot-Smith	Director of strategy and transformation	NHS Herefordshire Clinical Commissioning Group

10. APOLOGIES FOR ABSENCE

Apologies for absence had been received from Chris Baird and Stephen Vickers (Herefordshire Council), Ingrid Barker (Gloucestershire Health and Care NHS Foundation Trust), Jo Melling (NHS England and NHS Improvement), Russell Hardy (Wye Valley NHS Trust) and Simon Trickett (NHS Herefordshire Clinical Commissioning Group).

11. NAMED SUBSTITUTES

Duncan Sutherland was present as a substitute for Ingrid Barker.

12. DECLARATIONS OF INTEREST

No declarations of interest were made.

13. MINUTES

The minutes of the previous meeting were received.

Resolved: That the minutes of the meeting held on 8 July 2019 be approved and be signed by the chairperson.

14. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been received from members of the public.

15. QUESTIONS FROM COUNCILLORS

No questions had been received from councillors.

[note: agenda item 9 (minute 18), Integrated Care System and One Herefordshire, was considered next, but the original agenda order is preserved here for ease of reference]

16. HEREFORDSHIRE AND WORCESTERSHIRE LIVING WELL WITH DEMENTIA STRATEGY

The assistant director all ages commissioning presented the draft strategy and explained that, following consideration of an early iteration at the 5 March 2019 meeting, a joined up approach had been taken to the further development of the strategy by NHS Herefordshire Clinical Commissioning Group and Herefordshire Council.

It was reported that this was the first sustainability and transformation partnership footprint strategy for Herefordshire and Worcestershire and one of the aims of the strategy was to improve the Herefordshire rate of dementia diagnosis (58%) to the nationally targeted rate (67%); some of the reasons why people avoided diagnosis, particularly in rural communities, were outlined.

An overview was provided of the work of Dementia Friendly Leominster, Herefordshire Dementia Action Alliance, and Talk Community. The need to deliver the strategy cohesively and proactively was emphasised, with attention drawn to the delivery plan.

It was reported that the strategy would be considered by cabinet on 28 November 2019. The individuals, groups and organisations involved in the development of the strategy were thanked.

The cabinet member - children and families commented on the establishment of Dementia Friendly Leominster and its ongoing work in the community. The assistant director all ages commissioning said that the initiative had been incredibly supportive of the dementia agenda. The chief executive commented that it was a challenge and opportunity to extend the model to Hereford and the other market towns, and noted the importance of improving awareness and understanding of dementia.

It was reported that Gloucestershire Health and Care NHS Foundation Trust was developing proposals for revising its delivery model for dementia care to improve quality of life and reduce demand on the system in terms of urgent and emergency care.

The vice-chairperson commented that the strategy had involved significant effort and drew attention to the guiding principles of 'preventing well', 'diagnosing well', 'supporting well', 'living well', and 'dying well' in the context of helping people to plan for the future and before a time of crisis.

Resolved: That the board has reviewed and supports the draft Herefordshire and Worcestershire Living Well with Dementia Strategy 2019-2024.

17. HEREFORDSHIRE'S BETTER CARE FUND AND INTEGRATION PLAN 2019-20

The head of partnerships and integration reported that the Better Care Fund and integration plan 2019-20 had been submitted, as per the requirements of the national programme, with the agreement of the director for adults and communities and the Managing Director of NHS Herefordshire Clinical Commissioning Group, as delegated by the board.

It was reported that there were minimal changes from the previous plan, it reflected the local approach to integration, and the national conditions and metrics had remained the same. The board was advised that significant improvements had been made in terms of discharge and reducing delayed transfers of care. Attention was drawn to the financial summary 2019/20 (agenda page 62). It was noted that a regional assurance process was being undertaken and initial feedback suggested that the plan was likely to be approved.

The board acknowledged the work that had gone into the plan and thanked the officers involved.

Resolved: That the Herefordshire Better Care Fund and integration plan 2019-20 at be approved.

18. INTEGRATED CARE SYSTEM AND ONE HEREFORDSHIRE

The Director of Strategy and Transformation for NHS Herefordshire Clinical Commissioning Group (CCG) and One Herefordshire, and Joint Programme Director for the Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP) [hereafter referred to as 'director of strategy and transformation'] was invited to update the board on the Integrated Care System and One Herefordshire. In response to a question from the chairperson, the director of strategy and transformation clarified that the purpose of the item was to bring the proposals to the board for discussion and approval, rather than as a formal public consultation.

The director of strategy and transformation delivered the 'Integrated Primary and Community Services' presentation, starting with the slide 'The NHS Long Term Plan'. Questions and comments from attendees included:

1. The chairperson drew attention to paragraph 4 (agenda page 138) of the covering report, 'The plan commits funding to the networks for additional resources …', and questioned how much funding was being committed for Herefordshire and how this compared to Worcestershire. The director of strategy and transformation said that there was a national funding formula which would support a range of activities and provision of staff in the Primary Care Networks over the next five years.

2. Referring to paragraph 9 (agenda page 139), ‘As part of the development of STPs into ICSs the local ‘place’ will need to be developed…’ the chairperson questioned the stage that the local system was at and the role of the health and wellbeing board. The director of strategy and transformation commented on the work of the One Herefordshire integration programme and considered that partnership working was relatively mature compared to some other areas, although there was more work to be done. Local ‘place’ was seen as being coterminous with the health and wellbeing board boundaries and there was a strong role for the board as convenor of the system, particularly given its links with prevention, wellbeing, and local accountability.

3. The director of public health commented on the need to reflect on the roles of the system partners as ‘anchor’ organisations, including opportunities in terms of healthy workforces and the climate change agenda. The director of strategy and transformation suggested that this could be a future topic for the board and noted that addressing inequalities and prevention were key threads in the work being undertaken.

4. The Managing Director of Taurus Healthcare commented on the distinction between Primary Care Networks and general practice, and the vision to engage with communities and the prevention agenda. The vice-chairperson noted the importance of education and addressing the broader determinants of health and wellbeing. The cabinet member - children and families added that eating healthily was also a key factor.

5. The chief executive said that, as explored at a recent meeting of NHS and local authority leads across the Midlands, there was a clear need for the NHS to work with local authorities in the co-shaping of the plan. Therefore, the starting point needed the joint development of a long term plan for Herefordshire. The council had an aim for people to live at home healthily and independently for a longer period of time, with services constructed to allow this to happen and with support from voluntary and community sectors, which would have the outcome of fewer people requiring urgent and emergency care. The Non-Executive Director of Gloucestershire Health and Care NHS Foundation Trust said that the integrated approach was key to translating national strategy into a local context.

6. The Chair of Healthwatch Herefordshire said that the Long Term Plan was supported and that the STP had committed to take the 2019 Healthwatch Engagement Report into account. The need for the local ‘voice’ in the detailed plans, including the development of the Primary Care Networks, was emphasised. The vice-chairperson said it was important that the public, including representation through Healthwatch and local authority councillors, should not have to react to changes in the NHS but should be driving them, with more positive ownership and partnership. The chief executive commented on: the importance of community connection and direct support to enhance capacity; the need for mental health needs to play a more central role; and the opportunity to address the big questions jointly through a local long term plan.

The director of strategy and transformation continued the presentation with slides on: ‘NHS Action on Prevention’; ‘Integrated Care Systems (ICSs)’; ‘H&W STP Vision’; and ‘The Tiers in an ICS (work in progress)’. Questions and comments from attendees included:

7. In response to a question from the Chair of Healthwatch Herefordshire, it was reported that smoking cessation services were provided to high risk groups and would be extended to inpatients in hospitals.

8. The Leader of the Council, noting reference in the STP vision to 'Put prevention, self care and personal resilience at the heart of our plans' questioned whether the population was receptive to this or if a degree of education was needed. The director of strategy and transformation, noting the value of the recent engagement work, said that the position was mixed. The Chair of Healthwatch Herefordshire commented on the challenges in some parts of the population which required further exploration.

   The Leader of the Council noted that community participation was essential but it could be difficult to motivate some individuals. The director of strategy and transformation said that it was multi-faceted question, involving healthy environments and opportunities, which could be explored at a future workshop. The director of public health added that it was a complex topic, especially in view of inequalities, and reiterated the role of system partners as anchor organisations in helping their workforces to make healthy choices.

   The vice-chairperson said that it should be recognised that some people's lives started in more complicated places than others and mental health issues may limit access to, or interest in, certain lifestyle choices. He added that the recent launch of the Children and Young People's Plan had been a positive event and hoped that all the organisations represented on the board were fully engaged with this work.

   The chief executive emphasised the importance of getting people to change behaviours and attitudes, to take responsibility for their own health and their family's health, and do more to support others in the community. The example of Wigan Council's 'Deal for Health and Wellness' was outlined. The chief executive considered it critical to find ways for communities to take on and feel ownership of such matters.

Slides were presented on 'One Herefordshire' and 'Integrated Care in Herefordshire'.

9. In response to a question from the Leader of the Council about the statement that functional integration was 'not about Shifting Risk', the director of strategy and transformation noted that this was a high level principle which could be applied to many constructs, including finances, governance, clinical risk, and organisational risk. In terms of clinical or professional accountability, each service or intervention would need to be considered and agreed.

Slides were presented on '2019/20 Delivery and Assurance' and 'Talk Community Key Programmes'.

10. In response to a question from the Leader of the Council about motivating people to become involved, the head of partnerships and integration said that harnessing the interest in, and the experiences from, the initial Talk Community hubs would help to promote the initiative in other parts of the County. The assistant director all ages commissioning added that people were coming forward with their own ideas for their communities. The director of public health said that it was important to focus where there was energy but also to identify the more vulnerable groups within those communities and how to work with them.

11. With reference made to the way in which broad family intervention in Leeds had successfully reduced childhood obesity, the vice-chairperson questioned how a positive vision for population health and wellbeing would be picked up locally. In response, the director of public health commented on the potential for Herefordshire to become a sustainable food county.

A slide was presented on 'Integrated Care Alliance Board Work Plan'.

12. The chief executive commented that social care was on the frontline of prevention for NHS clinical needs and felt that there should be greater emphasis on prevention under the work plan. In response, the director for strategy and transformation outlined the work programmes for the identified projects and the linkages to prevention. The Managing Director of Wye Valley NHS Trust emphasised the need to address heightened emergency demand and to provide better and more efficient care for frail older people as a priority but recognised the potential of Talk Community and the prevention agenda, particularly in childhood. In response to a question from the vice-chairperson, the head of partnerships and integration said that the Home First team was primarily focused on discharge currently but there was an intention to invest further in admission avoidance and wrapping care around individuals at home. The director for public health reiterated the need to look at the broader determinants of health and wellbeing in order to have a real impact. The director for strategy and transformation acknowledged the need to articulate not only the operational specifics but also the context of the ongoing conversations about prevention.

A slide was presented on 'To Deliver the Vision of Our STP Long Term Plan Submission' and 'Delivering Our Commitment to Transform Out of Hospital Care and Fully Integrated Community Based Care, Reducing Pressure on Emergency Care'.

13. Referring to the system commitment to 'deliver digitally enabled care and self care…', the Chair of Healthwatch Herefordshire commented on the need to think differently in terms of localities that did not have access to reliable digital communications.

The director for strategy and transformation drew attention to slides showing the draft delivery plans for 'General Practice and PCN Development' and 'Integrated Primary and Community Services'. It was reiterated that addressing inequalities and prevention were key threads throughout the submission.

A slide was presented on 'The Four Strategic Priorities for Integrated Primary and Community Services'.

In conclusion, the director for strategy and transformation said that the presentation attempted to summarise a detailed piece of work to meet national policy requirements and in such a way which best meets local needs, makes health and care services more resilient and supportive, embeds prevention and reablement, and supports people in their communities.

The Chair of Healthwatch Herefordshire commented on the need for the board to ensure that all the right linkages were made.

The director for public health said that the board had a role in terms of: providing leadership and oversight; putting challenge into the system to identify where progress was not being made with this agenda and to address any associated issues; and to hold all partner organisations to account, on issues such as working with communities and changing employment practices, to achieve the objectives set out in the plan.

In response to a comment from the Leader of the Council, the head of partnerships and integration noted the need for the partner organisations to identify potential issues for inclusion in the work programme. The director for strategy and transformation said that it would be helpful if the board could identify where the system needed to focus on, including any specific matters to prioritise.

The assistant director all ages commissioning commented on the need to shift resources progressively to prevention and suggested that the board could come to a collective agreement on how it would evidence as a system this shift in resources and investment.

The chief executive commented that other initiatives would support the prevention agenda, such as extending cycle routes and installation of fitness furniture in public spaces.

The vice-chairperson proposed the following recommendation which was seconded, and supported by the board.

Resolved: That the board has an active interest in this work and recognises the need for oversight of the difference this will make to the people of Herefordshire, with a focus on prevention and on communication with, and active involvement of, our population(s).

19. DATES OF FUTURE MEETINGS

The scheduled dates for board meetings in public were noted as follows: Monday 9 December 2019, 2.30pm [note: this meeting was withdrawn subsequently]; Monday 10 February 2020, 2.30pm; and Monday 20 April 2020, 2.30pm.

The meeting ended at 4.33 pm **Chairperson**

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Monday 10 February 2020**
Title of report:	**Health and wellbeing board review and future working**
Report by:	**Director of adults and communities**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose and summary

To ratify the outcomes of the health and wellbeing board (HWBB) review, agree the board format and make recommendations for the future working arrangements including membership, the vision, priorities and cross-cutting themes. Any consequential changes to the council's constitution will be reported to the audit and governance committee for it to consider prior to any recommendations being made to Council.

The introduction of the national NHS long-term plan and reorganisation of the clinical commissioning group administrative footprint area are driving new local health priorities. Similarly, the council's new corporate plan also places strong emphasis on supporting more people to live active, healthy and supported lifestyles in their own communities. It is important that the HWBB responds positively to these changes to ensure it remains relevant to the priorities of the communities of Herefordshire and its functions, as set out in the Health and Social Care Act, 2002.

Recommendation(s)

That:

Further information on the subject of this report is available from
Amy Pitt, Tel: 01432 383758, email: apitt@herefordshire.gov.uk

(a) The new vision, priorities, cross-cutting themes and membership for the health and wellbeing board are supported; and

(b) The proposed working arrangements be recommended to the audit and governance committee, with a view to seeking full Council approval for the new board membership.

Alternative options

1. The HWBB does not support the recommended changes as suggested by the review and continues with the current format. This is not recommended as it would not address the new priorities emerging from the health and social care sectors; these priorities will have potentially implications for the communities of Herefordshire. It would also reduce the opportunity for closer, more integrated, local partnership working on well evidence local health and wellbeing priorities, as set out in the report below.

Key considerations

2. Following the elections in May 2019 the newly appointed chairperson of the HWBB, with the agreement of the current HWBB membership, commissioned a review of the board's function, membership and deliverables. This coincided with the Local Government Association (LGA) publishing 'What a difference a place makes – the growing impact of health and wellbeing boards,' which highlighted 23 good performing HWBBs across the country and the factors that made them successful. It was agreed that a review should be undertaken in Herefordshire to ensure that the HWBB is able to consider and strengthen its current priorities and working practices.

3. The review has been facilitated and supported by the Local Government Association (LGA). The review identified a number of areas for the members to consider which included the current vision, priorities, cross-cutting themes and membership and whether these reflected the current strategic landscape across health, social care and work of wider partners.

4. Effective HWBBs work in partnership and at a time of continuous change, HWBBs are anchors of place, providing leadership and stability, and helping to bring coherence to the new ways of working that connect communities, place and system. Building on the duty to promote health and wellbeing, the board aims to work in partnership across the public and community sector to tackle the wider determinants of health.

5. The review process identified that the alignment to the Herefordshire and Worcestershire Sustainable and Transformation Plan was important. However the 'place' in local system planning based on demographics, areas of need and local intelligence are vital in shaping the local approach. It was also identified that place brings a consistent shared purpose to more localised community working and meeting the needs of the Herefordshire population.

6. The need for an effective HWBB couldn't be greater. Herefordshire faces unprecedented demand for health and social care. Through collaborative leadership and a clear focus on good evidence, defining shared outcomes and deliverables, the HWBB will play a vital role in coordinating and directing health and social care interventions to the appropriate places when and where they are needed.

7. As the statutorily recognised forum bringing together political, community and health leaders the review has identified where change is required and in so doing has built a consensus around the value of the HWBB partnership, and its shared values. The outputs of the review include a new shared vision and priorities underpinned by cross-cutting themes and key deliverables.

8. The vision for the board builds on the existing one and is proposed as:

   Herefordshire residents are connected into communities to be resilient; lead fulfilling lives; are emotionally and physically healthy and feel safe and secure.

   Which is underpinned by five priorities:

   Helping you to help yourself by:

   - *Supporting our residents to eat well, drink safely and get active*
   - *Supporting our residents to live life to the full whatever their age*
   - *Supporting vulnerable residents of all ages to live and age well*
   - *Supporting the mental and emotional wellbeing of all our residents of all ages*
   - *Developing communities to help keep people connected*

9. The cross-cutting themes identified as part of the review are within appendix B and the key areas highlighted collaboration and partnership working between all stakeholders to ensure resources are maximised, ensuring equality for all residents in Herefordshire and building resilient communities for the future.

10. The proposed vision and priorities is providing a refreshed strategic approach to prevention and ensuring this sits at the core of the ambitions for integrated services and working with communities. These priorities ensure that prevention encompasses wider wellbeing and the wider determinants of health, helping people to help themselves to keep well and stay well.

11. The HWBB will be looking to add value through leveraging the impact of partnership working by aligning and having oversight of key strategic boards delivery plans that feed into these agendas and have an impact on health and wellbeing, ensuring accountability whilst providing a vehicle to help partners navigate local challenges or tensions. These boards are identified in appendix A.

12. As well as proposing the shared vision and priorities the HWBB review also considered the cross-cutting local themes which are in appendix B and focus on tackling inequalities, quality of life, community resilience and sustainable environments.

13. The membership for the board has been considered with a proposed structure of core and consultative representatives as suggested below, the core membership does include additional members to the existing membership which will need approval by full council for it to be agreed.

Core Membership	Consultative Representatives
Health partners – commissioners and providers	Education
Local Authority – all directorates represented by Directors	Parish and Town Councils
Police	Business Partners
Fire and Rescue	VCS
Key Strategic partnership board chairs or representatives	
Healthwatch	

14. Working groups will be established to focus on key areas of delivery and improvement with the appropriate representation considered for the work.

15. If the board is in agreement with the outputs of the review the board is invited to consider what new priorities it will wish to build in to its future work programme. With this consideration in mind, the board should be given scope to discuss and identify (at its meeting of 10 February) with key commissioning partners the board specific areas of transformational change and key developments in their respective commissioning plans. This with a view that those items are brought back to future board meetings to explore and discuss what this means for Herefordshire on the suggested areas

    - Integrated urgent care pathway
    - Primary Care Networks
    - Stroke services
    - Mental health services

Community impact

16. The revised vision, priorities and cross-cutting themes fully align to the recently updated county plan for Herefordshire Council. In addition these also align to the NHS long term plan and the prevention agenda being a key priority.

17. The HWBB has a statutory function for the Joint Strategic Needs Assessment which has informed the review and the revision of the vision, priorities and cross-cutting themes which demonstrates the need to focus on prevention and ensuring the wider wellbeing and the wider determinants of health. The revision of the board will also ensure that an 'all ages' agenda is considered to support children, families and adults across Herefordshire in collaboration with system partners.

Equality duty

18. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to -

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

19. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

20. The council and HWBB partners 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 taken into account.

21. It is not envisaged that the recommendations in this report will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender, reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

22. The HWBB aims to deliver better outcomes for the residents of Herefordshire and supports the council in proactively delivering its equality duty under the act. This is through improving the health and wellbeing of people in Herefordshire by enabling them to take greater control over their own health and the health of their families, and helping them to remain independent within their own homes and communities. There are no negative impacts for looked after children or with respect to the council's corporate parenting role.

Resource implications

23. There are no direct financial or resource implications for the proposed changes for the HWBB. The HWBB has a statutory function to approve the better care fund plan and quarterly reports, with full cabinet and council approval of budgets. This report does not recommend for this to change. The core members have budget and resource oversight within their own organisations.

Legal implications

24. Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from local health and social care work together to improve the health and wellbeing of their local population.

25. The core membership of health and wellbeing boards is prescribed in section 194 of the Health and Social Care Act 2012 as follows:- at least one councillor, director of adult services, director of childrens services, director of public health, representative of local Healthwatch, representative of each relevant clinical commissioning grouped and such other persons as the local authority thinks appropriate. Before appointing any other person to be a member of the Board, the local authority must consult with the health and wellbeing board.

26. The council's constitution sets all the basic rules governing the health and wellbeing board, including composition and role, functions and procedures. Paragraph 2.8.9 of the constitution provides the membership. The role of the Board is to carry out the statutory functions as required by the 2012 Act, and any other functions delegated to it, as set out in para 3.5.22 of the constitution.

27. The recommendations in the report comply with the legislation and statutory requirements.

Risk management

28. The board is invited to make additional recommendations to the audit and governance committee ahead of approval at full council. The changes and revisions proposed in this report will have minimal risks and by accepting the proposed changes this will reduce the risk of the board not aligning to system and national plans.

29. The key risk for ensuring the board's effectiveness is the appropriate leadership and membership and the influence and control within partner/board organisations. If the proposed changes are not embedded within the leaders of the board the opportunity to change will be minimal, which will have an impact on the residents of Herefordshire, future services, communities and resources.

30. The council's adults and wellbeing scrutiny committee will be appraised of and have the means to monitor progress against the HWBB work programme. It has the remit to scrutinise the effectiveness of the HWBB at achieving its stated outcomes.

31. The risks for the board will also be managed by a HWBB risk register which will be reported through the council's appropriate governance structure and reported via the adults and communities directorate risk register.

Consultees

32. The current members of the HWBB have been consulted and been an integral part of the review. Their input and evidence has been integral to the formulation of the new priorities and cross cutting themes developed during the review process. This has included representation from key health partners, Herefordshire Clinical Commissioning Group, Taurus Healthcare, Wye Valley Trust and 2gether Foundation Trust as well as Healthwatch, appropriate cabinet members and directors of the council.

33. The views of all of the current members have been taken into consideration underpin the proposed changes and the current members provided evidence to support the change. The current HWBB members are driving this change to ensure that the HWBB priorities are fit for purpose in a changing health and social care environment

Appendices

Appendix A - HWBB structure and relevant stakeholder boards

Appendix B - Cross-cutting themes

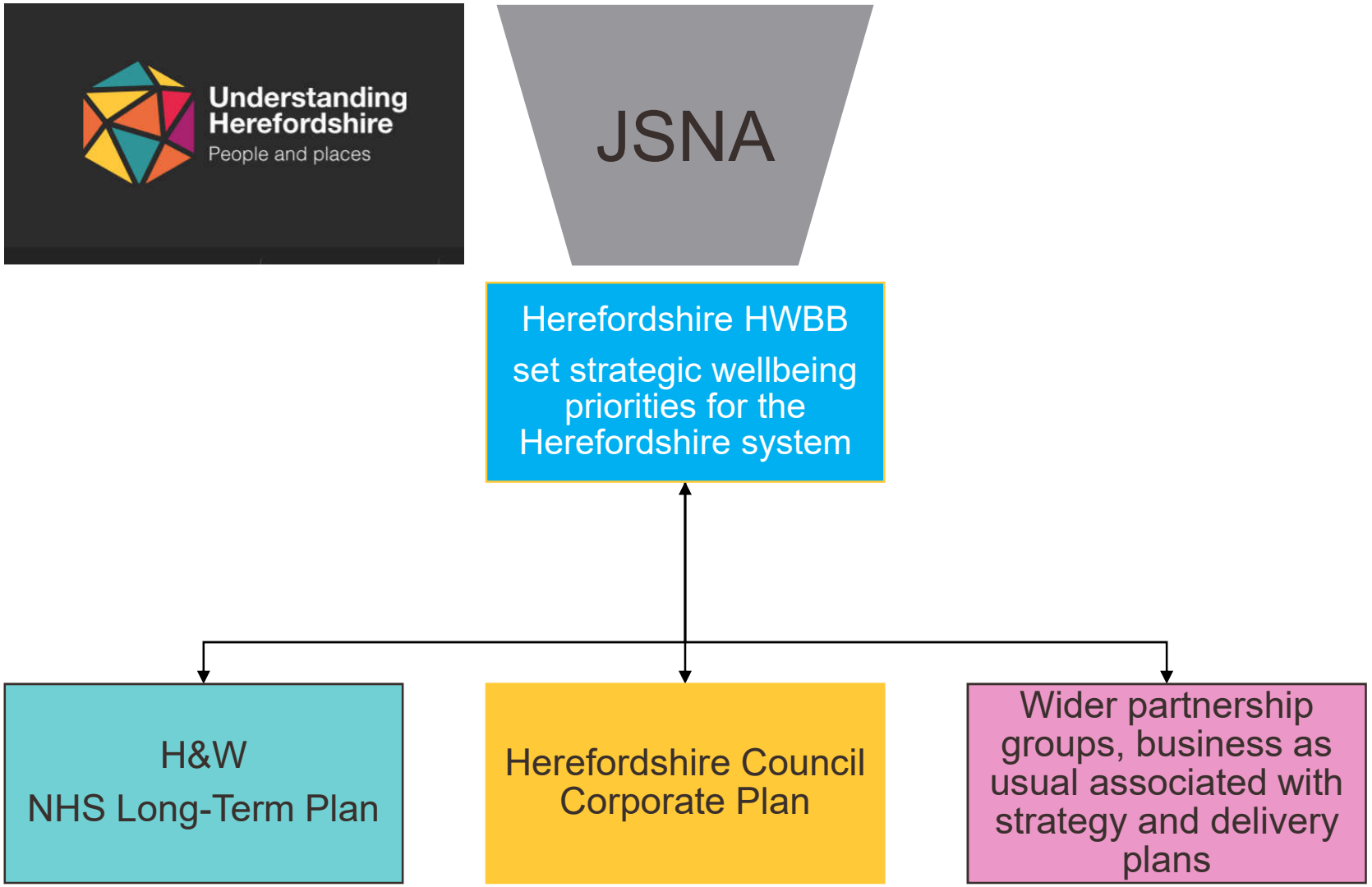
Background papers

None identified

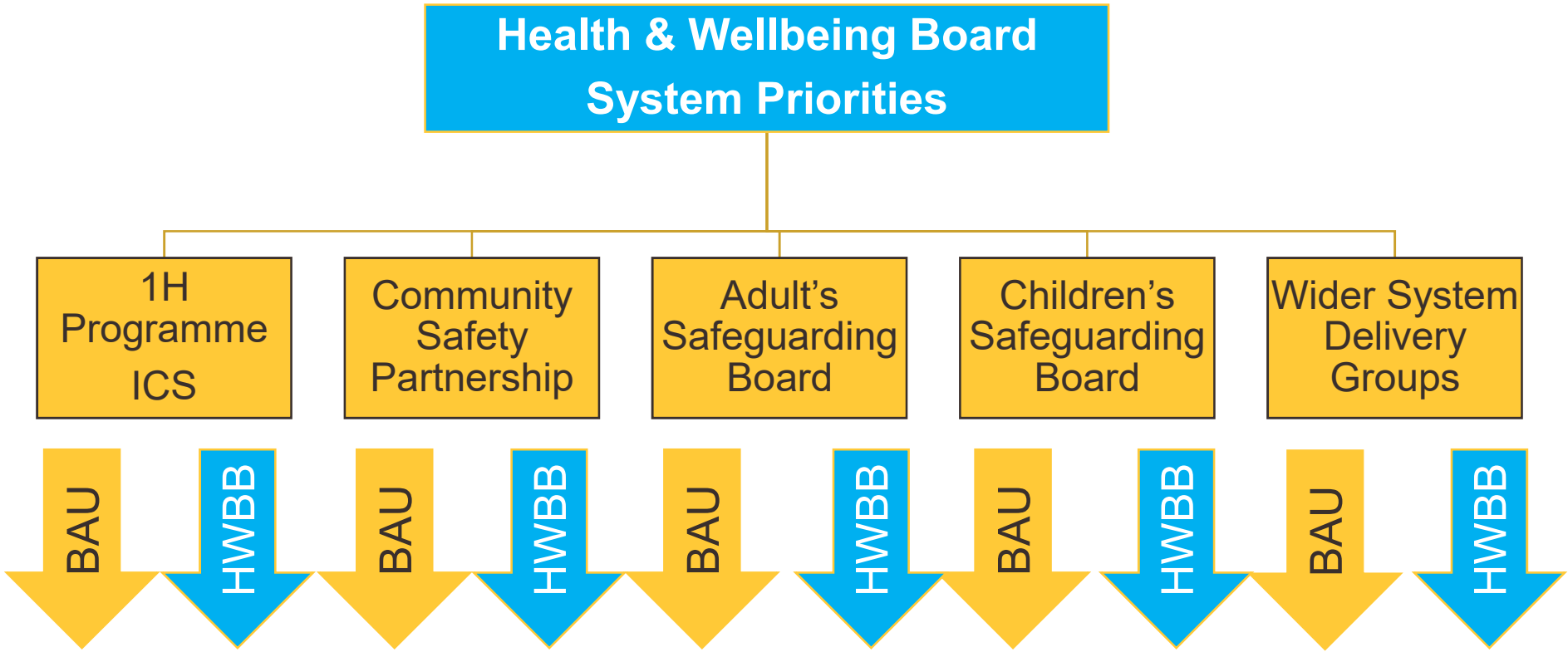
Further information on the subject of this report is available from
Amy Pitt, Tel: 01432 383758, email: apitt@herefordshire.gov.uk

Health and Wellbeing Board

Appendix One


Understanding Herefordshire
People and places
JSNA
Herefordshire HWBB
set strategic wellbeing priorities for the Herefordshire system
H&W
NHS Long-Term Plan
Herefordshire Council Corporate Plan
Wider partnership groups, business as usual associated with strategy and delivery plans

Focus on delivering system change



NHS Long Term Plan

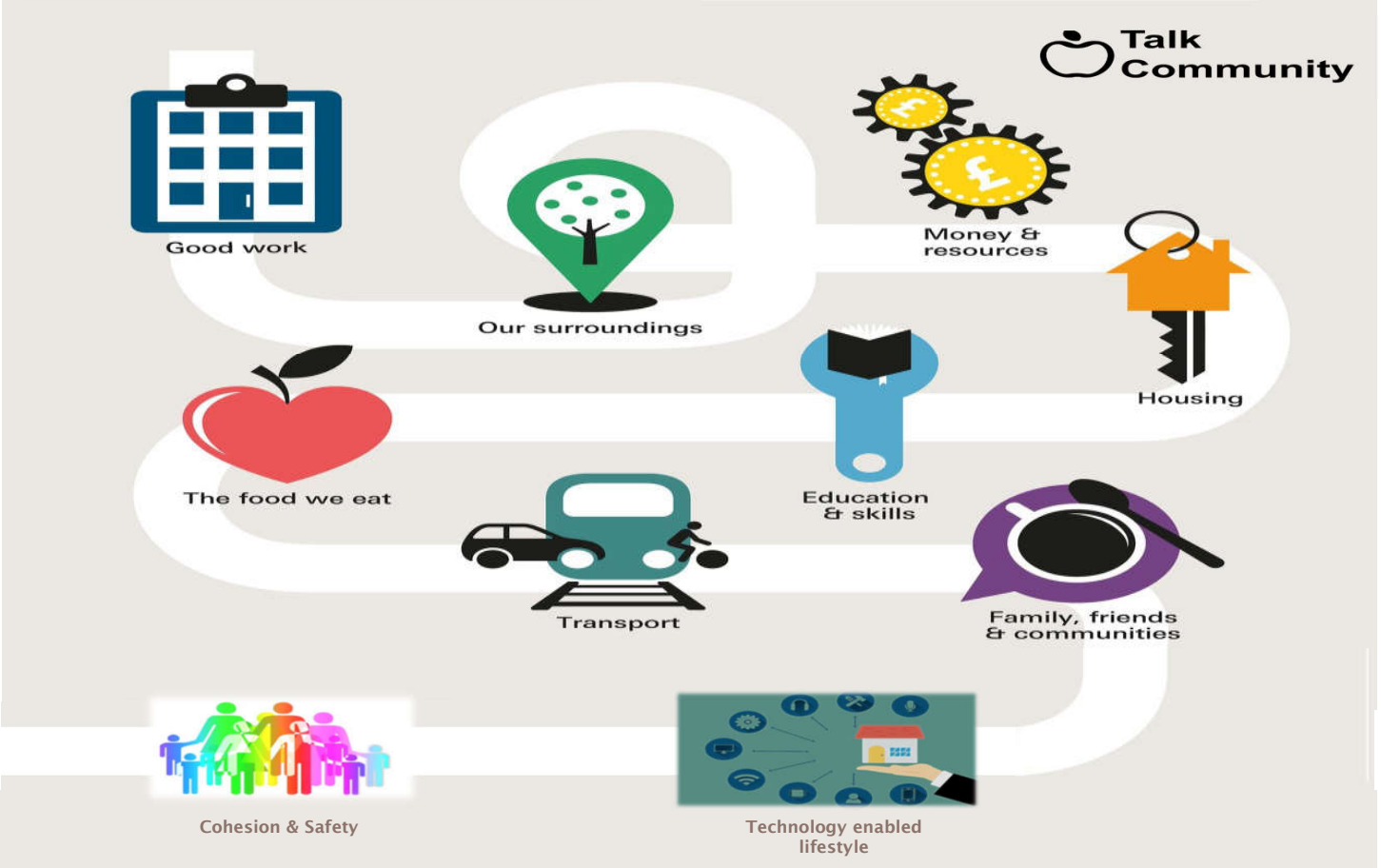
Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people

2019	A system too reliant on emergency access and beds where people believe that hospital is the best place to be when you are unwell
2024	A system built around excellent care close to home, where hospital beds are only used where somebody cannot be cared for safely in their own environment

Our 5 aims (The quintuple aim)
1. Improve health and well-being outcomes
2. Reduce health and care inequalities
3. Improve quality and performance enhancing the experience of care
4. Improve productivity and efficiency returning the system to financial sustainability
5. Sustain, develop and engage our workforce

Wellbeing – Everything is connected

As little as 10% of a populations health and wellbeing is linked to access to healthcare. We need to look at the bigger picture……..



Herefordshire Council
Corporate Ambition

Respecting the past, shaping our future – we will help build vibrant communities, create a thriving local economy and protect and enhance our environment

Community – Building communities to ensure everyone lives well and safely together

Economy – Support an economy which builds on the county's strengths and resources

Environment – Protect our environment and keep Herefordshire a great place to live

Health and Wellbeing Board

Appendix Two

Cross Cutting Themes

- Collaborative partnership working to maximise our resources across the county
- Ensuring services, support and opportunities are equitable and accessible to all
- Improving quality of life through healthy ageing
- Co-producing with communities and stakeholders to help people connect and engage with the board
- Identify climate change action in all aspects of operational delivery
- Supporting and enhancing our workforce skills and opportunities
- Building resilience across communities and all sectors
- Improving social mobility including housing, economic opportunities and learning

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Monday 10 February 2020**
Title of report:	**Director of public health annual report**
Report by:	**Director of public health**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

The purpose of this report is to present 2019 Director of Public Health (DPH) annual report and to seek the support of the health and wellbeing board in implementing the recommendations.

Directors of Public Health have a statutory requirement to write an independent annual report on the health of their population. The Director of Public Health Annual Report is a vehicle for informing local people about the health of their community, as well as providing necessary information for decision makers in local health services and authorities on health gaps and priorities that need to be addressed. The report is informed by and sits alongside the Joint Strategic Needs Assessment (Understanding Herefordshire). The focus of the 2019 report is rural Herefordshire. This is because to date we have not clearly understood both the challenges and opportunities in rural communities. This understanding is vital to informing the implementation and County Plan, the NHS Long Term Plan, the Talk Community approach being developed in Herefordshire, as well the emerging priorities being identified by the health and wellbeing board.

Herefordshire is a beautiful county, with large areas of rich and varied countryside which are sparsely populated. Overall people in rural areas of Herefordshire have better health than those in the urban areas, and indeed have slightly higher life expectancy. However, this masks significant pockets of deprivation and poor health outcomes which rurality can exacerbate. The report looks at those factors which drive deprivation and impact on life in rural communities.

Further information on the subject of this report is available from
Rebecca Howell-Jones, email: Becky.Howell-Jones@herefordshire.gov.uk

The recommendations set out in the report identify key areas for action to tackle some of the challenges associated with rural living, and reduce the impact of inequalities.

Recommendation(s)

That:

(a) The health and wellbeing board notes and considers the findings of the report, and supports the identified strategies and actions to address challenges of life in rural Herefordshire; and

(b) The health and wellbeing board provides leadership in addressing inequalities faced by rural communities through recognition of the challenges, communicating the key messages of the report to their constituent members and identifying further actions that can be taken by constituent organisations and across the system.

Alternative options

1. The health and wellbeing board may receive the report but determine that they will put in place different arrangements to support the health and wellbeing of people living in rural communities but under the relevant legislation, there are no alternative options in terms as to whether or not the annual report is published.

Key considerations

2. Rural areas pose different types of challenges for the people who live there compared to urban areas. Nationally, more emphasis is often given to urban areas and urban poverty, not least as across England the majority of the population reside in urban areas, but also our common measure of deprivation (Index of Multiple Deprivation) is known to be skewed towards identifying deprivation in an urban context.

3. Rural deprivation looks very different to urban deprivation. In rural areas, the most common types of deprivation relate to housing and physical access to services. Deprivation is often a hidden feature of rural communities and within even the most affluent areas, there can be pockets of real hardship, ill health and inequality.

4. The 2019 DPH annual report outlines data on health and wellbeing of people living in rural communities and the challenges they face. It outlines the work we are undertaking to improve health and wellbeing in the rural setting and makes recommendations to improve the health and reduce inequalities in rural settings.

5. The report sets out the work we are doing to address the barriers and challenges associated with rural setting. This includes i) strategic level drivers through Herefordshire Council Corporate Plan and Children and Young People's Partnership Plan, ii) working in partnership across the system and maximising the impact of anchor organisations, and iii) specific programmes of work which will help tackle the drivers of deprivation and challenges associated with living in rural environments, including Talk Community programme; Keep Herefordshire Warm scheme; Fastershire Broadband and Fastershire digital inclusion activities.

Community impact

6. The Director of Public Health Annual Report recommendations are all designed to have a positive impact on the community by delivering more robust and effective approaches to improve health and wellbeing and tackling inequalities.

7. The recommendations specifically identify priority areas which can have a positive impact for those living in rural settings, particularly vulnerable groups.

Equality duty

8. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

   A public authority must, in the exercise of its functions, have due regard to the need to -

   (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

   (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

   (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

9. This is a factual report that sets out the key areas for action to tackle some of the challenges associated with rural living, and reduce the impact of inequalities. Therefore we believe that this will not have a detrimental impact on anyone that shares a protected characteristic and as many of the recommendations are specifically targeted at vulnerable groups we believe this will support the council in fulfilling its equality duty in particular advancing equality of opportunity and fostering good relations.

Resource implications

10. There are no direct resource implications from the publication of the 2019 DPH annual report.

11. Not all of the activity outlined in the recommendations has been costed at this stage and where this is the case those projects will require further work across relevant organisations

Legal implications

12. Every Director of Public Health must produce an annual report. This is a statutory requirement and must be complied with.

Risk management

13. The risks and opportunities associated with the delivery of the recommendations of the Director of Public Health Annual Report are identified below:

Risk / opportunity	Mitigation
The impact of rurality on health and wellbeing, and the causes of health, are not understood.	Data presented to describe the drivers of health and wellbeing and the unique challenges for people living in, and delivering services to, rural settings.
HWBB constituent members do not utilise the findings reported in the DPH report to inform their decisions and actions, including provision of services, in Herefordshire.	Report shared with HWBB. DPH working with partners in the development and delivery of various plans, for example Herefordshire Council delivery plan for the Corporate Plan, the local NHS Long Term Plan, development of local Primary Care Networks.

Consultees

14. None.

Appendices

Appendix 1: Director of Public Health 2019 Annual Report. Rural Herefordshire: What does it mean for health and wellbeing?

Background papers

None identified.

Glossary of terms, abbreviations and acronyms used in this report

DPH: Director of Public Health

HWBB: Health and wellbeing board

Rural Herefordshire: what does it mean for health and wellbeing?

Foreword

I am pleased to present my 2019 Director of Public Health independent annual report. In this report, I have focused on rural Herefordshire, and particularly the often hidden inequalities in rural communities. Over the past two years, I have become increasingly aware that we need to more fully understand impact of living in rural areas on the health and wellbeing of our communities if we are both embrace the strengths and work with communities to tackle some of the real challenges faced on a daily basis.

Herefordshire is a beautiful county, with large areas of rich and varied countryside. It is one of England's most sparsely populated counties, with 95% of the land area classified as 'rural' and over half of the population living in these rural areas. Overall, people living in rural Herefordshire have better health than those in the urban areas, and indeed have slightly higher life expectancy. However, while overall health outcomes are more favourable, these averages mask significant pockets of deprivation and poor health outcomes which can be made worse by living in a rural location.

Rural areas pose different types of challenges for the people who live there compared to urban areas. Nationally, more emphasis is often given to urban inequalities, not least as across England the majority of the population live in urban areas, but also our common measure of deprivation (the government's Index of Multiple Deprivation) is known to be skewed towards identifying deprivation in an urban context.[1] Rural deprivation looks very different. In rural areas, the most common types of deprivation relate to housing and physical access to services. A study[2] Herefordshire Council commissioned this year has highlighted how Herefordshire is starkly different to the national picture in terms of the number of homes which are considered hazardous due to excess cold. Old, detached properties that are poorly insulated, combined with a lack of fuel options, increases vulnerability to fuel poverty in some of the most rural areas.

Deprivation can be a hidden feature of rural communities as it is often dispersed amongst more affluent households. Within even the most affluent areas, there can be pockets of real hardship, ill health and inequality. In this report I describe some of the nuances of common measures of deprivation in the rural setting and pull together data to show the impact on daily lives.

As a Council and wider system, we are working to reduce inequalities across the board, whether they arise from rurality or other determinants of wellbeing. This report will provide the context to enable the Council, our partners and other organisations to understand the factors that impact on health and wellbeing in rural environments, the inequalities these can generate in Herefordshire and how we can continue to address them.

[1] https://www.rsnonline.org.uk/whitehall-updates-the-index-of-multiple-deprivation

[2] BRE Integrated Dwelling Level Housing Stock Modelling and Database for Herefordshire Council, June 2019.

Contents

Introduction

Herefordshire is a great place to live, people live longer and generally in better health than many parts of the UK. The county is well known for its beautiful unspoilt countryside with rolling farmland, hilly uplands and remote rivers and valleys along with its distinctive heritage. As a result many people of all ages choose to live in Herefordshire with between six and seven thousand moving to the county each year from other parts of the UK and overseas.

Hereford City is the county's centre for most facilities, and is home to almost one-third of the county's population (61,400 people). There are five market towns of varying sizes and amenities, ranging from the relatively 'urban' Leominster, Ross and Ledbury[3] – each with over 10,000 residents – to the 'rural towns' of Bromyard and Kington with fewer than 5,000 residents each. Two in every five residents (80,300 people; 42%) live in areas officially classified as 'rural village and dispersed'[4], and the county has the fourth lowest population density in England (88 people per square kilometre).

Neither overall population density nor the proportion living in rural areas illustrates quite how scattered Herefordshire's population is. No other English county-level authority has a greater proportion of its population living in output areas[5] with a density of 50 people per square kilometre or below (described as 'very sparse' areas): 25% of Herefordshire residents live in 'very sparse' areas.[6] This presents particular challenges for service delivery in the county.

Herefordshire has an older age profile than nationally (see population pyramid) and furthermore there are relatively more people of older working and early retirement age (50-70 year-olds) in the most rural areas. Hereford city in comparison has a much younger profile than the rest of the county, with relatively high proportions of young adults and young children (see line chart). The current (mid-2018) estimate of Herefordshire's resident population is 192,100, with 24% (nearly 46,600 people) being aged 65 or over, compared to 18% across England. There is also a higher proportion of older working age adults (mid-forties to the age of 64y) than across England as a whole.

The natural ageing of the population structure as the post-war and 1960s 'baby boomers' move into older age, combined with net in-migration of people of all except the youngest adult ages (18 to 24), will continue to result in a disproportionate growth of the number of older people. By 2031, 30% of Herefordshire's population will be aged 65 or over compared to 22% nationally. In particular, the number aged 85+ is likely to grow most rapidly: by more than 50%, from 6,200 in 2018 to over 9,000 by 2031; and is likely to double by 2040.

Exacerbated by their already older age structures, rural areas are expected to see higher proportions of older residents sooner than other parts of the county. Already in Leominster rural and Kington rural more than one in three residents are aged 65 or over, and this is likely to be the case in many more areas by 2028 (see map).

[3] NB. Ledbury is technically classified as a 'rural town' for analytical purposes, because its population was smaller when the classifications were last updated.

[4] www.ons.gov.uk/methodology/geography/geographicalproducts/ruralurbanclassifications

[5] Output Areas are the smallest level of statistical geographies, with an average population of about 300 people (with a minimum of 100).

[6] *Sparsity of Population in Herefordshire,* available on the Understanding Herefordshire website

Chart: Herefordshire currently has an older population than nationally

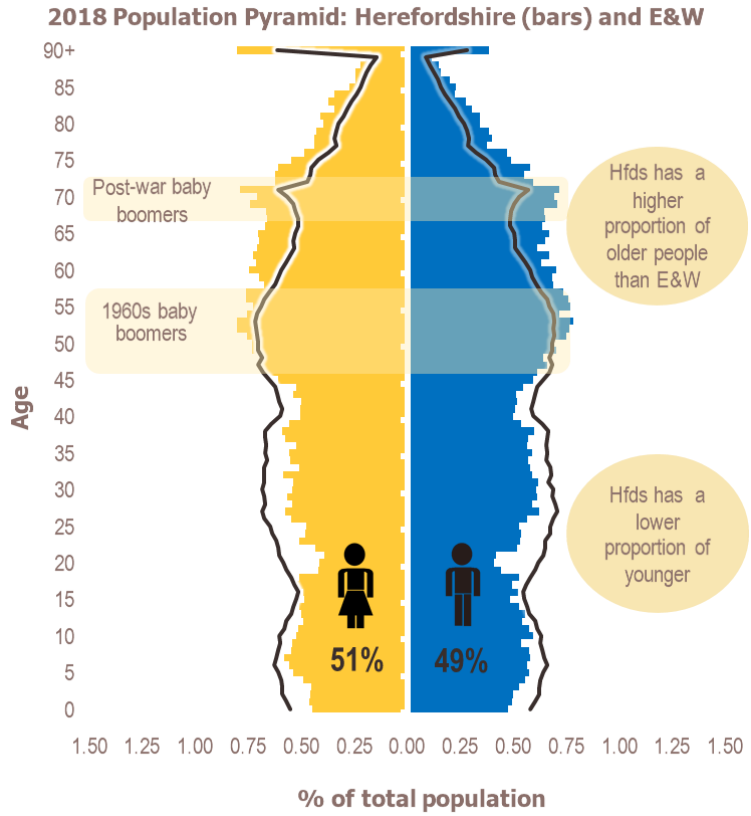
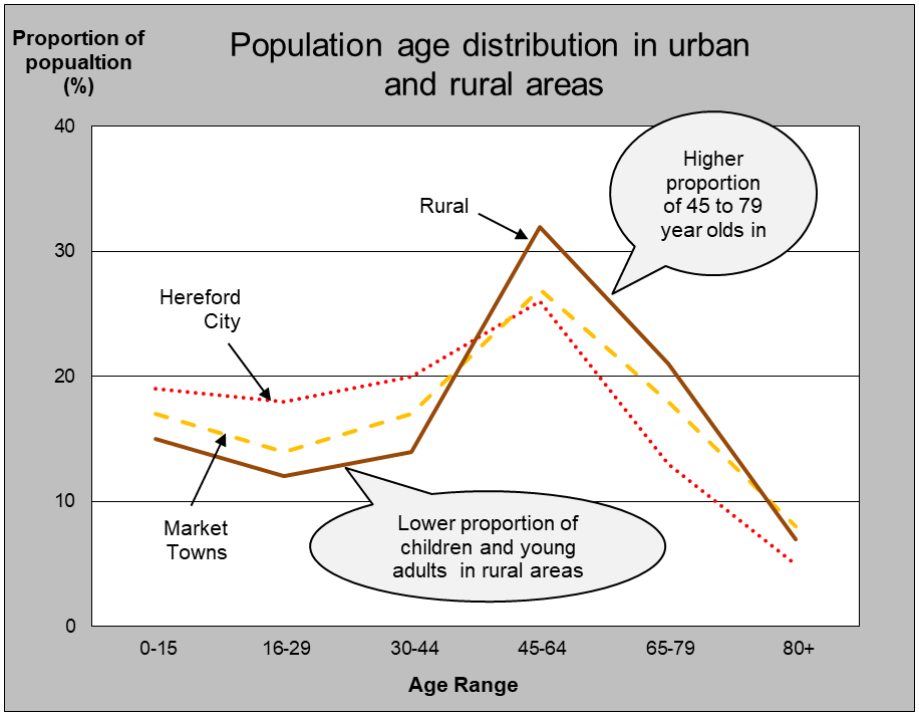
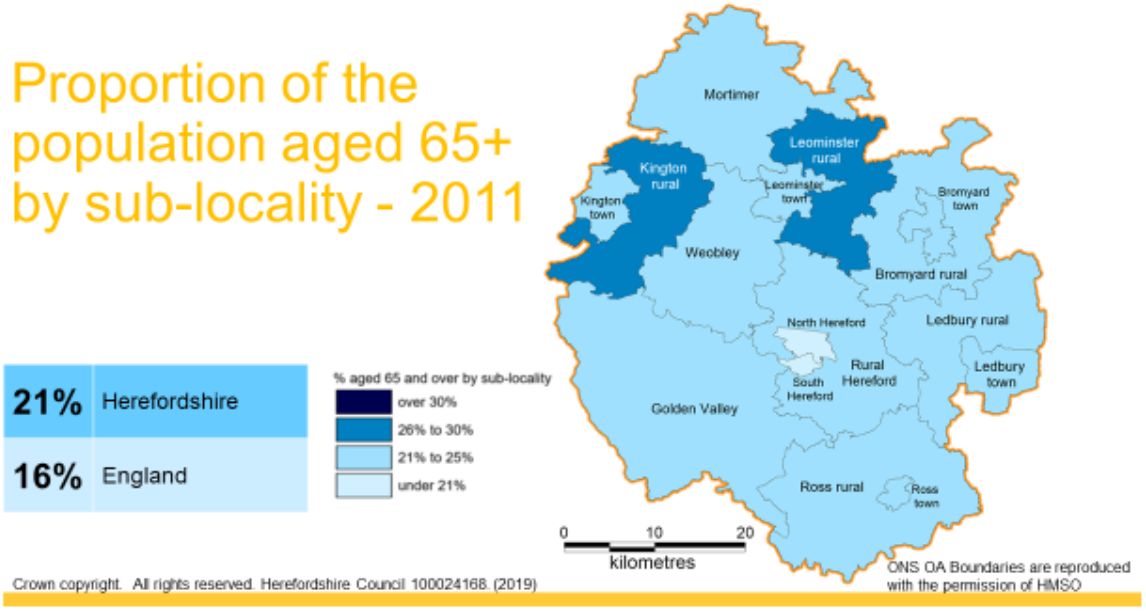
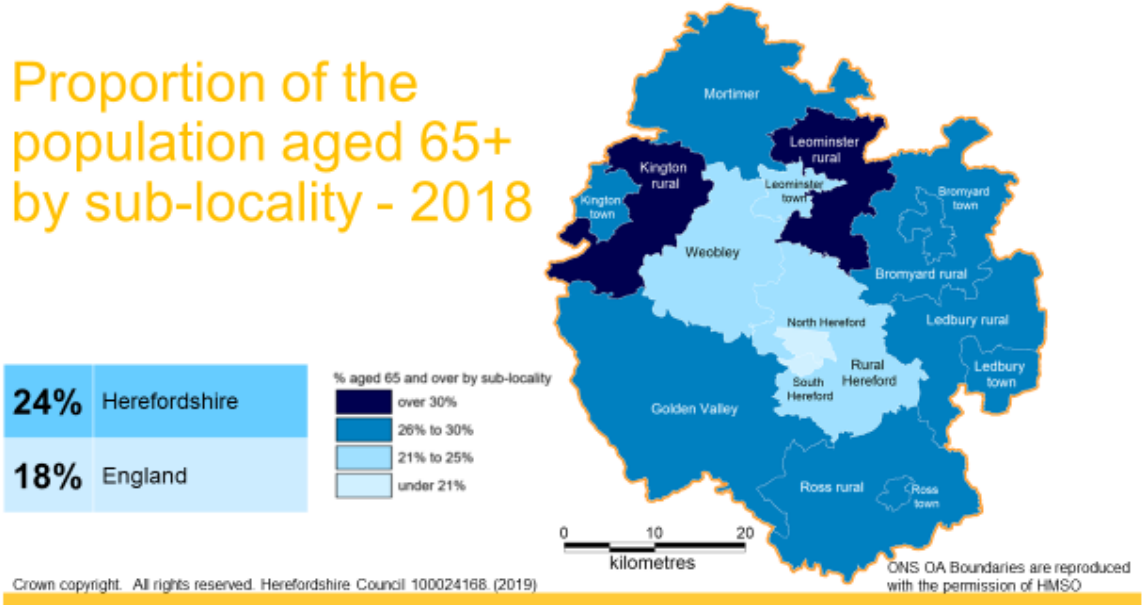


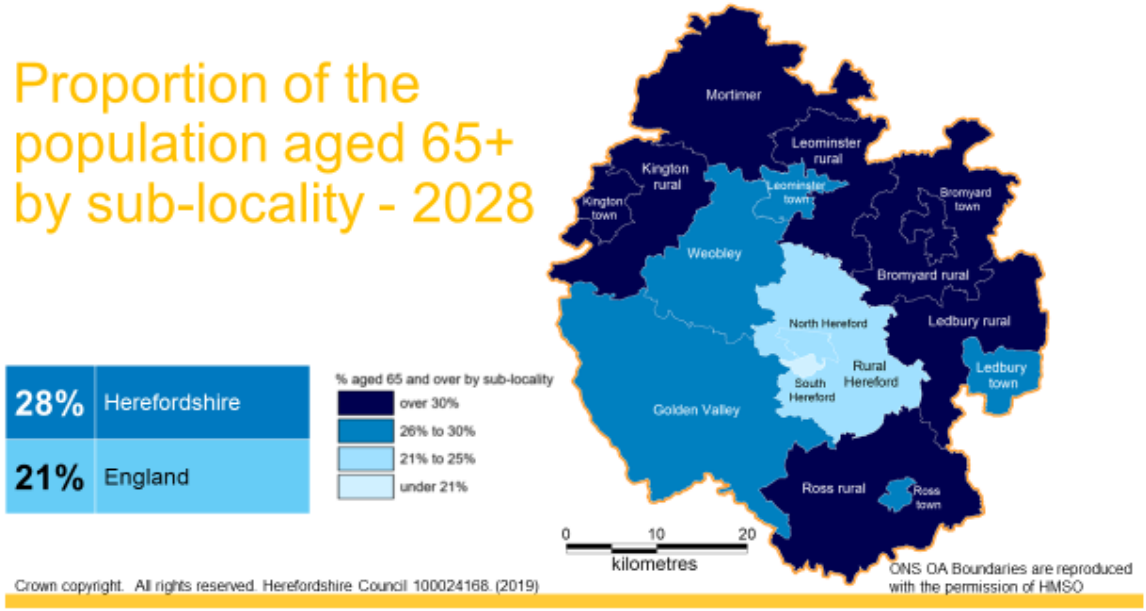
Chart: rural Herefordshire has an older age profile than the city



Maps: ageing population profiles around Herefordshire, particularly the rural north-west to south-east



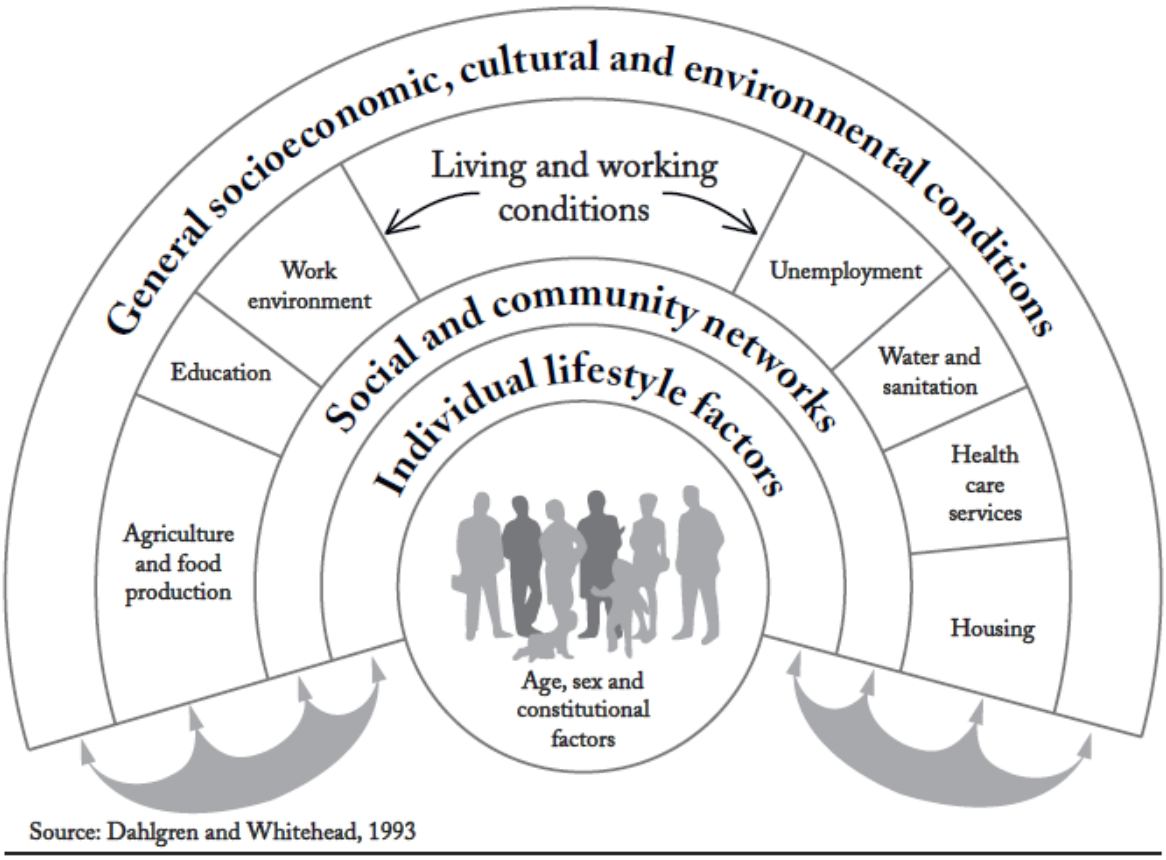




What makes us healthy?

Health and wellbeing are products of the complex interaction of genetics, wider determinants of health (social, economic and environmental factors), and lifestyle behaviours. This was captured several decades ago in a model by Whitehead and Dahlgren which remains relevant today. Factors that make and keep us healthy include such things as social and community connections, good living conditions, good employment, good education and access to good food.

The good influences on our lives, health and wellbeing are not evenly distributed throughout society. Some groups of people experience more factors that negatively influence their health and wellbeing such as poverty, lack of education, unemployment or isolation. Comparisons across our County and measures of deprivation can help us understand and describe some of these wider determinants of health and wellbeing, how they impact people's lives in Herefordshire and thus some of the issues we need to address as a County.



Health and wellbeing outcomes for rural population

The health and wellbeing of Herefordshire's rural population is, on average, slightly better than those living in urban areas for many indicators.

- In 2015/17, females born in the most rural areas of Herefordshire could expect to live 1.9 years longer than those living in urban areas; and males 2.2 years longer.
- Individuals living in rural areas are 29% less likely to die prematurely (i.e. before the age of 75).
- Individuals living in rural areas are 17% less likely to die prematurely from cancer
- Individuals living in rural areas are 29% less likely to die prematurely from cardiovascular diseases
- Individuals living in rural areas are 23% less likely to die prematurely from respiratory diseases
- Reception children living in rural areas are 6.3% less likely to be obese or overweight, a figure which rises to 15.1% in year 6 children.

Rural – Urban Based Inequalities

Rural	Urban
Female life expectancy = 85.5 years	Female life expectancy = 82.6 years
Male life expectancy = 80.8 years	Male life expectancy = 78.5 years
Proportion of households in fuel poverty = 15.9%	Proportion of households in fuel poverty = 12.2%
9 out of 100 children in the most rural areas live in income deprived households	15 out of 100 children in urban city and town live in income deprived households
8 out of 100 older people in the most rural areas live in income deprived households	13 out of 100 older people in urban city and town live in income deprived households
Premature mortality rate = 256 per 100,000	Premature mortality rate = 360 per 100,000
Proportion of reception age children overweight and obese = 23.3%	Proportion of reception age children overweight and obese = 24.9%

Rural	Urban
Premature cancer mortality rate = 118 per 100,000	Premature cancer mortality rate = 142 per 100,000
Premature cardiovascular disease mortality rate = 55 per 100,000	Premature cardiovascular disease mortality rate = 77 per 100,000
Premature respiratory disease mortality rate = 27 per 100,000	Premature respiratory disease mortality rate = 35 per 100,000
Proportion of working age residents that are employment deprived = 6.4%	Proportion of working age residents that are employment deprived = 9.8%
Average education, skills and trainig score = 13.8	Average education, skills and trainig score = 28.4
Proportion of year 6 children overweight and obese = 32.1%	Proportion of year 6 children overweight and obese = 37.8%

Better Worse

Rural deprivation and inequalities

Fact box:

The English Indices of Deprivation[1] (IoD) give an indication of how deprived an area is compared to all other areas of England based on a number of different types, or domains, of deprivation: income, employment, education and skills (distinguishing between children's and adults'), health, crime, barriers to housing and to services, and living environment (indoor and outdoor). The index of multiple deprivation (IMD) combines all of these into one single measure, assigning different weightings to the domains to reflect their impact on overall deprivation (see infographic on p12). Areas are often ranked by IMD and divided into quintiles (20% groups).

Overall Index of Multiple Deprivation across Herefordshire

As a county, Herefordshire experiences fairly average levels of overall, multiple deprivation. Nine out of 116 areas[7] of Herefordshire are amongst the 20% most deprived in England. These are all located in Hereford city and the market towns of Leominster, Ross-on-Wye and Bromyard. At the other end of the scale eight areas are in the least deprived 20% in England, mainly urban areas located north of the river within Hereford and in rural areas surrounding the city, in Ross-on-Wye, and Ledbury. The table below shows that although those areas classified as in the most deprived quintile are in urban locations, there are a significant number of people who live in areas considered to be in the second most deprived quintile in both rural and urban areas of Herefordshire.

Measures of deprivation are usually produced for geographies of about 1,500 people[8], which can mask smaller pockets of deprivation, particularly in rural areas. A study undertaken in 2008[9] revealed several such pockets of multiple deprivation in rural areas of Herefordshire that do not show up in the routine IMD. These areas, indicated on the map, were in or near Stanford Bishop parish (south of Bromyard), Weobley, Kingstone, Whitchurch (Goodrich Cross), Colwall, and Peterchurch.

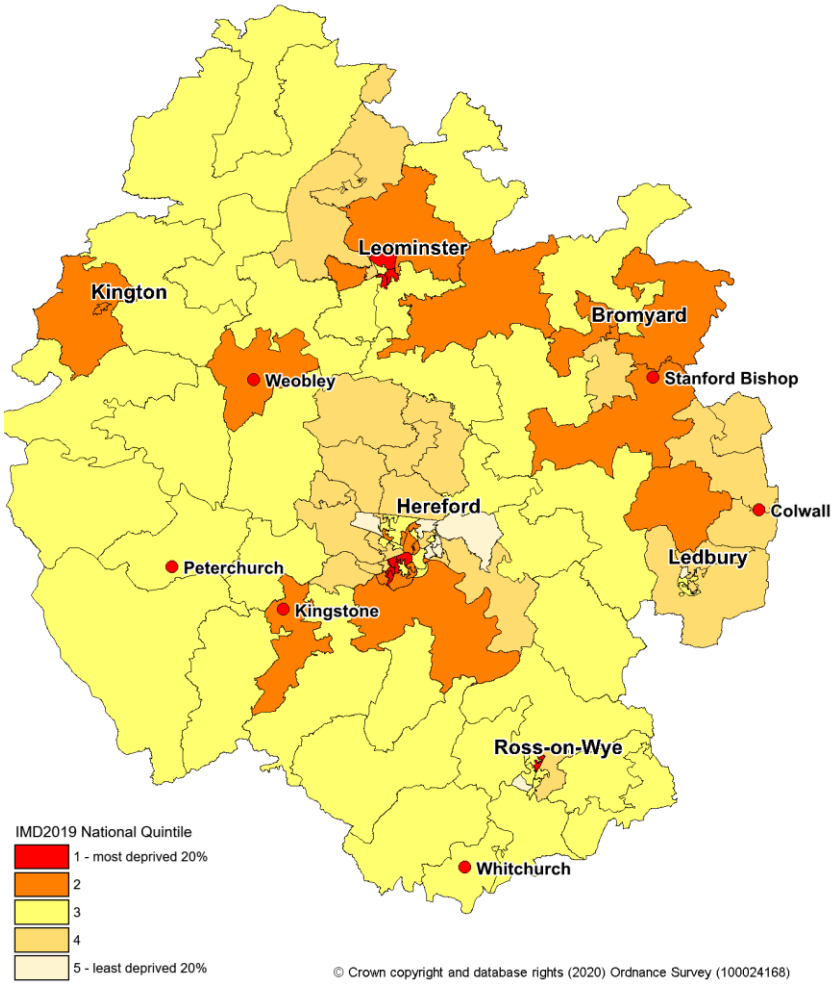
The distribution of overall deprivation around Herefordshire is shown in the map below.

[7] Areas refers to Lower Super Output Areas (LSOAs).
[8] LSOAs (Lower-layer Super Output Areas) are small areas designed by the Office for National Statistics to be of a similar population size, with an average of approximately 1,500 residents or 650 households.
[9] By the Oxford Consultants for Social Inclusion using the results of the 2004 Indices of Deprivation, see https://ocsi.uk/2008/07/04/ocsi-output-area-index-of-multiple-deprivation-data-available/. Note that the rankings won't necessarily be the same as those quoted in the rest of this report, which are from the 2019 Indices of Deprivation.

Herefordshire population, and percentage aged over 60 years, by rurality and deprivation (IMD2019 quintiles).

	Index of Multiple Deprivation ranking					
	1 (most deprived)	2	3	4	5 (least deprived)	Total
Total rural population estimate	0	18,900	53,200	24,500	3,900	100,500
% of whom are 60+ years		34%	35%	37%	25%	35%
Total urban population estimate	14,500	16,900	29,200	20,700	9,200	90,500
% of whom are 60+ years	21%	19%	26%	31%	34%	26%

Levels of deprivation around Herefordshire (IMD2019 quintiles) showing high levels in south Hereford and Leominster.

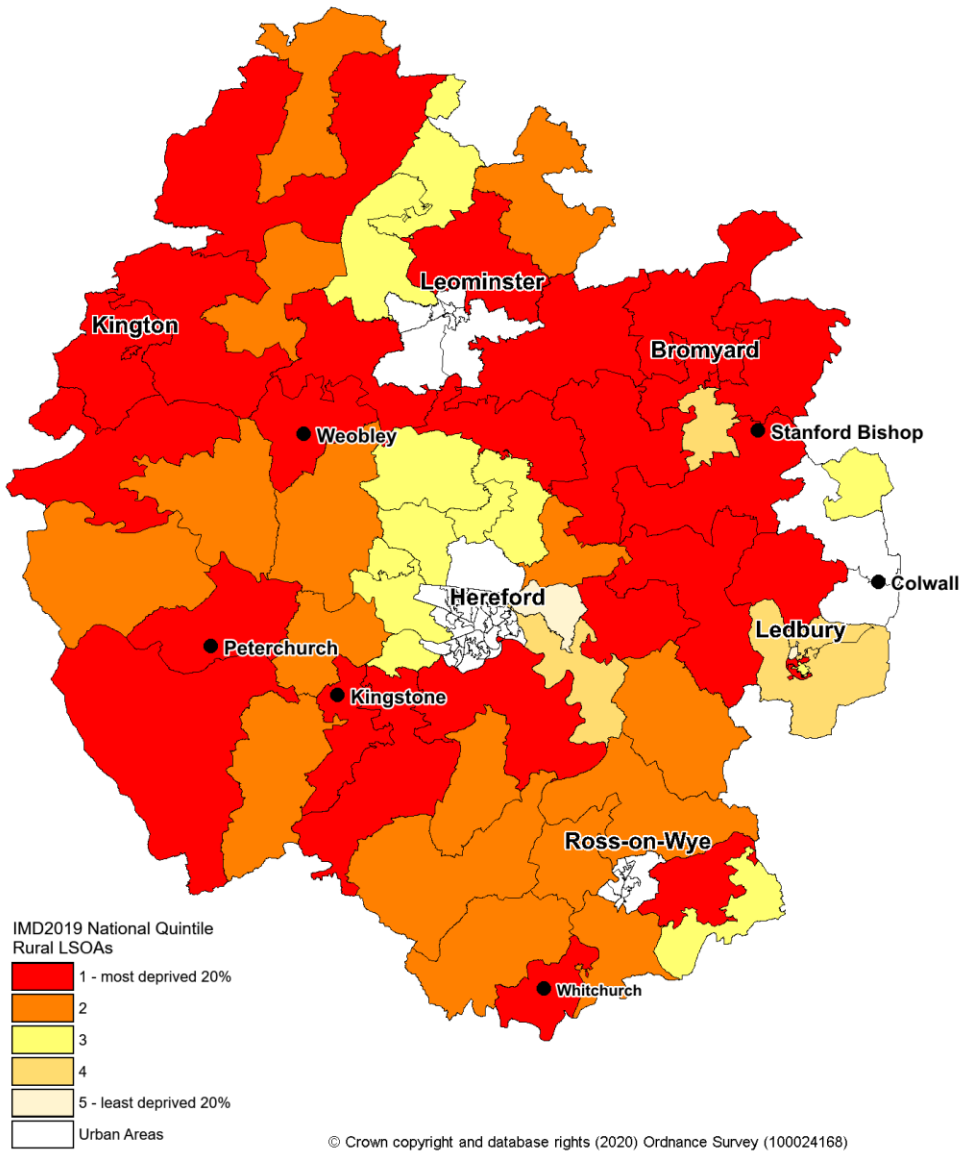


Comparison with other rural areas

The Indices of Deprivation measures were designed to focus on types of deprivation that tend to be most relevant in urban areas. Analysis excluding the urban areas of England highlights that Herefordshire, along with other border and some coastal counties, includes some of the highest levels of rural deprivation in the country[10]. Looking only at rural areas of England, of the 62 rural LSOAs across Herefordshire, almost half (28) fall within the 20% most deprived rural LSOAs nationally (see map below); including two which are in the most deprived 10% nationally – Bromyard Central and Greater Weobley.

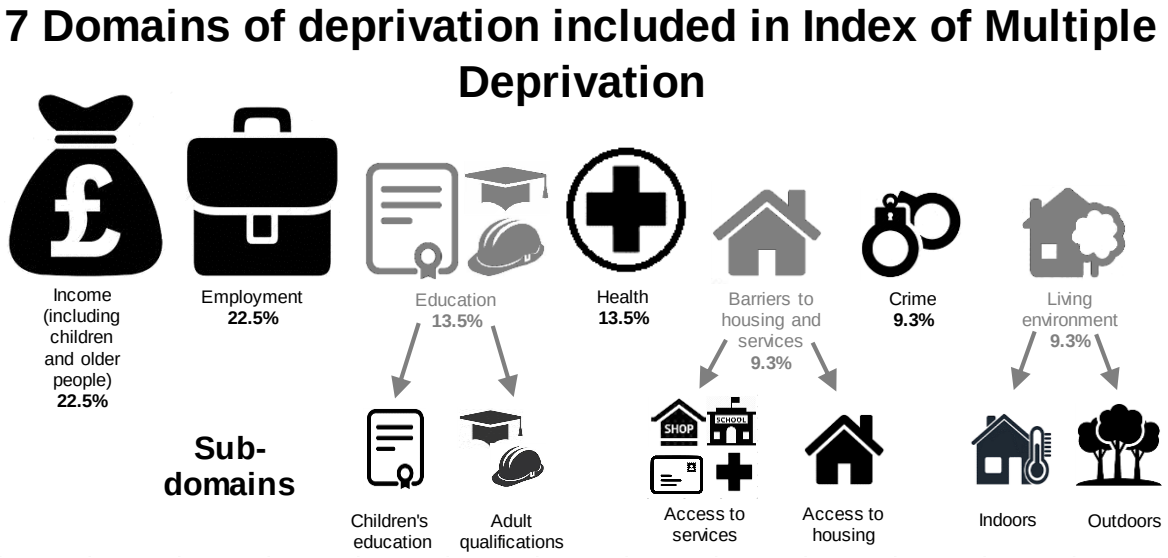
[10] Adapting deprivation indices for rural settings, Journal of Public Health, Volume 40, Issue 2, June 2018

Levels of deprivation around Herefordshire rural areas (IMD2019 quintiles) showing the high number of rural LSOAs within the 20% most deprived across England.

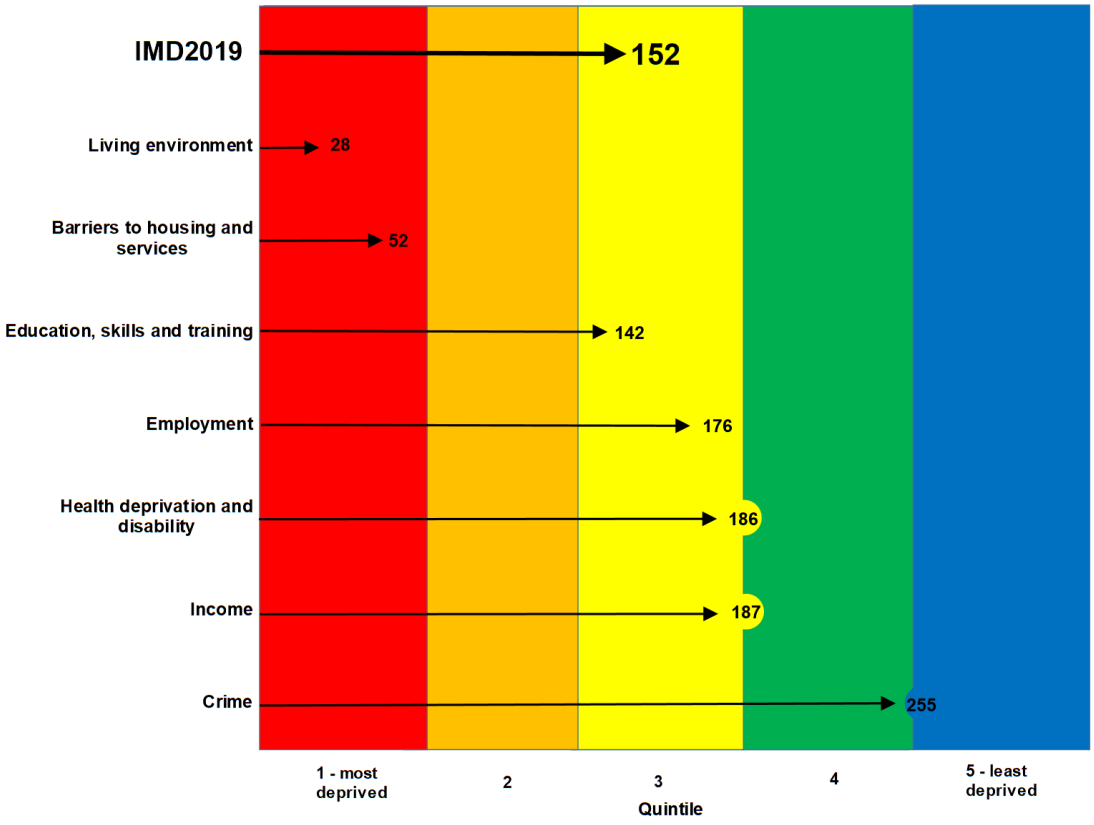


Key aspects (domains) of deprivation in Herefordshire

The domains that make up the index of multiple deprivation are shown in Infographic below, which includes the emphasis given to each domain in the overall IMD. When ranked against all 317 local authorities in England, the overall IMD score for Herefordshire and a number of other domains fall within the central national quintile. Although Herefordshire fairs well on "crime", it is particularly deprived in terms of "living environment" and "barriers to housing and services". We'll see later that this it is specifically the *indoor* living environment and geographical barriers to *services* that most affect Herefordshire.



Rank of Herefordshire scores for IOD2019 domains against national quintiles showing most falling within middle quintile as does the overall IMD2019 score.



The factors that drive an overall IMD can be very different, particularly between rural and urban areas. The chart above illustrates how the levels of two distinct types of deprivation are higher in rural areas compared to urban areas of Herefordshire. These are 'indoor living

environment' (i.e. housing in poor condition and housing without central heating) and 'access to services' (i.e. road distances to post office, primary school, GP surgery and general store/supermarket). Notably, these are the only types of deprivation for which either urban or rural Herefordshire falls into the most deprived 20% of England.

According to the Income Domain, 10% of the Herefordshire population live in income deprived households, which corresponds to 18,500 individuals and is lower than that for England as a whole (15%). A lower proportion of people in rural areas of Herefordshire live in income deprived households (8%), corresponding to 7,900 individuals. When considering the income sub-domains it is evident that across Herefordshire 12% of under 16s and 11% of people aged 60 and above live in income deprived households. Although these figures are lower than that for England (16% and 17% respectively), in some areas of south Hereford and Leominster as many as 30% of children and 32% of older people live in income deprived households. In general, a lower proportion of residents of rural areas live in income deprivation: 9% of children and 8% of older people compared to 15% and 13% respectively in urban areas. However, this still equates to approximately 1,200 children and 3,200 older people living in income deprived households in a rural setting. Furthermore, the headline figure for Herefordshire's rural areas can mask pockets of deprivation and looking more closely it is evident that rural areas in and around the parishes of Kingstone, Wormbridge, Weobley, Weston under Penyard, Linton, Shobdon and Pembridge have child poverty rates of at least the national level.

Comparison of the types of deprivation affecting urban and rural Herefordshire: rural areas are amongst the most deprived in England in terms of indoor living environment and access to services.

What do we know about the two key drivers of deprivation in rural Herefordshire?

Indoor living environment: housing condition and warmth

Unhealthy homes (cold, damp or otherwise hazardous) increase the risk of respiratory illness, cardiovascular problems, excess winter deaths, and physical injuries - particularly from falls and domestic fires. In addition, fuel poverty adversely impacts on health and wellbeing through associated financial hardship. It has been shown that the death rate rises nearly 3% for every degree Celsius drop in the outdoor temperature for people in the coldest 10% of homes, compared with less than a 1% rise for people in the warmest 10% of homes.[11] Age Concern UK have estimated the cost to the NHS in England arising from cold homes to be around £1.36 billion per year.[12]

In 2019, Herefordshire Council commissioned a report from BRE (the Building Research Establishment) on the condition of the county's housing stock.[13] This found that overall Herefordshire housing stock is slightly worse than England in terms of disrepair, fuel poverty and falls hazards but significantly worse for all hazards[14] (25% compared to 12%) and for excess cold hazards (17% compared to 3%) than England. Owner occupied housing were found to have slightly higher levels of all hazards and excess cold. An overview of Herefordshire's housing stock is given in the infographic below.

Whilst on average fuel poverty was only slightly worse than England, there is considerable variation in fuel poverty across Herefordshire. Fuel poverty is found in higher concentrations in the more rural parts of Herefordshire: people living in rural areas of Herefordshire are 21% more likely to be subject to fuel poverty compared to urban areas.[15]

Rural households are more likely to be living in older, less thermally efficient, semi-detached or detached dwellings and to lack a connection to the mains gas grid. Such homes have larger surface areas to lose heat from, and there tends to be a higher proportion of older homes where little work has been done by the occupiers to improve energy performance in rural areas. Furthermore, fuel options for off-grid homes are often more expensive and less energy efficient than mains gas. Approximately, 40% of Herefordshire's dwellings stock is detached (compared to less than 25% nationally and regionally), 29% of detached dwellings were built pre-1900 (compared to 8% nationally and regionally) and around a third of dwellings in Herefordshire are not connected to mains gas. [13]

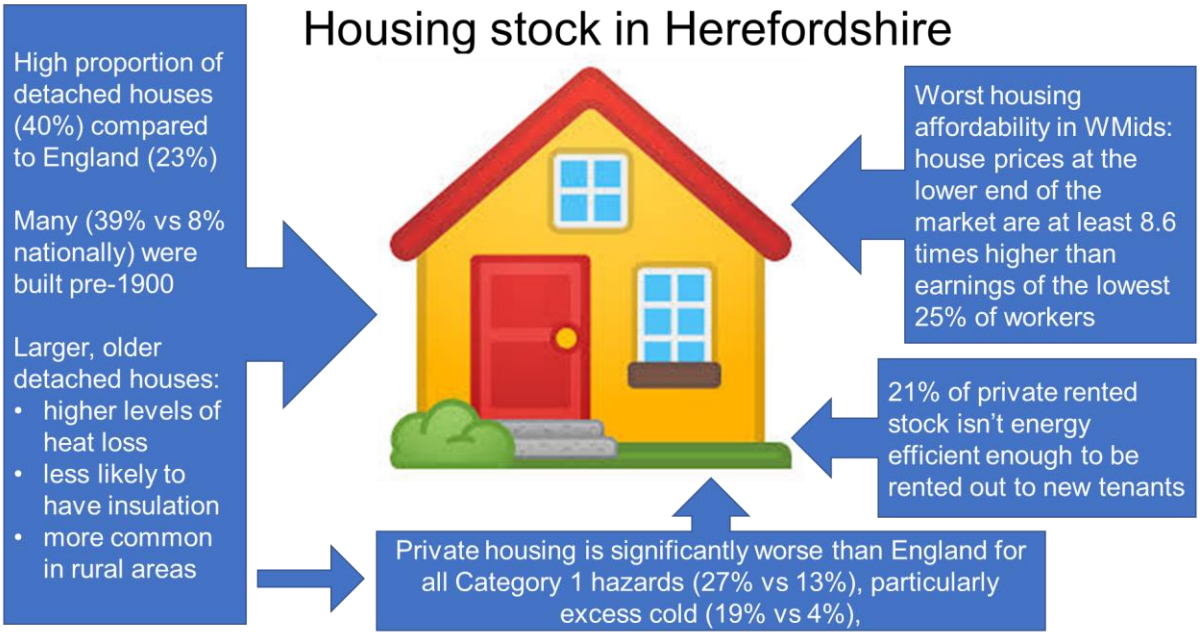
The drivers of fuel poverty (low income, poor energy efficiency and energy costs) are strongly linked to cold homes. The map below shows the percentage of households that are both low income and identified as excess cold: the highest percentages are found in the Golden Valley, Kington and Mortimer localities on the western border of the county. A

[11] Cold comfort Joseph Rowntree Foundation
[12] Age UK. The Cost of Cold, 2012. https://www.ageuk.org.uk/Documents/EN-GB/Campaigns/The_cost_of_cold_2012.pdf?dtrk=true
[13] BRE Integrated Dwelling Level Housing Stock Modelling and Database for Herefordshire Council, June 2019.
[14] The Housing Health and Safety Rating System (HHSRS) is a risk assessment tool used to assess potential risks to the health and safety of occupants in homes - the assessment method focuses on a list of 29 hazards that are most likely to be present in homes.
[15] Department for Business, Energy and Industrial Strategy LSOA level data for 2017 (released June 2019)

household is considered to be fuel poor if they have required fuel costs that are above average (the national median level) and, were they to spend that amount, they would be left with a residual income below the official poverty line.[16]

Affordability, poor quality housing and significant fuel poverty in the most rural areas are considered threats to the wellbeing and sustainability of communities.[17] The LGA reported that in rural communities there is often a lack of housing for people who cannot afford to rent privately or buy in rural areas, and that housing in the most rural areas is, on average, less affordable than in other types of area. In some areas this lack of housing now extends to those on average incomes, not just people on lower incomes, leading to people moving out of rural areas and increasing concerns about the sustainability of rural communities. This problem is particularly acute in Herefordshire, which is the worst area in the West Midlands for housing affordability. Across the county, house prices at the lower end of the housing market are at least 8.6 times higher than the annual earnings of the lowest 25% of earners.

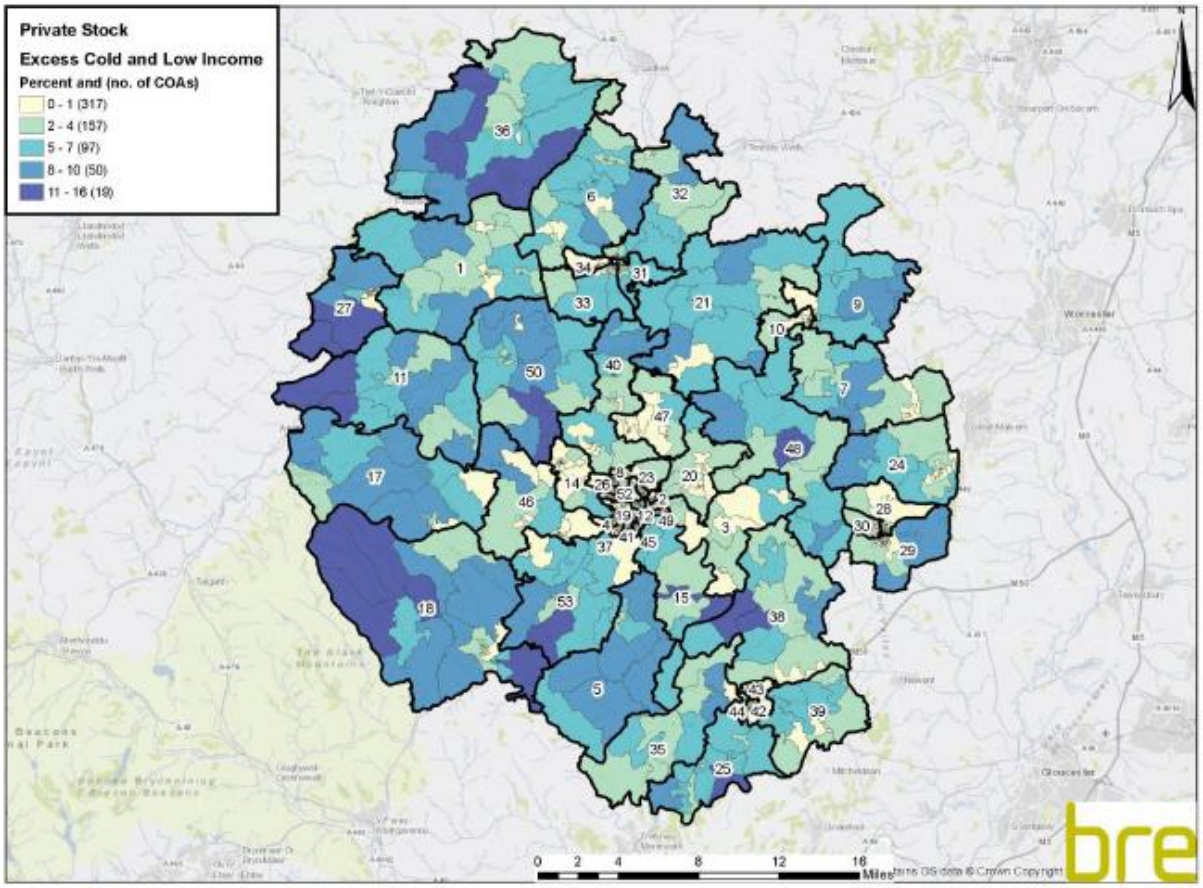
Figure: Overview of housing stock in Herefordshire



16 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808300/Fuel_poverty_factsheet_2019__2017_data_.pdf

17 LGA https://www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf

Output areas in Herefordshire with the highest percentages (darkest blue) of households that are both low income and identified as excess cold are found in the Golden Valley, Kington and Mortimer localities on the western border



Source: Building Research Establishment, 2019; data for census output areas

Access to services, amenities and communities in rural Herefordshire

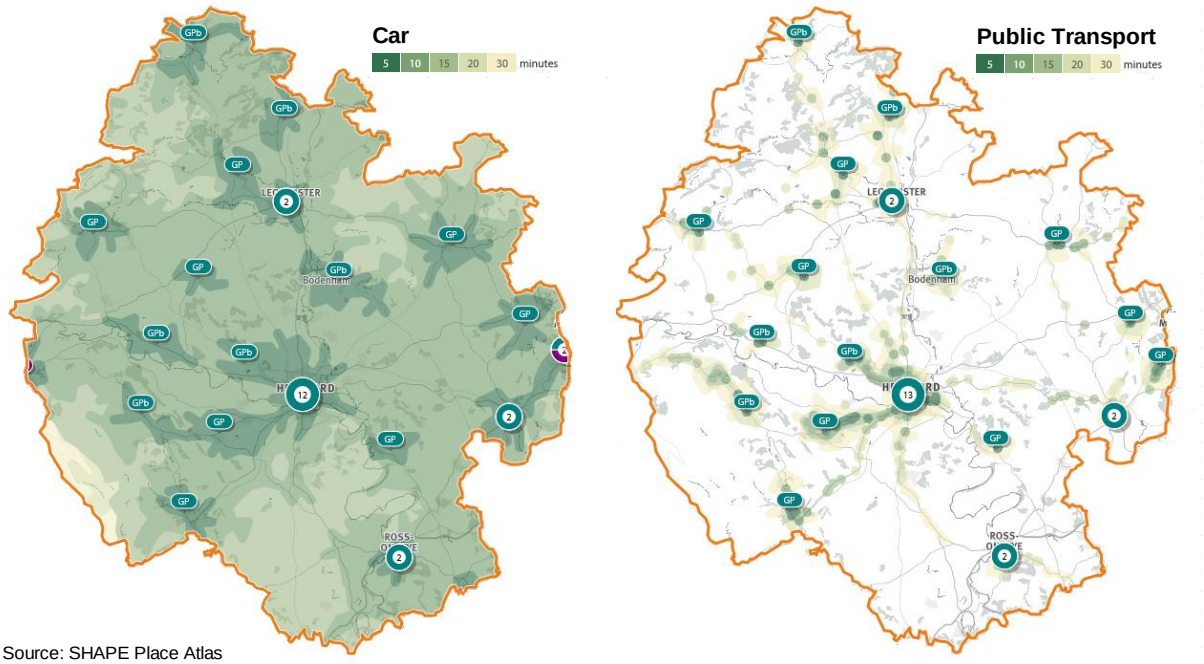
The sparsely populated nature of Herefordshire presents a unique challenge in terms of ensuring that everyone has good access to services and will have different impacts across the life-course of people living in rural areas and for vulnerable groups.

There are only four railway stations and the county is particularly dependent on road transport, with a road network that comprises mainly rural 'C' or unclassified roads leading off single carriageway 'A' roads. As an illustration, the maps in figure x show the travel times to one of the county's General Practices by i) road and ii) public transport. From many places travel to a Herefordshire GP by public transport is not possible and by road travel times exceed 20 minutes.[18] This reliance on car travel is particularly challenging for those who do not have their own transport or are unable to drive due to young age, old age, disability or poverty.

[18] Note that the available data includes travel times to GPs which are outside of the county, and at which some Herefordshire residents will be registered.

The long distances are costly to individuals, organisations, the economy and the environment. Across the Herefordshire and Worcestershire STP, the cost to patients of travelling to outpatient appointments has been estimated at £4.68 million in car travel, public transport and car parking; the cost to the economy from time spent travelling to outpatient appointments by patients who are working age and in employment has been estimated to be £17.8 million, 38% of which is travel time; and to neutralise the impact of the CO^2 emissions from outpatient car travel would require around 200,000 trees to be planted each year.[19] Clearly, for health and social care services provided in residents' homes, organisations incur travel costs and opportunity costs in rural areas which wouldn't necessarily be incurred in areas where people live more closely together.

Access times for Herefordshire residents to GP surgeries



Source: SHAPE Place Atlas

Outcomes and impact on people living in rural areas

Strengths of rural communities

Herefordshire has a strong sense of community: four out of five residents are satisfied with the area in which they live, and nine out of ten people feel that the members of their community treat each other with dignity and respect. There are high levels of community engagement in the county, as demonstrated by higher than national volunteering rates. A third of adults regularly give unpaid help to a group, club or organisation at least once a

[19] The Strategy Unit. The Economic Impact of Health and Social Care Services in Herefordshire and Worcestershire. NHS Midlands and Lancashire Commissioning Support Unit, 2019.

month. Just over a quarter feel they could influence decision-making in their local area, and a fifth had been part of a local decision-making group.[20]

A large number of people provide unpaid care for family members or friends, with estimates suggesting that as many as a third of adults provide at least an hour a week, and one in ten providing 50 or more hours per week. According to both the 2011 Census and the 2018 Herefordshire Quality of Life Survey[21], indications are that rates are slightly higher in rural areas than in towns or the city, although this may reflect the different age profiles of these areas. Estimates suggests that in Herefordshire unpaid care is worth £157.2 million a year in terms of opportunity cost of the leisure time foregone by carers, whilst the cost of replacing informal care with funded home care would be £294.3 million.[22]

Natural environment

According to Public Health England, an "ever-increasing body of research indicates that the environment in which we live is inextricably linked to our health across the life course."[23] Access to good quality green space is linked with better health outcomes. Research suggest that access can be problematic in rural areas due to lack of amenities (e.g. lighting, suitability of paths) or maintenance (e.g. play equipment).[24] The natural environment is a big asset for Herefordshire, supporting a wide range of habitats. Two Areas of Outstanding Natural Beauty cover parts of the county (Wye Valley and Malvern Hills). The richness of biodiversity is reflected in the number of sites designated for nature conservation, which cover 9% of the county's land area.

This is clearly valued by local people, with 'access to nature / green space' featuring as the most important aspect in making somewhere a good place to live in the 2018 Quality of Life Survey for the first time, and being rated as easy to access by 85% of respondents. The majority (60%) spent time outdoors daily, although conversely 13% had spent no time outside in the last week. Middle aged people spent more time outdoors than younger people.

Impact on children, young people and families

Income deprived families living in rural areas within the county are likely to have difficulty accessing services. Services for children and families, as with other facilities, tend to cluster in the urban areas. For example, in rural areas travel has been identified as a barrier to accessing dental care for children, particularly for parents without access to a car and where

[20] Cited in: Herefordshire VitalSigns 2018, The Herefordshire Community Foundation, p. 15. Available at: http://www.herefordshirecf.org/vitalsigns/
Original source: 2018 Herefordshire Quality of Life Survey. The results are not currently published.
[21] 2018 Herefordshire Quality of Life survey www.herefordshirecarerssupport.org/wp-content/uploads/2019/03/Hfds-Quality-of-life-2018-Carers-v-1.0E.pdf
[22] The Strategy Unit. The Economic Impact of Health and Social Care Services in Herefordshire and Worcestershire. NHS Midlands and Lancashire Commissioning Support Unit, 2019.
[23] Spatial Planning for Health: An evidence resource for planning and designing healthier places, Public Health England, 2017, p.6.
[24] Public Health England. Local action on health inequalities: Improving access to green spaces. 2014 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/357411/Review8_Green_spaces_health_inequalities.pdf

public transport was considered expensive and infrequent.[25] And, activities for teenagers was highlighted as one of the top five things most in need of improvement in the local area in the Herefordshire Quality of Life Survey.[26]

For young people in rural Herefordshire, getting to education, work or social activities often necessitates travelling by car on the county's network of country roads. Across England, the number of road traffic accidents that result in serious or fatal young car occupant injuries increases from the age of 17 and 18. Fatalities are associated with driving in the evening and early morning and with the 60mph roads more commonly found in rural areas.[27] Absolute numbers of children and young people who are harmed on Herefordshire's roads are small, with an average of around 25 under 25 year-olds killed or seriously injured as a result of road traffic accidents each year. A number of the official population-based rates are significantly higher than nationally (for example under 25s being casualties in road traffic accidents), but these measures can be affected by the sparsity of population in large rural areas, so it is worth noting that local rates are in line with similar rural authorities. Conversely, they are less likely to be injured as pedestrians than across England as a whole – another pattern seen in similar rural areas.

Road safety was an issue highlighted by children and young people who participated in the engagement activities to inform the children and young people's plan 2019-24: "We want Herefordshire roads to be safer for children and young people". Specifically mentioned were concerns about the dangers of traffic, and that the road surface on some roads can make them challenging to cycle on.

Special educational needs and disabilities (SEND) refer to learning difficulties or disabilities which can affect a child or young person's ability to learn, and require special educational provision to be made for them. For the majority, this means some extra help (SEN support) at school, but those who need more should have an education, health and care plan (EHCP) setting out their range of needs and the additional support to meet them.

Numbers of children with EHCPs in Herefordshire have increased more rapidly than in other similar areas since they were introduced 2015; in 2018 there were almost 900. Although somewhat over-represented in deprived areas, they are scattered all across the county – including in some of the most rural areas in the north- and south-west. Specialist schools in the county are mainly located in Hereford, which can mean longer journeys for those rural students who need to attend them. In addition, pressure on specialist education places has led to an increase in placements at schools further afield, both in and out of county. Both of these factors have also led to a disproportionate rise in the cost to the local authority of providing transport due to the distances and low passenger to vehicle ratios involved.

[25] Herefordshire Oral Health Needs Assessment.2019 https://understanding.herefordshire.gov.uk/media/1880/herefordshire-oral-health-needs-assessment-2019.pdf

[26] 2018 Herefordshire Quality of Life Survey: www.dataorchard.org.uk/case-studies/herefordshire-quality-of-life-survey

[27] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/695781/Reducing_unintentional_injuries_on_the_roads_among_children_and_young_people_.pdf

Analysis by the County Council Network and Local Government Authority has highlighted that these pressures are also affecting other rural areas[28].

Impact on working age adults

Individuals of working age living in the rural areas of Herefordshire are 40% less likely to experience employment deprivation compared to urban areas. However, Herefordshire has low wages, with 28% of county jobs paying less than the living wage of £8.75 an hour (2018) and an average (median full time) residents' salary in 2019 of just over £500 per week[29] – amongst the lowest 20% in England. The majority of residents who travel to get to work do so by driving themselves in a car or a van, and unsurprisingly this is most common in the most rural 'villages, hamlets and isolated dwellings': 80% compared to 61% of urban commuters and 66% of those in 'rural town and fringe' areas.

Low wages and transport have a significant impact on social mobility. Herefordshire is flagged as a 'cold spot' by the government's social mobility index. This means that it's one of the worst 20% of local authorities in England in terms of the chances that disadvantaged children will do well at school and go on to get a good job and secure housing. According to the 2017 index, the key driver of Herefordshire's poor social mobility rating is low wages: the progress of young people from disadvantaged backgrounds in Herefordshire is hindered by the job opportunities available in the county, making it harder for them to translate a good education into a well-paid job and a good standard of living as adults. Transport links play a part in social mobility: being further away from good jobs means that people either need to relocate or commute, both of which have costs that may prove a barrier, particularly for those from poorer backgrounds. In 2010, the Joseph Rowntree Foundation[30] estimated that people living in rural areas need to spend between 10% and 20% more on everyday requirements than people living in urban areas, principally due to dependency on cars for transport and domestic fuel costs

Impact on older people

Involuntary social isolation and loneliness can be more prevalent in rural areas, where there is a reliance on private road transport to access services and, increasingly, a lack of places to meet, such as community centres, pubs, or village halls.[31] Older people and those with disabilities are particularly at risk and the risk is higher in places without an engaged and active community.[32] Fortunately, Herefordshire has a relatively strong sense of community

[28] See for example www.local.gov.uk/school-transport-under-threat-bill-set-rise-ps12-billion-2024
[29] Office of National Statistics. Annual Survey of Hours and Earnings. Employee earnings in the UK statistical bulletins. Employee earnings in the UK.
https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours
[30] www.jrf.org.uk/report/minimum-income-standard-rural-households
[31] Commission for Rural Communities. Social isolation experienced by older people in rural communities. 2012
https://www.basw.co.uk/system/files/resources/basw_111815-1_0.pdf
[32] Public Health England and UCL Insitiute of Health Equity. Local action on health inequalities Reducing social isolation across the lifecourse. 2015
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

with high levels of engagement. However, it is estimated that 7% of people 65+ in England always or often feel lonely[33].

The physiological effects of ageing lead to increased prevalence of long-term health conditions and loss of functional ability, resulting in increased need for health and social care input. Accessing services requires the coordination of a range of resources, such as social support, information and transport. However, as older people are more likely to be deficient in one or more of these resources than other age groups, accessing services can present a barrier to older people, a fact exacerbated by living in rural areas where poorer access to services is most evident.

It is not just physical exclusion that can affect rural communities, digital exclusion can also be a concern.[34] Whilst digital exclusion is not confined to rural areas, its effects can be felt more acutely by those also experiencing geographical barriers to services associated with rural communities. Digital exclusion has been linked to deprivation, with social housing tenants, people on lower wages or who are unemployed, and people with registered disabilities much more likely never to have used the internet. Furthermore, over half of people who lack basic digital skills are aged over 65. Locally, it is estimated that around 7% of adults (16+) are not regular internet users (that's over 11,000 people). A recent survey of Telecare users in Herefordshire found that 52% of respondents did not use the internet, with a high proportion of these not wanting to use it. With services moving to digital platforms, it is important that we understand more about digital exclusion in the county and its impact on people living in isolated rural communities.

Vulnerable groups

Some groups of people are more at risk of inequality than others, regardless of where they live – whether in deprived areas or not, or in urban or rural. People with physical, mental, or learning disabilities; people with mental illness; those who were in care as children; people who are homeless, Gypsies, Travellers and Roma, and refugees and asylum seekers are all at higher risk of poor health and other outcomes. These groups are not exclusive and those who occupy multiple groups are particularly at risk.

Distinct from the other groups mentioned above, Gypsies and Irish Travellers are represented more in rural areas than in urban (according to the 2011 census, they represent 0.14 per cent of the population in rural areas, compared with 0.09 per cent in urban areas) and, as a result, are more likely to experience the effects of rural inequality. It is estimated there are 360 Gypsies, Roma and Travellers[35] in Herefordshire.

The UK Government has recognised that "Gypsies, Travellers and Roma are among the most disadvantaged people in the country and have poor outcomes in key areas such as health and education" and The House of Commons Women and Equalities Committee has described how "Roma and Traveller people feel that they are, at best, ignored and, at worst, actively discriminated against in public services and policy making."

[33] Age Concern and Help the Aged
[34] 2018 Herefordshire Quality of Life Survey: www.dataorchard.org.uk/case-studies/herefordshire-quality-of-life-survey
[35] Census 2011

Nationally, Gypsies and Travellers have the lowest rate of economic activity of any ethnic group, at 47%, compared with 63% for England and Wales. They also have the lowest educational attainment of all ethnic groups throughout their school years and are the group least likely to stay in education after the age of 18.

In 2011, 14% of Gypsies and Travellers described their health as “bad” or “very bad”, more than double the proportion of the “white British” group. Subsequent research undertaken by the University of Bedfordshire found that life expectancy is 10 to 12 years less than that of the non-Traveller population; 42% of English Gypsies are affected by a long term condition, as opposed to 18 per cent of the general population; and one in five Gypsy Traveller mothers will experience the loss of a child, compared to one in a hundred in the non-Traveller community. Gypsies and Travellers often experience poor access to healthcare with difficulties in registering with GPs with poor access to other services as a result, including health screening, home visits and access to secondary health care, a factor often exacerbated by a lack of cultural understandings on behalf of service providers.[36]

Gypsies and Travellers are more likely to be providing unpaid care and those who are settled are disproportionately likely to be living in social housing located in the most deprived areas. It has been suggested that welfare reforms (specifically benefits cap) and cuts to local authority budgets (specifically resulting in cuts to Traveller Education Services) have had a significant negative effect on Gypsy and Traveller communities.

Although available Herefordshire data is sparse, it is not unreasonable to assume that many of the issues affecting Gypsy and Traveller communities nationally are also being felt locally.

Access to healthcare is also an issue for migrant workers with a large proportion reporting not even trying to access healthcare due to perceived barriers to access to such as administrative issues, lack of understanding of how to access services, language barriers, fears of being arrested, and fear of unaffordable cost, and/or preference for services in their country of origin.[37,38]

Recently, a report by the National Rural Crime Network[39] highlighted the "hidden" problem of domestic abuse in rural areas, concluding that "for rural areas, the scale of the barriers faced is significantly greater than for urban victims. In rural areas a range of additional impacts stemming from geographic, cultural and social differences and isolation have an impact which makes reporting abuse a much harder thing to do for rural victims to the extent they may delay or inhibit reporting altogether."

[36] https://www.cqc.org.uk/sites/default/files/20160505%20CQC_EOLC_Gypsies_FINAL_2.pdf
[37] Migrant Workers Accessing Healthcare in Norfolk 2015. https://healthwatchnorfolk.co.uk/wp-content/uploads/2015/11/15-07-Migrant-Workers-Accessing-Healthcare-in-Norfolk.pdf
[38] Nuffield Foundation. Vulnerable migrants and wellbeing: a pilot study. 2019 https://www.doctorsoftheworld.org.uk/wp-content/uploads/2019/02/Final-report-February-2019-Project-43383.pdf
[39] www.ruralabuse.co.uk/

What are we doing to support the health and wellbeing of people living in rural areas?

As a newly appointed Director of Public Health in 2018 my focus was to strengthen the public health team, create a better understanding of the public health priorities in Herefordshire and embed a council wide approach to improving health and wellbeing and tackling health inequalities. Over the past year we have been working across the council and wider partners to support a new direction of travel, which will focus on building resilient communities and creating healthier places and spaces and considering the impact on health and wellbeing of all our decisions.

- Key strategic plans that are being taken forward by the council and partners which are working to reduce inequalities are set out below.

    - Herefordshire Council's County Plan makes commitments on improving "*the sustainability, connectivity and wellbeing of our county by strengthening our communities, creating a thriving local economy and protecting and enhancing our environment*". These ambitions and supporting programmes of work will sit well with supporting the health and wellbeing of our residents and communities in rural areas.

    - Herefordshire Children and Young People's Partnership plan has set out its priorities to enable children and young people to Be Safe from Harm; Be Healthy; Be Amazing and Feel Part of the Community. The action plan includes commitment to improve road safety, including through the development of community transport and rural transport hubs. Free travel[40] is currently provided for children to school with extended options for those on low incomes and college transport, as well as bus and bike initiatives for people trying to get into employment for whom travel is an issue. This year we will undertake a survey of children and young people to gain a better understanding of their wellbeing and lifestyles and will look at differences between those living in urban and rural settings.

    - Developing Talk Community as a council wide approach to strengthening communities and building health and wellbeing through the wider determinants of health. This is a wide ranging programme of work which aims to build strength, resilience, skills and inclusivity in communities; develop community hubs; develop healthy places, workplaces, travel and communities; and develop technology enabled living. The vision is for a system "*where independence and wellbeing are inevitable*". Two aspects of particular relevance to rural communities are:

        - The development of Talk Community hubs across the county, including rural areas, as part of Talk Community model aims to help people participate in their local community, support vulnerable people in their local community, reduce isolation and help communities to help

[40] Pupils attending their nearest suitable school are entitled to free transport if they live over 2 miles from school aged up to 8, and 3 miles if aged over 8.

themselves. The hubs will be rolled out over the next couple of years, with 50 established by the end of 2021.

- As part of the Talk Community initiative, we will be making a proposal to Cabinet that Herefordshire becomes a Sustainable Food County which will address the key issues of 1) promoting healthy and sustainable food to the public; 2) tackling food poverty, diet-related ill health and access to affordable healthy food; 3) building community food knowledge, skills resources and projects; 4) promoting a vibrant and sustainable food economy; 5) transforming catering and food procurement; and 6) reducing waste and the ecological footprint of the food system. We have mapped the work going on across the County around these issues and will be proposing an action plan to maximise the impact and address gaps. Rural communities will be key to this work, both because of the agricultural interests, but also as the solutions and innovations might need to be quite different to urban areas.

- As part of the NHS Long term Plan and the Wellbeing in all Decisions work, we are encouraging the NHS and other Anchor organisations in Herefordshire to utilise their capacity as large employers, commissioners of services and buyers of goods in the area to reduce health inequalities and improve conditions for local people. This includes improving recruitment processes, staff health and wellbeing and investing in the local area.

- We are working with Primary Care Networks to support them understanding the needs of their local population, including the impact of rurality and developing plans to connect with and support the community based offer in place or being developed through Talk Community.

- Herefordshire Council continues to commission the Keep Herefordshire Warm scheme for all residents, which provides advice, support and referrals in relation to fuel poverty and affordable warmth. A key part of this is referring eligible residents for home energy efficiency improvements ranging from first time central heating systems to suitable property insulation. The scheme will also be working with partners to draft an updated version of the County's Affordable Warmth Strategy in 2020.

- The Fastershire Broadband Project has helped increase broadband connectivity greatly, with over 90% of homes and businesses in Herefordshire now able to access superfast broadband. Fastershire's digital inclusion activities encourage new people to use the internet and benefit from this improved connectivity. The programme offers a range of free computer courses in communities, monthly workshops for beginners at the main libraries, and Go-online@fastershire grants to local organisations, as well as working with parish councils and voluntary groups. With services moving to digital platforms, it is important that we understand more about digital exclusion in the county and its impact on people living in isolated rural communities.

The Housing Strategy, which sets priorities and actions to address housing issues and needs, will be reviewed in 2020 and the provision of affordable rented homes in rural areas will be considered. I am heartened that as a council we are tackling some of the complex, intertwined issues of rural health, inequalities and an ageing population. There is a solid strategic platform on which to build. In implementing these plans we will need to remain vigilant to the needs of those most vulnerable in our county, especially when they are less visible, and the different challenges faced by our residents in rural and urban communities.

There are significant opportunities over the next 5 years to make a real impact in tackling rural inequalities and building stronger and more resilience communities. I would like this report to provide an important milestone in this journey and to use this report as benchmark against which we measure our success.

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Monday 10 February 2020**
Title of report:	**Better Care Fund Quarter 2 and Quarter 3 report 2019/20**
Report by:	**Director of adults and communities**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

As part of the statutory function of the board the purpose is to review the better care fund (BCF) quarter two and three performance reports and recommend any future improvements.

The better care fund (BCF) provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

In Herefordshire managing the demand remains a challenge for the system and pressures continue which has impacted on the non-elective admission target not being met. Achieving the ambition rates for the proportion of older people who were still at home 91 days after discharge from the reablement service continues to pose a challenge to partners. Although there continues to be a constant pressure for partners, in quarter three, the target for delayed transfers of care has been achieved. Integration plans and jointly agreed funding allocations are in place for the improved better card fund and partners continue to work together to progress these.

Further information on the subject of this report is available from
Amy Pitt, Tel: 01432 383758, email: apitt@herefordshire.gov.uk

Recommendation(s)

That:

(a) the better care fund (BCF) quarter two and three performance reports for 2019/20, at appendix 1 and 2 as submitted to NHS England, be reviewed; and

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

Alternative options

1. There are no alternative options. The content of the returns have already been approved by the council's director for adults and communities and Herefordshire Clinical Commissioning Group's (CCG) accountable officer and submitted prior to the meeting of the board, in accordance with national deadlines, however this gives the board an opportunity to review and provide feedback.

Key considerations

2. The national submission deadlines for the quarter two and three performance returns have already passed and therefore the board is requested to note the completed data, at appendix one and two, following its submission to NHS England.

3. The quarter two performance report only required information on the Improved BCF (iBCF) and this was specifically in relation to fees, this was due to the timings of the reporting which was during the planning and approval process of the 2019/20 BCF plan.

4. As detailed in the quarter three report, achieving the target rate for non-elective admissions, continues to pose a challenge to all partners. A number of key schemes continue to be delivered to assist in supporting individuals at home and avoiding admissions and to reduce demand, where possible. Managing the demand remains a challenge for the system.

5. As reflected in the quarter three report, recent performance indicates that Herefordshire is currently on track to meet the target for the national metric of reducing the rate of permanent admissions into residential care. Based on the last three months, there is potential by the end of the year the target will have been achieved. However, it should be noted, seasonal pressures could have an impact on the target being reached.

6. Quarter three report indicates that Herefordshire is currently not on track to meet the target for the proportion of older people who were still at home 91 days after discharge from the reablement service. Capacity within the service and demand continues. There is a focus on recruitment to meet demand and the recruitment for the post of Head of Integrated Community Services has been successful. The new post will support the delivery of the transformation programme by influencing, challenging and facilitating change to drive improvements across the health and wellbeing system. The role will build capacity and resilience within the services to promote wellbeing and sustain independence through a strengths based approach.

7. For the first three quarters of 2019-20, 72.3% of service users 65+ discharged from hospital into reablement were still at home 91 days later. Due to work recently undertaken, a significant amount of checks have been completed and therefore, for quarter three the

percentage still at home after 91 days is 77.5%, above the year to date performance indicating a move closer to the target of 80%.

8. Quarter three data demonstrates the overall delayed transfers of care (DToC) target has been achieved, however it continues to be a constant pressure. Investment in the urgent care part of the system has been undertaken and redesign of services, however demand still continues across the health and social care system in Herefordshire

9. To support DToC improvements, daily integrated DToC meetings are taking place to ensure the current delay codes are agreed on the day and a review of DToC codes has been undertaken with delays being recorded as jointly.

10. Furthermore, pre-screening for all new referrals to adult social care has commenced to ensure that priority work is focused on those patients that are about to become medically stable rather than responding to those that may not be ready for discharge.

11. Throughout quarter three partners have continued to discuss and develop integration arrangements. Development by three operational teams across different providers who have used patient, carer and peer review feedback to change the way they work, establishing an integrated model of care for adults requiring palliative and end of life care.

12. Winter pressures 2019/20 funding has been invested in additional capacity in home care, particularly for hard to place clients and rural areas of the county. Additional capacity in residential and nursing care homes, a mix of spot purchases of short-term and respite placements and a contract for long term nursing placements has also been invested in.

Community impact

13. The BCF plan is set within the context of the national programme of transformation and integration of health and social care. The council and CCG continue to work 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

14. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

    A public authority must, in the exercise of its functions, have due regard to the need to -

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

15. The council and CCG are committed to equality and diversity using the public sector equality duty (Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. All equality considerations are taken into account.

16. It is not envisaged that the recommendations in this report will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender, reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

17. The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the act. This is through improving the health and wellbeing of people in Herefordshire by enabling them to take greater control over their own health and the health of their families, and helping them to remain independent within their own homes and communities. There are no negative impacts for looked after children or with respect to the council's corporate parenting role.

Resource implications

18. The finance position of the better care fund represents the forecast outturn at month 8 (November 2019), most recent month available.

19. Overall the schemes that comprise the section 75 agreement have a net forecast overspend of £1,939k (3.2%), chiefly due to forecast overspends in Pool 2 (Additional Contributions to BCF) and Pool 5 (Children's Services), partially offset by underspends in Pool One (BCF) and Pool 3 (IBCF).

Section 75 Agreement- Summary of Pool Balances	Annual Plan	Forecast Out-turn M8	Forecast Over / (Under) Spend	% Over / (Under) Spend
	£,000	£,000	£,000	
Total Pool One- Mandated Revenue & Capital Contributions to BCF	14,942	14,744	(198)	(1.3%)
Total Pool Two- Additional Voluntary Contributions to BCF	34,552	35,221	669	1.9%
Total Pool Three- Improved Better Care Fund	5,703	5,392	(310)	(5.4%)
Total Pool Four- Winter Pressures Grant	881	881	0	0.0%
Total Pool Five- Children's Services	3,787	5,515	1,728	45.6%
Total Pool Six- Integrated Community Equipment Store (ICES)	1,300	1,350	50	3.9%
Total Section 75 Agreement Funding	61,165	63,104	1,939	3.2%

20. The table below shows a summary forecast outturn for the schemes that comprise the section 75 agreement. A more detailed forecast for each pool within the section 75 agreement is available upon request.

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 invited to review the content of the performance template, which is based on statistical and financial information and therefore the risk is minimal.

23. In relation to the iBCF funding element of this report, there is a risk that if the funding has not been spent in year, then the Department for Communities and Local Government may clawback any underspend at year end, which would reduce the impact and outcomes achieved. Actual spend is monitored by the better care partnership group (BCPG) on a monthly basis. Any slippage in spend will be identified as soon as possible and will be reallocated to other schemes, following the agreement from both the council and CCG.

24. There is a risk that the schemes invested in do not achieve the desired outcomes and impact planned. In order to mitigate this implementation milestones and clear outcomes have been agreed for each scheme, the delivery of which will be monitored on a regular basis by a dedicated project manager and reported to the BCPG.

25. Partners continue to work together to ensure sufficient schemes are in place and that the risks identified are mitigated. Quarterly reporting is undertaken to track performance and risk and reported to Adults directorate leadership team (DLT), Joint Commissioning Board (JCB) and the Integrated care alliance programme board (iCAB).

Consultees

26. The content of the returns have already been approved by the council's director for adults and communities and Herefordshire Clinical Commissioning Group's (CCG) accountable officer and submitted prior to the national deadlines.

Appendices

Appendix 1 – better care fund quarter two 2019/20 report

Appendix 2 – better care fund quarter three 2019/20 report

Background papers

None.

Further information on the subject of this report is available from
Amy Pitt, Tel: 01432 383758, email: apitt@herefordshire.gov.uk

Better Care Fund Template Q2 2019/20

2. Cover

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

- For this quarter no BCF related reporting is required accommodating planning and assurance timeframes. Only iBCF Grant related reporting is required in Quarter 2.

- As in previous quarters, the BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF Grant information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately.

Health and Wellbeing Board:	Herefordshire, County of
Completed by:	Emma Evans
E-mail:	evevans@herefordshire.gov.uk
Contact number:	01432 260460
Who signed off the report on behalf of the Health and Wellbeing Board:	Stephen Vickers, Director Adults and Communities

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'

Incomplete, please click on the links below to see a sheet breakdown

	Pending Fields
2. Cover	0
3. improved Better Care Fund	0

<< Link to Guidance tab

2. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C12	Yes
Completed by:	C14	Yes
E-mail:	C16	Yes
Contact number:	C18	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C20	Yes

Sheet Complete:	Yes

3. improved Better Care Fund

^^ Link Back to top

	Cell Reference	Checker
1. Average amount paid to external providers for home care in 18/19	D21	Yes
1. Average amount expected to pay external providers for home care in 19/20	E21	Yes
1. Uplift if rates not known	F21	Yes
2. Average amount paid for external provider care homes without nursing for clients aged 65+ in 18/19	D22	Yes
2. Average expected pay for external provider care homes without nursing clients aged 65+ in 19/20	E22	Yes
2. Uplift if rates not known	F22	Yes
3. Average amount paid for external provider care homes with nursing for clients aged 65+ in 18/19	D23	Yes
3. Average expected to pay for external provider care homes with nursing for clients aged 65+ in 19/20	E23	Yes
3. Uplift if rates not known	F23	Yes

Sheet Complete:	Yes

^^ Link Back to top

Better Care Fund Template Q2 2019/20

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

Overall note for quarterly reporting in 2019/20 and Quarter 2:

As per the previous year, quarterly reporting for Better Care Fund (BCF) in 2019/20 will continue to act as single collection mechanism for standard BCF related reporting and iBCF Grant related reporting. With the inclusion of the Winter Pressures Grant into the Better Care Fund pool, any reporting required for that purpose will also be carried out via the BCF reporting mechanism.

Wider BCF reporting is not required for Quarter 2, to accommodate the BCF planning and assurance timeframes, and will commence from Quarter 3.

The details of each sheet within the template are outlined below.

Checklist (1.Cover)

1. This section on the cover sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Clicking on the corresponding 'Cell Reference' column will link to the incomplete cell for completion. Once completed the checker column will change to 'Green' and contain the word 'Yes'
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. improved Better Care Fund

Please fill the sections out on sheet '3. iBCF'. To report on the additional iBCF Grant quarterly reporting for your local area.

To reflect this change, and to align with the BCF, data must now be entered on a Health and Wellbeing Board level.

Specific guidance on individual questions is present on the relevant tab.

Better Care Fund Template Q2 2019/20

3. Additional improved Better Care Fund

Selected Health and Wellbeing Board: Herefordshire, County of

Additional improved Better Care Fund Allocation for 2019/20: £ 1,241,926

These questions cover average fees paid by your local authority (including client contributions/user charges) to external care providers for your local authority's eligible clients.
The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

We are interested ONLY in the average fees actually received by external care providers for your local authority's eligible supported clients (including client contributions/user charges). Specifically the averages SHOULD EXCLUDE:
- Any amounts that you usually include in reported fee rates but are not paid to care providers e.g. your local authority's own staff costs in managing the commissioning of places.
- Any amounts that are paid from sources other than eligible local authority funding and client contributions/user charges, i.e. you should EXCLUDE third party top-ups, NHS Funded Nursing Care and full cost paying clients.

Respecting these exclusions, the average fees SHOULD INCLUDE:
- Client contributions /user charges.
- Fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.
- Fees that did not change as a result of the additional IBCF allocation, as well as those that did. We are interested in the whole picture, not just fees that were specifically increased using additional iBCF funding.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing requested below (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) **please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:**

1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

If you are unable to provide rates for both 2018/19 and 2019/20, please ensure that you provide the estimated percentage change between 2018/19 and 2019/20 in the table below.
Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	For information - 2018/19 fee reported in Q2 2018/19	2018/19 fee. If you have newer/better data than at Q2 2018/19, enter it below and explain why it differs in the comments. Otherwise enter the Q2 2018/19 value	2019/20 fee on a consistent basis with the 2018/19 fee in Column D	If 2019/20 rates not yet known, please provide the estimated uplift as a percentage change between 2018/19 and 2019/20
1. Please provide the average amount that you paid to external providers for home care in 2018/19, and on the same basis, the average amount that you expect to pay in 2019/20. (£ per contact hour, following the exclusions as in the instructions above)	£16.29	£16.29	£18.02	
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+ in 2018/19, and on the same basis, the average amount that you expect to pay in 2019/20. (£ per client per week, following the exclusions as in the instructions above)	£518.00	£560.00	£625.58	
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+ in 2018/19, and on the same basis, the average amount that you expect to pay in 2019/20. (£ per client per week, following the exclusions in the instructions above)	£721.00	£623.00	£642.80	
4. If you would like to provide any additional commentary on the fee information provided please do so (particularly if your 2018/19 fee is different from that reported at Q2 2018/19). Please do not use more than 250 characters.		The revised 2018/19 figures are based on more recent data and therefore more accurate and more consistent with the basis used for 2019/20.		

Footnotes:
- ".." in the column C lookup means that no 2018/19 fee was reported by your council in Q2 2018/19

Planned impact on fees paid to external care providers, Self-reported local authority returns
Quarter 2 2018/19

2018-19 figures are indicative planned figures as reported at Quarter 2; National Statistic unit cost outturn data are produced by NHS-Digital using the Adult Social Care Finance Return (ASC-FR) and published annually in the Adult Social Care Activity and Finance Report.*

		Average amount paid to external providers for home care (£ per contact hour)			Average amount paid to external providers of care homes without nursing for clients aged 65+ (£ per client per week)			Average amount paid to external providers of care homes with nursing for clients aged 65+ (£ per client per week)			Additional Comments
ONS Code	Local authority	2017-18	2018-19	% Change 2017-18 to 2018-19**	2017-18	2018-19	% Change 2017-18 to 2018-19**	2017-18	2018-19	% Change 2017-18 to 2018-19**	
E09000002	Barking & Dagenham	£15.90	£16.38	3.0%	£565	£580	2.7%	£575	£590	2.6%	The home care hourly rate was increased by 3% while the residential and nursing rates increased by 2.7%.
E09000003	Barnet	£17.06	£18.00	5.5%	£602	£626	4.0%	£697	£725	4.0%	
E08000016	Barnsley	£15.30	£15.76	3.0%	£434	£462	6.5%	£434	£462	6.5%	
E06000022	Bath & North East Somerset UA	£26.17	£25.69	-1.8%	£739	£740	0.1%	£720	£734	1.9%	Home Care values in 2018-19 based on current users of the service; weekly cost will be revised as next two quarters data submitted
E06000055	Bedford UA	£15.54	£16.01	3.0%	£564	£580	2.8%	£586	£592	1.0%	
E09000004	Bexley	£13.84	£16.08	16.2%	..	..	5.0%	..	..	5.0%	Home care rates: £14.88 (from April 2018) and £16.08 (from Oct 2018). D2A is set at £17.16 and Reablement at £16.44. Ave weekly gross cost of care home placements for over-65s was £661 in 2017/18 and is expected to be £694 in 2018/19 (+5%).
E08000025	Birmingham	£13.44	£13.73	2.2%	£521	£560	7.5%	£533	£592	11.1%	
E06000008	Blackburn with Darwen UA	£12.98	£13.53	4.2%	£590	£592	0.2%	£711	£643	-9.5%	Actual provider rate increases (3%) are not immediately evident in the average rates due to the method of calculation which takes into account actual activity and care package changes throughout the year.
E06000009	Blackpool UA	£14.02	£14.26	1.7%	£487	£490	0.6%	£508	£519	2.2%	Care at home hourly rates calculated for all clients, aged 18+ using sum of hours provided in period and total cost for those hours calcuated as average cost per hour. 65+ Residential and Nursing costs have been provided for long-term provision only.
E08000001	Bolton	£14.62	£15.57	6.5%	£487	£530	8.8%	£486	£529	8.8%	17/18 res and nursing figures from 17/18 ASC-FR. 18/19 res and nursing figures derived from applying inflationary uplift to 17/18.
E06000058	Bournemouth and Poole	£18.17	£18.48	1.7%	£620	£639	3.1%	£711	£734	3.2%	Residential and Nursing are based on council paid fees and exclude the sec 117 contribution to bed price paid directly by CCG.
E06000036	Bracknell Forest UA	£16.80	£17.63	4.9%	£782	£781	-0.1%	£861	£838	-2.7%	Rates have reduced this year- we have alleviated pressure on bed prices through the block contract. As per the guidance, the average rates exclude FNC, which is paid directly by the CCG.
E08000032	Bradford	£14.03	£15.44	10.0%	£482	£509	5.6%	£501	£533	6.4%	Above is average only. Actuals are paid on a vast range with a framework base rate plus negotiated amounts between provider, MDT/SW and SU's
E09000005	Brent	£14.68	£15.07	2.7%	£608	£616	1.3%	£737	£774	5.0%	
E06000043	Brighton & Hove UA	£17.54	£17.78	1.4%	£618	£651	5.3%	£779	£815	4.6%	The 2018/19 expected average payment is subject to changes in demand
E06000023	Bristol UA	£16.82	£17.68	5.1%	£779	£692	-11.2%	£798	£706	-11.5%	Bristol set a provider rate for those over 65 in a residential and nursing setting for 2018/19, prior to that a form of Dynamic Purchasing System (DPS) was used for individual placements as a result the rates for 2017/18 is the average rate paid.

E09000006	Bromley	£14.36	£15.04	4.7%	£656	£685	4.4%	£692	£714	3.2%	
E10000002	Buckinghamshire	£18.13	£19.44	7.2%	£745	£717	-3.8%	£918	£905	-1.4%	These residential and nursing figures include block and spot provisions.
E08000002	Bury	£14.60	£15.07	3.2%	£460	£476	3.5%	£615	£634	3.1%	N.B. 2017/18 home care rate is w.e.f. 1.9.17 following reprocurement
E08000033	Calderdale	£15.27	£15.90	4.1%	£477	£497	4.2%	£522	£544	4.2%	Above exclude 65+ for LD MH PD Home Care - The external providers are now Approved Provider List and under set hourly rate which reflects NLW & is modelled on UKHCA pricing mechanism. Current rate is £15.90 (urban) and £16.65 (rural).
E10000003	Cambridgeshire	£16.06	£16.12	0.4%	£508	£553	8.9%	£728	£768	5.5%	We have seen average care costs consistently increasing.
E09000007	Camden	£18.12	£17.40	-4.0%	£730	£753	3.2%	£716	£731	2.1%	Residential & Nursing fees are based on comparison from 2017/18 - 2018/19. Homecare rates will be reduced in 2018/19 following the procurement of new homecare contracts through competitive tender.
E06000056	Central Bedfordshire UA	£17.70	£20.22	14.2%	£552	£605	9.6%	£572	£625	9.3%	Our fee rates have been uplifted to reflect the National Living Wage increase. For domiciliary care this was 3% . We have framework contracts for care homes and domiciliary care but we also spot contract for these services.
E06000049	Cheshire East UA	£14.20	£16.33	15.0%	£436	£462	6.0%	£475	£503	5.9%	
E06000050	Cheshire West and Chester UA	£14.74	£15.32	3.9%	£455	£474	4.2%	£498	£532	6.8%	The boxes above do not allow us to show EMI and Standard placements seperately so these have been wrapped up into one figure. The care at home rates are based purely on standard care at home for the 65+ age group. This does not include MH or LD.
E09000001	City of London	£21.00	£21.65	3.1%	£655	£633	-3.4%	£728	£494	-32.1%	All our residential and nursing care is spot purchased based on need. The figures for 18/19 are based on our packages year to date.
E06000018	City of Nottingham UA	£15.52	£15.80	1.8%	£551	£569	3.3%	£578	£607	5.0%	The average costs for Residential / Nursing are for long term placements only and do not include citizens with a primary support reason of Mental Health or Learning Disability.
E6000052 & E6000053	Cornwall and Isles of Scilly	£17.09	£18.88	10.5%	£663	£699	5.5%	£761	£811	6.5%	Home care: Budgeted Rate (Weighted for introduction to Foundation Living Wage in June '18. Care homes: 2018/19 average is calculated using snapshot data as at May 2018 and therefore subject to change as we move through the year.
E08000026	Coventry	£13.96	£14.24	2.0%	£476	£495	4.0%	£500	£503	0.6%	
E09000008	Croydon	£15.53	£16.00	3.0%	£432	£478	10.6%	£718	£756	5.3%	We are currently conducting a cost of care exercise with KPMG to finish Novemeber. This may lead to change of rates in year and will form policy decisions for 2019/20
E10000006	Cumbria	£15.80	£17.02	7.7%	£559	£589	5.4%	£604	£646	7.0%	n/a
E06000005	Darlington UA	£13.87	£14.20	2.4%	£488	£523	7.2%	£504	£609	20.8%	
E06000015	Derby City UA	£16.67	£17.18	3.1%	£504	£521	3.3%	£489	£506	3.6%	none
E10000007	Derbyshire	£21.31	£22.35	4.9%	£490	£555	13.3%	£513	£581	13.3%	
E10000008	Devon	£17.96	£18.64	3.8%	£553	£605	9.4%	£607	£679	11.9%	
E08000017	Doncaster	£14.84	£15.52	4.6%	£485	£510	5.2%	£505	£527	4.4%	Homecare rates based on standard contracted homecare rates. Residential and Nursing Residential rates based on data as at 31/03/18 for 17/18, and 17/09/18 for 18/19.
E06000059	Dorset	£20.00	..	2.5%	£803	..	2.5%	£743	..	2.5%	n/a
E08000027	Dudley	£14.12	£14.12	0.0%	£452	£460	1.8%	£496	£507	2.2%	
E06000047	Durham UA	£13.64	£14.20	4.1%	£543	£562	3.5%	£561	£582	3.7%	N/A

E09000009	Ealing	£15.16	£15.97	5.3%	£559	£576	3.0%	£578	£600	3.8%	Inflation pressures for care homes and home care are being negotiated in the region of 3-4%. BCF includes a contribution of £295k from the NHS towards inflationary pressures.
E06000011	East Riding of Yorkshire UA	£15.85	£16.48	4.0%	£485	£514	6.0%	£522	£563	7.9%	
E10000011	East Sussex	£17.37	£17.98	3.5%	£532	£560	5.3%	£564	£586	3.9%	
E09000010	Enfield	£14.00	£14.31	2.2%	£589	£599	1.7%	£595	£605	1.7%	average reflects all cases. New cases with dementia typically attract rates of between £700-£850 p.w.
E10000012	Essex	£14.94	£15.95	6.8%	£486	£492	1.2%	£603	£626	3.8%	
E08000037	Gateshead	£13.76	£15.38	11.8%	£551	£581	5.4%	£551	£581	5.4%	Represents band 1 rates. EMI rate is £605. Residential and nursing care paid at same rate for LA care with FNC payable in addition for nursing
E10000013	Gloucestershire	£19.28	£19.87	3.1%	£578	£591	2.2%	£709	£703	-0.8%	
E09000011	Greenwich	£14.72	£15.82	7.5%	£842	£854	1.4%	£669	£678	1.3%	
E09000012	Hackney	£16.34	£17.05	4.3%	£619	£653	5.5%	£635	£671	5.7%	
E06000006	Halton UA	£13.59	£14.75	8.5%	£404	£417	3.2%	£621	£650	4.7%	N/A
E09000013	Hammersmith & Fulham	£16.92	£17.14	1.3%	£885	£878	-0.8%	£663	£698	5.3%	Nothing further to add in Q2
E10000014	Hampshire	£17.30	£19.17	10.8%	£608	£665	9.4%	£650	£722	11.1%	17/18 rate estimate in 3. adjusted to reflect actual. Following price review rates have been revised across all care settings
E09000014	Haringey	£14.22	£14.21	-0.1%	£699	£731	4.6%	£746	£811	8.7%	
E09000015	Harrow	£14.16	..	4.4%	£642	..	4.4%	£588	..	4.4%	Inflationary uplift expected to be agreed up to a maximum of 4.4% (based on the increase in the national living wage) for those providers requesting an increase
E06000001	Hartlepool UA	£15.17	£15.94	5.1%	..	..	3.7%	..	..	3.7%	
E09000016	Havering	£16.43	£16.92	3.0%	£609	£626	2.8%	£553	£579	4.7%	N/A
E06000019	Herefordshire UA	£15.90	£16.29	2.5%	£491	£518	5.5%	£681	£721	5.9%	
E10000015	Hertfordshire	£20.45	£19.65	-3.9%	£562	£567	0.9%	£581	£593	2.1%	iBCF funds are not being directly utilised for residential care therefore these fields have not been completed.
E09000017	Hillingdon	£15.56	£16.13	3.6%	£538	£554	2.9%	£569	£599	5.2%	
E09000018	Hounslow	£16.00	£18.00	12.5%	£770	£777	0.8%	£712	£736	3.4%	Residential and nursing uplifts not yet applied but likely to be 4% and 5% respectively
E06000046	Isle of Wight UA	£16.88	£17.60	4.3%	£528	£552	4.5%	£682	£735	7.8%	
E09000019	Islington	£16.50	£17.16	4.0%	£643	£691	7.5%	£682	£749	9.8%	
E09000020	Kensington & Chelsea	£16.13	£16.76	3.9%	£721	£744	3.2%	£817	£838	2.6%	2. and 3. are for Permanent Placements Only, no short term placements included
E10000016	Kent	£17.38	£19.39	11.6%	£490	£523	6.7%	£586	£618	5.5%	
E06000010	Kingston upon Hull UA	£15.13	£15.95	5.4%	£447	£477	6.7%	£465	£483	3.9%	Average nursing rate for 17/18 revised down from 17/18 Q2 submission as some FNC payments appear to have previously been included in error.
E09000021	Kingston upon Thames	£15.00	£16.00	6.7%	£771	£768	-0.4%	£770	£791	2.7%	It is difficult to secure placements at average costs in Borough. The averages mask a wide range and particularly premiums being charged for clients with advanced dementia. This will drive price increases in the medium term
E08000034	Kirklees	£15.23	£15.88	4.3%	£523	£540	3.3%	£588	£596	1.4%	
E08000011	Knowsley	£12.50	£14.50	16.0%	£442	£477	7.9%	£471	£488	3.6%	The figures supplied are based on standardised rate values for each year. The residential and nursing figure have been averaged out to take into consideration the higher rate paid for EMI support.
E09000022	Lambeth	£17.44	£17.96	3.0%	£619	£658	6.3%	£605	£660	9.1%	
E10000017	Lancashire	£13.55	£13.98	3.2%	£488	£506	3.7%	£547	£507	-7.3%	
E08000035	Leeds	£15.06	£15.29	1.5%	£525	£549	4.6%	£539	£571	5.9%	A further increase of 6.7% has been agreed for Home Care to enable a minimum wage of £8.25 to be paid. This increase and the Care home increases have been made via recurrent iBCF to ensure sustainability of the local care market.

E06000016	Leicester City UA	£14.72	£15.24	3.5%	£540	..	4.1%	£524	..	4.1%	Fee increase for 2018/19 not yet finalised, current proposal above
E10000018	Leicestershire	£15.96	£16.71	4.7%	£559	£583	4.3%	£559	£583	4.3%	The average amounts paid to external residential and nursing providers are taken from the ASC Finance Return. The 18/19 indicative price is based on 17/18 and uplifted by 4.3% in line with The Council's agreed fee uplift.
E09000023	Lewisham	£17.06	£17.68	3.6%	£659	£682	3.5%	£668	£686	2.7%	
E10000019	Lincolnshire	£15.36	£16.13	5.0%	£474	£504	6.3%	£485	£531	9.5%	n/a
E08000012	Liverpool	£13.62	£14.32	5.1%	£407	£426	4.7%	£445	£466	4.7%	
E06000032	Luton UA	£14.45	£15.70	8.7%	£568	£579	1.9%	£597	£609	2.0%	The average fee is based on current placements as at October 2018. It includes all Older Person client groups including 65+ Learning Disability and Mental Health need clients
E08000003	Manchester	£13.90	£15.20	9.4%	£506	£516	2.0%	£557	£561	0.7%	1) H/care figure for 17/18 taken from ASC FR return (for PD, MH & LD). H/care 18/19 figure is the Framework rate. None Framework/Spot providers used will be above & below £15.20 2&3) 18/19 based on year to date info at Aug 18 (covers PD, MH & LD) .
E09000024	Merton	£15.18	£15.70	3.4%	£691	£692	0.0%	£806	£816	1.1%	Care home fees vary between providers and placements. Uplifts for existing res & nursing placements have been between 2-3%, but we have used expensive providers less & negotiated some better fees with these so the increase is hidden in the average.
E06000002	Middlesbrough UA	£13.84	£15.00	8.4%	£525	£540	2.9%	£535	£581	8.6%	
E06000042	Milton Keynes UA	£16.73	£16.73	0.0%	£588	..	1.0%	£772	..	1.0%	The home care rates are consistent per hour through our home care providers framework. There are 4 zones in MK, and I have provided the average price per hour across the 4 zones.
E08000021	Newcastle upon Tyne	£13.90	..	5.0%	£701	..	6.0%	£689	..	6.0%	Figures given are taken from the ASC-FR return for 2017/18. Uplifts to contracts include NLW and apply from 1/4/18.
E09000025	Newham	£13.43	£14.00	4.2%	..	..	2.5%	..	..	3.1%	Estimates provided on increases expected from Nursing and Residentail Care - higher increases expected in Residential as start from a lower baseline.
E10000020	Norfolk	£16.48	£17.51	6.3%	£468	£497	6.2%	£488	£519	6.4%	Resi std rates above. Resi Enhanced £523/£556 and Nursing Enhanced £522/545 + FNC. iBCF investment in the market in 18/19 inc. inflationary pressures inc NLW £11.3m, cost of care increase for older people £1.7m and home care framework £2.1m.
E06000012	North East Lincolnshire UA	£13.12	£14.00	6.7%	£462	£456	-1.3%	£484	£476	-1.7%	Please note reduction of average weekly value for Nursing care between 17/18 and 18/19 is in the main due to high cost client within a small cohort. Average fees are also sensitive to the mix of quality payments attained by care home providers.
E06000013	North Lincolnshire UA	£14.73	£14.96	1.6%	£474	..	3.9%	£470	..	3.9%	
E06000024	North Somerset UA	£17.59	£18.93	7.6%	£545	£579	6.2%	£607	£630	3.8%	We have experienced upward pressure on prices in all areas of care. Causes cited include increases in the National Living Wage, pensions auto-enrolment case law on travel payments and for sleep-in duties. Unemployment is 25% below national average.
E08000022	North Tyneside	£14.00	£15.40	10.0%	£518	£549	6.0%	£524	£543	3.6%	Discussions with providers pending which could affect 17/18 and 18/19.
E10000023	North Yorkshire	£16.14	£16.94	5.0%	£555	£578	4.1%	£642	£668	4.0%	The above data for 2018/19 are based up estimates to August 2018

E10000021	Northamptonshire	£15.41	£15.92	3.3%	£560	£571	2.0%	£593	£610	2.9%	All figures are for people aged 65+. Expected average Homecare cost/hour based on service commitments to 31-03-18. Care Home with & without Nursing figures exclude top & bottom 5% (outliers).
E06000057	Northumberland UA	£14.36	£14.75	2.7%	£518	£536	3.5%	£520	£540	3.8%	
E10000024	Nottinghamshire	£15.52	£16.26	4.8%	£549	£555	1.1%	£576	£611	6.1%	
E08000004	Oldham	£14.58	£15.22	4.4%	£516	£522	1.2%	£570	£605	6.1%	
E10000025	Oxfordshire	£22.83	£23.73	3.9%	£677	£703	3.8%	£705	£753	6.8%	
E06000031	Peterborough UA	£14.07	£14.23	1.1%	£508	£513	1.0%	£708	£735	3.8%	We have seen average care costs consistently increasing.
E06000026	Plymouth UA	£14.05	£15.58	10.9%	£560	£573	2.3%	£619	£622	0.5%	
E06000044	Portsmouth UA	£16.31	..	4.0%	£570	£574	0.7%	£594	£615	3.5%	
E06000038	Reading UA	£16.80	£21.76	29.5%	£662	£739	11.6%	£727	£712	-2.1%	In home care Day / Night sitting is excluded, double up calls are included (hour cost x2 more than the regular price per hour). Residential price is up because of MH and LD clients have reached 65 but still in the original placements
E09000026	Redbridge	£13.82	£14.21	2.8%	£602	£618	2.7%	£546	£554	1.5%	
E06000003	Redcar & Cleveland UA	£13.97	£15.16	8.5%	£524	£547	4.4%	£679	£705	3.8%	
E09000027	Richmond upon Thames	£18.65	£19.25	3.2%	£741	..	1.1%	£1,099	..	1.1%	
E08000005	Rochdale	£14.36	£14.65	2.0%	£450	£470	4.4%	£450	£470	4.4%	A significant investment has also gone into an increase in supported living rates and the rate we pay for sleep ins at those properties. Overall 37% of the increases in fees in 2018/19 went against supported living increases.
E08000018	Rotherham	£14.51	£15.01	3.4%	£458	£469	2.4%	£502	£515	2.6%	
E06000017	Rutland UA	£16.46	£16.66	1.2%	£533	£543	1.9%	£530	£517	-2.5%	Avg cost for resi+nursing is affected by variable numbers of s117 clients @ higher cost. Small system so disproportionate impact of outliers. 2017-18 - we excluded an outlier client @£1750 pw (avg would otherwise be £653).
E08000006	Salford	£14.40	£14.40	0.0%	£442	£454	2.7%	£442	£454	2.7%	
E08000028	Sandwell	£12.96	£13.74	6.0%	£408	£421	3.2%	£409	£420	2.7%	None
E08000014	Sefton	£13.83	£14.50	4.8%	£475	£494	4.0%	£479	£498	4.0%	Nursing fees do not include the FNC rates (£155.05 & £158.16) which although we do pay in our contracted rate, we claim back from the CCG. The rates are a weighted average of the Standard & EMI rates
E08000019	Sheffield	£15.38	£16.00	4.0%	£389	£463	19.0%	£433	£463	6.9%	
E06000051	Shropshire UA	£16.94	£17.37	2.5%	£521	£551	5.8%	£672	£705	4.9%	
E06000039	Slough UA	£17.85	£18.00	0.8%	£854	£893	4.6%	£841	£873	3.8%	Prices are still being negotiated this year for providers on a case by case basis. The weekly cost of nursing care placements (net FNC) is slightly below the cost of residential due to numnber of long standing care placements.
E08000029	Solihull	£13.98	£15.01	7.4%	£566	£576	1.8%	£647	£670	3.6%	Significant additional funding was put in to homecare in order to ensure capacity and quality to support DToC.
E10000027	Somerset	£17.38	£18.00	3.6%	£506	..	5.5%	£547	..	4.9%	
E06000025	South Gloucestershire UA	£18.61	£19.55	5.1%	£666	£744	11.7%	£690	£735	6.5%	We have experienced upward pressure on prices in all areas of care. Causes cited include increases in the National Living Wage, pensions auto-enrolment case law on travel payments and for sleep-in duties. Unemployment is 25% below national average.
E08000023	South Tyneside	£13.00	£14.00	7.7%	£600	£690	15.0%	£725	£800	10.3%	predicted cost however at present in neg with care home providers

E06000045	Southampton UA	£15.05	£15.78	4.9%	£615	£638	3.7%	£745	£764	2.6%	Growth in the average cost of a care home placement should be viewed within the context of declining number of lower need placements owing to a more strengths based approach and increase in complexity which can't be met at standard rate
E06000033	Southend-on-Sea UA	£14.04	£14.72	4.8%	£485	£504	3.9%	£485	£504	3.9%	
E09000028	Southwark	£15.34	£16.96	10.6%	£624	..	2.0%	£611	..	2.0%	
E08000013	St Helens	£14.02	£14.95	6.6%	£511	£526	2.9%	£521	£541	3.8%	
E10000028	Staffordshire	£16.40	£16.70	1.8%	£515	£520	1.0%	£587	£593	1.0%	The price for residential and nursing care in 2018/19 is based on the 2017/18 average price plus 1% (annual inflation award). Care Home prices are increasing above this and we expect a significant overspend on OP Care Homes in 2018/19.
E08000007	Stockport	£14.12	£14.78	4.7%	£505	£557	10.3%	£525	£614	17.0%	Stnd rate of homecare mainly over 65's. Res/Nurs figures above ceiling rate price due to enhanced rate to secure beds.
E06000004	Stockton-on-Tees UA	£13.43	£13.84	3.1%	£502	£520	3.6%	£502	£520	3.6%	
E06000021	Stoke-on-Trent UA	£16.20	£16.20	0.0%	£445	£455	2.2%	£463	£474	2.4%	
E10000029	Suffolk	£17.60	£17.86	1.5%	£656	£671	2.3%	£691	£706	2.2%	The figures here are based on our new finance package for adult social care: ContrOCC. The data has been cleansed upon migration from our old system, so these amounts may differ from previous forecasts.
E08000024	Sunderland	£13.25	£13.50	1.9%	£574	£598	4.2%	£581	£604	4.0%	The figures above for residential and nursing are the EMI rates. The non EMI rates are £555 and £578 for both types of home
E10000030	Surrey	£16.47	£16.91	2.7%	£703	£729	3.7%	£777	£790	1.7%	HBC rates changed October 17 so 17/18 average is based on two rates. 18/19 average should predominantly be on one rate.
E09000029	Sutton	£15.00	£16.50	10.0%	£779	£795	2.1%	£806	£822	2.0%	Please note that these figures are very volatile as the market can change rapidly as providers enter and leave the market.
E06000030	Swindon UA	£17.40	£17.63	1.3%	£651	£664	2.0%	£596	£608	2.0%	The price of residential placements is higher than nursing due to the impact of the learning disability cohort. In Swindon we have a relatively high number of residential learning disability placements.
E08000008	Tameside	£14.20	£14.77	4.0%	£495	£544	9.9%	£506	£582	15.0%	The increase in Nursing rates is reflective of the increased complexity of individuals following a full costy of care analysis. The Council operates a local quality / price framework for Care Homes within Tameside.
E06000020	Telford and the Wrekin UA	£14.21	£14.72	3.6%	£488	£506	3.7%	£650	£711	9.4%	
E06000035	The Medway Towns UA	..	..	3.1%	£530	£537	1.3%	£589	£611	3.7%	
E06000034	Thurrock UA	£15.20	£16.25	6.9%	£495	£462	-6.7%	£546	£555	1.6%	Variance between 17/18 and 18/19 residential placement accounts commissioning decision to remove additional 1:1 support and increase weekly rates.
E06000027	Torbay UA	£17.50	£18.17	3.8%	£566	£609	7.6%	£672	£684	1.8%	
E09000030	Tower Hamlets	£16.96	..	6.2%	£620	..	1.5%	£664	..	1.5%	
E08000009	Trafford	£14.90	£15.53	4.2%	£473	£498	5.3%	£540	£587	8.7%	The rates quoted above are above our set price for care due to having to go off framework to meet demand. Further info in narrative.
E08000036	Wakefield	£14.30	£14.94	4.5%	£527	£534	1.3%	£477	£504	5.7%	Q1 includes all home care including support & supprted living. Domicilary care only rates are 17/18 £16.97 and 18/19 £17.60. Q2 & 3 17/18 are based on adj ASC-FR figures
E08000030	Walsall	£13.75	£14.05	2.2%	£491	£493	0.4%	£558	£597	7.0%	

E09000031	Waltham Forest	£14.50	£14.70	1.4%	£746	£773	3.6%	£619	£669	8.1%	Costs for care homes with nursing do not include Funded Nursing Care (FNC) allocations. This is why the weekly rate is lower than homes without nursing.
E09000032	Wandsworth	£15.50	..	3.5%	£712	£726	2.0%	£681	£720	5.7%	
E06000007	Warrington UA	£15.57	£16.57	6.4%	£554	£602	8.7%	£598	£635	6.2%	1. Based upon average unit costs across 15/30/45min and 1 hour visits and calculated hourly equivalent (not weighted). 2/3 based upon the average weekly costs of open packages of care at a point of time in each year- ie 1.9.17 and compared to 1.10.18
E10000031	Warwickshire	£15.85	£15.97	0.8%	£512	£517	1.0%	£521	£531	1.9%	The average rate provided for 2017/18 for care homes with nursing is based on package data at the start 2018/19 due to changes in data recording following transfer to a new care recording system during 2017/18.
E06000037	West Berkshire UA	£19.02	£19.37	1.8%	£712	£809	13.6%	£716	£751	4.9%	The figures in 2018/19 are the rates paid so far this year. The nursing rates above exclude FNC of £158.16
E10000032	West Sussex	..	..	3.9%	..	..	4.2%	..	..	4.2%	WSCC pays a range of rates for care. Partly as a result of availability of the IBCF, increases above inflation have been agreed for 2018/19. see link for more details - particualrly 2.8: http://www2.westsussex.gov.uk/ds/edd/ah/ah07_17-18.pdf
E09000033	Westminster	£15.94	£16.80	5.4%	£603	£605	0.3%	£753	£769	2.1%	2. and 3. are for Permanent Placements Only, no short term placements included
E08000010	Wigan	£14.32	£14.76	3.1%	£458	£473	3.3%	£551	£589	6.9%	
E06000054	Wiltshire UA	£20.36	£20.36	0.0%	£760	£785	3.3%	£732	£746	1.9%	The care at home rate is unchanged as we are currently undertaking a procurement exercise to increase capacity across the system.
E06000040	Windsor & Maidenhead UA	£17.95	£17.95	0.0%	£573	£626	9.2%	£620	£728	17.4%	The figures provided exclude cases where Health are making a contribution. In such cases the provider invoices the CCG directlly for their contribution.
E08000015	Wirral	£13.84	£14.86	7.4%	£462	£475	2.8%	£656	£665	1.4%	Home care average hourly rates are calculated on daytime hours only, therefore exclude waking nights, mobile nights.
E06000041	Wokingham UA	£17.00	£17.00	0.0%	£749	£753	0.5%	£795	£800	0.6%	2018/19 rates are estimates based on first 5 months actuals in 2018/19.
E08000031	Wolverhampton	£14.12	£14.52	2.8%	£466	£465	-0.2%	£511	£511	0.0%	
E10000034	Worcestershire	£14.81	£16.31	10.1%	£528	£529	0.2%	£771	£793	2.9%	figure for question 1 excludes core funding paid to external providers for the delivery of extra care. Can include if requested.
E06000014	York UA	£17.70	£18.11	2.3%	£547	£628	14.8%	£535	£599	12.0%	Capacity in the market has reduced as CYC have closed 8 out of 9 council run homes and the additional capacity expected to be developed has been delayed resulting in CYC paying higher market rates

Notes

.. Invalid or missing data

* See: https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report

** A small number of local authorities reported a percentage increase in fees but not the underlying fee amounts. Where only a 2017-18 fee rate and a percentage uplift have been provided, the implied 2018-19 fee rate has not been calculated. A small number of comments contain fee uplift percentages for existing providers that are different from the uplift implicit in the reported average fee rates, which can be affected by changes in the mix of client needs and market conditions in each year

In calculating the average figures above, local authorities were asked to exclude:
-Any amounts usually included in fee rates but not paid to care providers e.g. the local authorities' own staff costs in managing the commissioning of places
-Any amounts that are paid from sources other than the local authorities' funding i.e. third party top-ups, NHS funded Nursing Care and full cost paying clients

Local authorities were asked to include fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by local authorities and fees commissioned by the local authorities as part of a managed personal budget

fees directly commissioned by local authorities and fees commissioned by the local authorities as part of a managed personal budget.

Better Care Fund Template Q3 2019/20

1. Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements document for 2019-20 which supports the aims of the Integration and BCF Policy Framework and the BCF programme jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of the BCF quarterly reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
3) To foster shared learning from local practice on integration and delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service providers) for the purposes noted above.

BCF quarterly reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the Better Care Support Team (BCST) will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange (BCE) prior to publication.

Quarterly reporting for the 'improved Better Care Fund' (iBCF grant) will be required in Q4 19/20 and is not required for the current quarter Q3 19/20.

The Winter Pressures Grant is pooled within the BCF and is part of the BCF plans. Q3 and Q4 19/20 quarterly reporting for the BCF include a separate tab to report on the Winter Pressures Grant.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear "Red" and contain the word "No" if the information has not been completed. Clicking on the corresponding "Cell Reference" column will link to the incomplete cell for completion. Once completed the checker column will change to "Green" and contain the word "Yes"

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2019/20 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.gov.uk/government/publications/better-care-fund-planning-requirements-for-2019-to-2020

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

4. Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and achievements realised.

As a reminder, if the BCF plans should be referenced as below:
- Residential Admissions and Reablement: BCF metric plans were set out and collected via the BCF Planning Template
- Non Elective Admissions (NEA): The BCF metric plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions at a HWB footprint. These plans were made available to the local areas via the respective Better Care Managers and remain valid. In case a reminder of your BCF NEA plan at HWB level is helpful, please write into your Better Care Manager in the first instance or the inbox below to request them:
england.bettercaresupport@nhs.net
- Delayed Transfers of Care (DToC): The BCF metric ambitions for DToC are nationally set and remain the same as the previous year (2018/19) for 2019/20. The previous year's plans on the link below contain the DTOC ambitions for 2018/19 applicable for 2019/20:
https://www.england.nhs.uk/publication/better-care-fund-2018-19-planning-data/

This sheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional estimate.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. HICM

The BCF National Condition 4 requires local areas to implement the High Impact Change Model (HICM) for Managing Transfers of Care. This section of the template captures a self-assessment on the current level of implementation, for the reported quarter, and anticipated trajectory for the future quarter, of each of the eight HICM changes and the red-bag scheme along with the corresponding implementation challenges, achievements and support needs.

The maturity levels utilised on the self-assessment dropdown selections are based on the guidance available on the published High Impact Changes Model (link below). A distilled explanation of the levels for the purposes of this reporting is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area
Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement
Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement
https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model
For the purposes of the BCF in 2019/20, local areas set out their plans against the model applicable since 2017/18. Please continue to make assessments against this erstwhile HICM model and any refreshed versions of the HICM will be considered in the future as applicable.

In line with the intent of the published HICM model self-assessment, the self-assessment captured via BCF reporting aims to foster local conversations to help identify actions and adjustments to progress implementation, to understand the area's ambition for progress and, to indicate where implementation progress across the eight changes in an area varies too widely which may constrain the extent of benefit derived from the implementation of the model. As this is a self-assessment, the approaches adopted may diverge considerably from area to area and therefore the application of this information as a comparative indicator of progress between areas bears considerable limitations.

In making the self-assessment, please ensure that a representative range of stakeholders are involved to offer an assessment that is as near enough as possible to the operational reality of the area. The recommended stakeholders include but are not limited to Better Care Managers, BCF leads from CCGs and LAs, local Trusts, Care Sector Regional Leads, A&E Delivery Board representatives, CHIAs and regional ADASS representatives.

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. The AEDB lens is a more representative operational lens to reflect both health and social systems and where there are wide variations in implementation levels between them, making a conservative judgment is advised. Where there are clear disparities in the stage of implementation within an area, the narrative section should be used to briefly indicate this, and the rationale for the recorded assessment agreed by local partners.

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide supporting detail on the features of the initiatives and the actions implemented that have led to this assessment.

For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter with any impact observed, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

To better understand the spread and impact of Trusted Assessor schemes, when providing the narrative for "Milestones met during the quarter / Observed impact" please consider including the proportion of care homes within the locality participating in Trusted Assessor schemes. Also, any evaluated impacts noted from active Trusted Assessor schemes (e.g. reduced hospital discharge delays, reduced hospital Length of Stay for patients awaiting care home placements, reduced care home vacancy rates) would be welcome.

Hospital Transfer Protocol (or the Red Bag Scheme):
- The template also collects updates on areas' implementation of The optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of The Better Care Fund, but it has been agreed to collect information on its implementation locally via The BCF quarterly reporting template as a single point of collection.
- Please report on implementation of a Hospital Transfer Protocol (also known as The 'Red Bag scheme') to enhance communication and information sharing when residents move between Care settings and hospital.
- Where there are no plans to implement such a scheme Please provide a narrative on alternative mitigations in place to support improved communications in Hospital Transfer arrangements for social Care residents.
- Further information on The Red Bag / Hospital Transfer Protocol: The quick guide is available on the link below:
https://www.england.nhs.uk/publication/redbag/
Further guidance is also available on the Kahootz system or on request from the NHS England Hospital to Home team through:
england.ohuc@nhs.net

6. Integration Highlights

Please tell us about an integration success story observed over reported quarter highlighting the nature of the service/scheme or approach and the related impact.
Where this success story relates to a particular scheme type (as utilised in BCF planning) please select the scheme type to indicate that or the main scheme type where the narrative relates to multiple services/scheme types or select "Other" to describe the type of service/scheme.
Where the narrative on the integration success story relates to progressing one of the Enablers for Integrated Care, please select the main Enabler from the drop down. SCIE Logic Model for Integrated Care:
https://www.scie.org.uk/integrated-care/measuring-evaluating/logic-model

7. WP Grant

Reporting for Winter Pressures Grant is being collected alongside the BCF in a single mechanism. For this quarter, the reporting is primarily seeking narratives and confirmation on progress against the delivery of the plans set out for the Winter Pressures Grant as part of the BCF planning process.

Better Care Fund Template Q3 2019/20

2. Cover

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Version 1.1

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

- As in previous quarters, the BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF Grant information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately.

- The Winter Pressures Grant is pooled within the BCF and is part of the BCF plans. Q3 and Q4 19/20 quarterly reporting for the BCF include a separate tab to report on the Winter Pressures Grant.

Health and Wellbeing Board:	Herefordshire, County of
Completed by:	Marie Gallagher
E-mail:	Marie.Gallagher1@herefordshire.gov.uk
Contact number:	01432 260435
Who signed off the report on behalf of the Health and Wellbeing Board:	Stephen Vickers

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'

Complete

	Pending Fields
2. Cover	0
3. National Condition & s75	0
4. Metrics	0
5. HICM	0
6. Integration Highlights	0
7. WP Grant	0

<< Link to Guidance tab

2. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C19	Yes
Completed by:	C21	Yes
E-mail:	C23	Yes
Contact number:	C25	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C27	Yes

Sheet Complete:	Yes

3. National Conditions ^^ Link Back to top

	Cell Reference	Checker
1) Plans to be jointly agreed?	C9	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C10	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C11	Yes
4) Managing transfers of care?	C12	Yes
1) Plans to be jointly agreed? If no please detail	D9	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D10	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D11	Yes
4) Managing transfers of care? If no please detail	D12	Yes

Sheet Complete:	Yes

4. Metrics ^^ Link Back to top

	Cell Reference	Checker
Non-Elective Admissions performance target assesment	D12	Yes
Residential Admissions performance target assesment	D13	Yes
Reablement performance target assesment	D14	Yes
Delayed Transfers of Care performance target assesment	D15	Yes
Non-Elective Admissions challenges and support needs	E12	Yes
Residential Admissions challenges and support needs	E13	Yes
Reablement challenges and support needs	E14	Yes
Delayed Transfers of Care challenges and support needs	E15	Yes
Non-Elective Admissions achievements	F12	Yes
Residential Admissions achievements	F13	Yes
Reablement achievements	F14	Yes
Delayed Transfers of Care achievements	F15	Yes

Sheet Complete:	Yes

5. High Impact Change Model

^^ Link Back to top

	Cell Reference	Checker
Chg 1 - Early discharge planning - Q3 19/20 (Current)	D15	Yes
Chg 2 - Systems to monitor patient flow - Q3 19/20 (Current)	D16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Q3 19/20 (Current)	D17	Yes
Chg 4 - Home first/discharge to assess - Q3 19/20 (Current)	D18	Yes
Chg 5 - Seven-day service - Q3 19/20 (Current)	D19	Yes
Chg 6 - Trusted assessors - Q3 19/20 (Current)	D20	Yes
Chg 7 - Focus on choice - Q3 19/20 (Current)	D21	Yes
Chg 8 - Enhancing health in care homes - Q3 19/20 (Current)	D22	Yes
Red Bag Scheme - Q3 19/20 (Current)	D27	Yes
Chg 1 - Early discharge planning - If Q3 19/20 mature or exemplary, Narrative	F15	Yes
Chg 2 - Systems to monitor patient flow - If Q3 19/20 mature or exemplary, Narrative	F16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - If Q3 19/20 mature or exemplary, Narrative	F17	Yes
Chg 4 - Home first/discharge to assess - If Q3 19/20 mature or exemplary, Narrative	F18	Yes
Chg 5 - Seven-day service - If Q3 19/20 mature or exemplary, Narrative	F19	Yes
Chg 6 - Trusted assessors - If Q3 19/20 mature or exemplary, Narrative	F20	Yes
Chg 7 - Focus on choice - If Q3 19/20 mature or exemplary, Narrative	F21	Yes
Chg 8 - Enhancing health in care homes - If Q3 19/20 mature or exemplary, Narrative	F22	Yes
Red Bag Scheme - If Q3 19/20 no plan in place, Narrative	F27	Yes
Chg 1 - Early discharge planning - Challenges and Support needs	G15	Yes
Chg 2 - Systems to monitor patient flow - Challenges and Support needs	G16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Challenges and Support needs	G17	Yes
Chg 4 - Home first/discharge to assess - Challenges and Support needs	G17	Yes
Chg 5 - Seven-day service - Challenges and Support needs	G18	Yes
Chg 6 - Trusted assessors - Challenges and Support needs	G19	Yes
Chg 7 - Focus on choice - Challenges and Support needs	G20	Yes
Chg 8 - Enhancing health in care homes - Challenges and Support needs	G21	Yes
Red Bag Scheme - Challenges and Support needs	G27	Yes
Chg 1 - Early discharge planning - Milestones / impact	H15	Yes
Chg 2 - Systems to monitor patient flow - Milestones / impact	H16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Milestones / impact	H17	Yes
Chg 4 - Home first/discharge to assess - Milestones / impact	H18	Yes
Chg 5 - Seven-day service - Milestones / impact	H19	Yes
Chg 6 - Trusted assessors - Milestones / impact	H20	Yes
Chg 7 - Focus on choice - Milestones / impact	H21	Yes
Chg 8 - Enhancing health in care homes - Milestones / impact	H22	Yes
Red Bag Scheme - Milestones / impact	H27	Yes

Sheet Complete:	Yes

6. Integration Highlights

^^ Link Back to top

	Cell Reference	Checker
Integration success story highlight over the past quarter	B10	Yes
Main Scheme/Service type for the integration success story highlight	C13	Yes
Integration success story highlight over the past quarter, if "other" scheme	C14	Yes
Main Enabler for Integration (SCIE Integration Logic Model) for the integration success story highlight	C17	Yes
Integration success story highlight over the past quarter, if "other" integration enabler	C18	Yes

Sheet Complete:	Yes

7. Winter Pressures Grant

^^ Link Back to top

	Cell Reference	Checker
Brief narrative on progress in delivering the Winter Pressures Grant spending plan	B8	Yes
Indication whether the planned spend for the Winter Pressures Grant is on track	C10	Yes
Where "NOT ON TRACK", please indicate actions being planned or in place to get back on track	C11	Yes
Have acute hospital trusts continued to be involved in the delivery of the Winter Pressure Grant plan?	C13	Yes
Please describe how this involvement is being ensured	C14	Yes

Sheet Complete:	Yes

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Better Care Fund Template Q3 2019/20

3. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Herefordshire, County of

Confirmation of Nation Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Better Care Fund Template Q3 2019/20

4. Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	Assessment of progress against the metric plan for the quarter	Challenges and any Support Needs	Achievements
NEA	Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population	Not on track to meet target	Achieving the NEA is challenging to partners throughout the system.	A number of key schemes including Home First and Hospital at Home, continue to be delivered to assist in supporting individuals at home and avoiding admissions, where possible.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Capacity within the home care market continues to challenge partners, specifically in relation to complex residential care.	The number of admissions YTD compared to the same period in 2018-19 shows a 13.4% reduction. Within Q3 there was a rate per 100,000 population of 124.39 (58 admissions) compared to a rate of 184.45 (86 admissions) over the same period in 2018-19, reduction of 32.5%. Figures show that we are moving closer to achieving the target rather than moving further away.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	Demand for the service continues to grow and new staff are being recruited to meet this demand.	For Q3 the percentage still at home after 91 days is 77.5%, above the YTD performance of 72.3% indicating a move closer to the target of 80%.
Delayed Transfers of Care	Average Number of People Delayed in a Transfer of Care per Day (daily delays)	On track to meet target	Q3 data demonstrates although the overall DToC target has been achieved, it continues to be a constant pressure. Investment in the urgent care part of the system has been undertaken and redesign of services, however demand still continues.	1. Commencement of Daily DTOC review to ensure that delay code agreed on the day(involved ASC and Health colleagues) 2. Pre-screening for all new referrals to ASC to ensure that priority of work is focused on those patients that are about to become medically stable rather than responding to all ANs that may not be ready for discharge. 3. Discharge manager attending daily capacity meeting within WVT to ensure that an understanding of the challenges are known to support with focusing on priorities for earlier discharge

Better Care Fund Template Q3 2019/20

5. High Impact Change Model

Selected Health and Wellbeing Board: Herefordshire, County of

Challenges and Support Needs — Please describe the key challenges faced by your system in the implementation of this change, and Please indicate any support that may help to facilitate or accelerate the implementation of this change

Milestones met during the quarter / Observed Impact — Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change

			Narrative		
		Q3 19/20	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges and any Support Needs	Milestones met during the quarter / Observed impact
Chg 1	**Early discharge planning**	Plans in place		Further work required to ensure that the whole system is aware of the EDD and are committed to working together to achieve.	Wye Valley NHS Trust have created and launched a programme of improvement based on national best practice. This includes Patient 4 Questions, R2G, SAFER bundle. Alongside this the Local Authority and hospital Trust have established an improvement working group to ensure discharge services are linked and service improvement is created and delivered jointly.
Chg 2	**Systems to monitor patient flow**	Plans in place		Both LA and WVT currently have separate tracking systems, this is being reviewed as part of the Integrated hospital and community functions	Separate tracking systems still in place. However, new admin post in WVT liaises daily with member of staff in ASC to ensure that both recording systems are reflecting the same details.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place		Current separate flows and processes for the discharge teams and new integrated team embedding practices. Educational awareness within the hospital.	Daily integrated DTOC meeting to ensure the current delay of the patient is chased to support discharge daily. Education on wards continues with all the discharge team.

Chg 4	**Home first/discharge to assess**	Established		Capacity within current services and demand on HF provsion for step up step down provision. Winter pressures.	Operational recommendations for an Integrated Therapy resource completed. Head of Integrated Community Services post advertised and interviews recently held. iBCF review of projects include the D2A scheme with recommendation to review model.
Chg 5	**Seven-day service**	Not yet established		Several areas of service provision are not delivered on a seven day basis eg. community therapy services, which can often cause delays. However, seven-day services are being delivered in some areas e.g. Homefirst	Seven-day services continue to be delivered where relevant, appropriate and demand evident.
Chg 6	**Trusted assessors**	Established		Overcoming barriers of trust, signing up homes, resignation of 1 TA	Recruitment of TA. 20 /84 care homes signed up to MoU. 19 care homes out of county have signed the MoU. It has been estimated that 57 bed days have been saved since the TA service commenced. 100% of the assessments have been completed within 24 hours of referral (given that the patient is medically optimised).
Chg 7	**Focus on choice**	Established		Remains a challenge against backdrop of high demand and limited capacity.	The choice policy is currently being reviewed to ensure that the one currently in place is in line with the national choice policy. The Trust is also reviewing the choice letters that will be issued to patients again in line with the choice policy.
Chg 8	**Enhancing health in care homes**	Plans in place		Review of service area following resignation of team members	Redesign of service area in partnership with Wye Valley Trust. 3 care home practitoners posts to be recruited to. S

Hospital Transfer Protocol (or the Red Bag scheme) Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.					
		Q3 19/20 (Current)	**If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.**	**Challenges**	**Achievements / Impact**
UEC	**Red Bag scheme**	Established		Engagement from all partners and the number of red bags lost.	Urgent Care Programme Board have supported the red bag scheme and Joint Commissioning Board has asked that the number of additional bags needed and costs be scoped. A proposal is being developed.

Better Care Fund Template Q3 2019/20

6. Integration Highlight

Selected Health and Wellbeing Board: Herefordshire, County of

Remaining Characters:	15,979

Integration success story highlight over the past quarter:

Please give us an example of an integration success story observed over the past quarter. This could highlight system level collaborative approaches, collaborative services/schemes or any work to progress the enablers for integration (as per the SCIE logic model for integrated care). Please include any observed or anticipated impact in this example.

Development by 3 operational teams across different providers who have used patient, carer and peer review feedback to change the way they work, establishing an integrated model of care for adults requiring palliative and end of life care. Focusing on need rather than specific conditions recognising that there are many trajectories towards the end of life. Core to this transformational journey has been the feedback gained from the public, patients and their carers, staff, managers and clinicians during the Healthwatch focus groups, the West Midlands Quality Review Service peer review and CQC inspections 2016/18. This external scrutiny highlighted: the need for a single integrated service with clear access points; duplication in service delivery and overlap of professional input; the person and their carer were not always at the centre of the care delivery. The operational teams during the last 12 months have developed a clear & simple framework of how they can deliver an effective Integrated Model of Palliative and End of Life Care. The model is built around the shared principles of;
1. Improved Identification: people who are deteriorating from their condition(s) including increasing frailty and are likely to die within the next 12 months;
2. Improved Coordination: better, proactive conversations, shared decision making, personalised care and support planning;
3. Improved Communication: appropriate sharing of key information, Community Emis/one care record

Delivered through an integrated care model linking together District Nursing, Specialist Palliative Care and Hospice at Home. Co-located within a 7 day clinical coordination hub including out of hours advice, who will receive all referrals for urgent on the day assistance and also notification of patients with newly identified palliative and end of life care needs. Access to Community Emis as the single care record will form the bedrock of the integrated co-ordination hub and attendance by a member of the integrated team at General Practice Palliative Care meetings will ensure that a comprehensive view of community team involvement with the patient is available to support continuity of care planning, minimise duplication and reduce crisis presentations. Telephone access for carers and patients plus a dedicated health professional point of contact will enable 7 day access to care and support to meet palliative and end of life care needs. Clinical coordination of care will include senior nurse assessment of need based on access to the Herefordshire One Record (Community Emis) and clinical presentation to enable allocation of the most appropriate response, with the hub holding clinical responsibility for an urgent response and/or onward transfer to the most appropriate care provider. Clinical care coordination will also include identification and management of patients requiring Continuing Health Care Fast Track support within a local framework to enable direct access from the coordination hub to domiciliary support at home or a nursing home placement. A pilot project during winter 2018/19 between Hereford Medical Group (HMG), St Michaels Hospice at Home Team, Community District Nurses and Specialist Palliative Care Nurses. The pilot established a shared approach to improving identification of palliative care patients and a locality based mechanism to coordinate care and triage responses to urgent, sudden or unexpected need. During the course of the pilot there was a 20% increase in the identification of patients with palliative and end of life care needs. All these patients now have alerts on their records so that anyone opening the records are aware that the patient is palliative and is on the register. The integrated model commences in April 2020, work on shared clinical protocols, data sharing agreements, a shared telephony system and IT support to utilise Community Emis as the underpinning enabler are underway and the integrated model will be supported by a formal agreement eg SLA/MOU.

Where this example is relevant to a scheme / service type, please select the main service type alongside or a brief description if this is "Other".

Scheme/service type	Integrated Care Planning and Navigation
Brief outline if "Other (or multiple schemes)"	

Where this example is relevant to progressing a particular Enabler for Integration (from the SCIE Integration Logic Model), please select the main enabler alongside.

SCIE Enablers list	5. Integrated workforce: joint approach to training and upskilling of workforce
Brief outline if "Other"	

Better Care Fund Template Q3 2019/20

7. Winter Pressures Grant

Selected Health and Wellbeing Board: Herefordshire, County of

Please provide a brief narrative on progress made towards delivering the Winter Pressures Grant spending plan (as expressed within the BCF planning template 2019-20)
2019/20 winter pressures funding is invested in additional capacity in home care, particularly for hard to place clients and rural areas of the county; and in additional capacity in residential and nursing care homes, a mix of spot purchases of short-term and respite placements and a contract for long term nursing placements. All of the placements are commissioned via Adult Social Care.

Please indicate whether the planned spend for the Winter Pressures Grant is on track	On Track
Where "NOT ON TRACK", please indicate actions being planned or in place to get back on track	

Have local acute hospital trusts continued to be involved in delivery of the Winter Pressures Grant including any changes in the use of the grant as compared to 2018-19?	Yes
Where 'No' is selected above, please describe how this involvement is being ensured	