Appendix One

Herefordshire September BCF Plan Assurance Briefing Note

October 1st 2014

1. Introduction

In February of this year Herefordshire set out its Health and Wellbeing Vision. The BCF submissions made earlier this year described the implementation of that vision and were well received by NHS England.

Our vision for 2018/19 puts Herefordshire at the leading edge of seamless integration of care and support. We will provide services that wrap around patients, service users and their families. We will provide coordinated, consistent and high quality services across organisational boundaries.

The commissioners and providers of health and social services in Herefordshire face significant challenges – We estimate that the CCG, NHS England, the local authority and other commissioners share a combined health and social care expenditure of some £400m. Over the next 5 years, the required savings are estimated to be in excess of £60m across our joint health and care budget. Over the same period our provider organisations have efficiency saving requirements in excess of £50m. This puts an insoluble strain on the system but is a powerful incentive for us to work together.

Since the April BCF submission considerable progress has been achieved in developing a joint approach to our System Transformation.

In April and May of this year we undertook four system lead workshops with the commissioning and provider organisation Chief Officers, their Senior Management teams, CCG Governing Body and LA elected members. From these workshops and subsequent consultation and challenge a System Transformation Programme has been developed and, in July, a Transformation Board, accountable to the Health & Wellbeing Board was established.

Similarly a Joint Commissioning Group has been established between the CCG and the LA, and a Joint Commissioning Plan is currently under development.

We are very clear that the BCF is a key enabler within our approach to Transformation.

Following on from the changes to the BCF guidelines in July, we have had a series of difficult conversations. The financial situation; coupled with increased demands on the system are challenging factors but there is a total commitment to move to agreement as quickly as possible.

The way forward –

To date we have agreed the BCF Minimum Fund and commenced detailed discussions on the scale of the requirement for the protection of social care and implementation of the Care Act.

Alongside this we have commenced joint work on key areas of service redesign such as the Integrated Urgent Care Pathway for community health and social care services and Rapid Access to Assessment and Care. We are currently reviewing the opportunities to merge or disband projects in favour of revised or new areas of work that will be both integrated and truly transformational.

Our Joint Commissioning Board is developing joint commissioning strategies for Mental Health and Learning Difficulties, both of which offer significant opportunities as current contracts reach their conclusion.

We have made significant progress since April, there is strong commitment across the health and social care system and we have clear plans for the future.

2. The Strategic Outcomes that we will deliver from the BCF conversations agree to and developing plan are

Integrated Personal Budgets – all groups, all ages

- To harmonise systems and processes to enable a common approach to personal budgets.
- To embed a common approach across health and social care professionals to support the delivery of integrated personal budgets.
- To build capabilities across health and social care, through joint personalization training to support shifts in culture and practice.
- To embrace integrated Personal Budgets as the catalyst for enhancing choice and control for individuals and outcomes that they want.
- To ensure that constrained resources are targeted and used to best effect.
- To move to effective and efficient micro commissioning by individuals that delivers positive outcomes.
- To support a wider agenda of intelligent commissioning across health and social care economies, inclusive of public health and children and young people.

Fully mobilised Integrated Urgent Care Pathway across health and social care, alongside a redesigned Community Health Service

- To implement and embed service practice models that ensure effective care co-ordination
- To ensure closer alignment of community health and social care services with primary care.
- To build capability and capacity within the current workforce that assures the shift to effective care co-ordination.

- To enhance the pace of service redesign that brings into play a complementary range of services that supports admissions prevention and avoidance and ensures timely and appropriate hospital discharges.
- To accelerate the provision of the Integrated Urgent Care Service to enable and ensure assessment and care planning to support the integrated urgent care pathway.
- To provide system oversight and coordination to maximise the redesign of health and social care to ensure a comprehensive and complementary approach.
- To ensure clarity and rigor allied to performance matrix to evidence benefits realisation to the change agenda that underpins the Better Care Plan

Co- commissioning Operating Model (Starting with LD & Mental Health) has already begun and further work is underway

- To recognise opportunities across health and social care to develop intelligent commissioning that enhances outcomes for the population and makes best use of available resources.
- To be prospective in reviewing together commissioning work requirements and to identify service areas that would benefit from co commissioning.
- To adopt areas of common interest to pool commissioning and allied capabilities and capacity to develop a joint position in relation to future commissioning intentions.
- To develop coordinated and integrated service specifications and make best use of available resources and market procurements.
- To enable the sharing and distillation of evidence and good practice across health and social care.
- To enable real co-production with service users, patients, carers and all other interested parties.
- To adopt the dynamic of learning through experience to inform and evidence the importance of working together.
- The CCG and the LA recognise the impending cessation of current contracts underpinning Mental Health and Learning Disability Services and the opportunities to co-commission services across health and social care within the wider market place that exists within Herefordshire.
- Such an approach will maximise available capability and capacity and build systems; processes and confidence co-commission other work streams to support better service user outcomes.

Prevention & Early Intervention Programme to include

- Information, Advice and Guidance including Herefordshire Advice Handbook
- Carer's Support Services
- Health Improvement including Campaigns and Well Being Innovation and behaviour change

- Falls Response
- Health Protection including Flu
- Care and Nursing Home Education and training
- Winter Warm, Fuel Poverty and Voluntary sector coordination e.g. Street pastors, Lean on me
- Well Being Innovation Fund

Mental Health Social Care, we have an opportunity to look across the CCG and LA to commission Mental Health in a different way

- Mental health Social Care is critical to a holistic approach to mental health recovery and complements health interventions.
- Mental Health Social Care supports those natural supports that aid health and wellbeing in terms of housing, finance, social interests and networks, positive relationships, a sense of worth and community being, to maintain employment or embark upon further education and training.
- Mental Health Social Care is also able to use professional relationships to promote personalization and access to Personal Budgets that builds choice and control and supports potential for continued independent living.
- Mental Health Social Care is at the forefront of Mental Health Legislation and assessment to determine formal detentions
- Mental Health Social Care has a joint responsibility with Health to ensure effective Aftercare under Section 117 of the Act
- Legislative responsibilities also embrace the Mental Capacity Act.

3. **In terms of our Programme Grip we have got a clear process, are well organised and have the key decision makers on board.**

   Our key decisions for immediate focus are

   - Funding the Protection of Social Care
   - Funding the Implementation of the Care Act
   - Risk Sharing Agreements
   - Section 75 Agreements

   To ensure that we deliver these effectively and efficiently alongside our joint project planning we have

   - Put in place a 10 week action plan that will take us to the beginning of December;
   - Established a weekly BCF Task and Finish Group, with membership from the CCG and LA, that will ensure and review delivery against the action plan;

- Moved the monthly Joint Commissioning Group to fortnightly meetings in order to mobilise commissioning strategies, plans and activity in support of the BCF and wider transformation agenda;

This will enable a significant step from our current position to one of an agreed, assured and jointly owned plan for delivery through 2015/16 and onwards.

4. The Technical Template

The Minimum Fund and Technical template reflects the strategic direction of travel outlined above

  - within this are that the Virtual Ward and Community Service elements of the BCF reflect the Community Services Transformational Changes that are planned

- The Performance Fund is set at 1.5% with agreement between the CCG and the Local Authority and has been agreed and signed off with our acute provider Wye Valley Trust
  - The target reflects the pressures within our system of an increase of 8% demand on outturn
- The Protection of Social Care is reflected within the plans at the 14/15 baseline and there is work to be done around further investment and agreements
- The Care Act allocation has been agreed at the minimum national formula level and there is work to be done about further investment and agreements based on modelling against the Lincolnshire model
- Growth on the non-elective admissions is predicted at 8% outturn to outturn, and there are in year schemes put in place by the CCG to mitigate this as far as is possible
- **Delayed transfers**: the implementation of the Integrated Urgent Care Pathway will support more rapid movement through the system for patients, speeding up the assessment and discharge processes for people who require acute admission. Implementation will commence in November. In the meantime, specific resources have been identified through the System Resilience Group – Operational Resilience and Capacity Plan, which are providing additional support to acute and community hospitals to ensure rapid discharge.

As noted in the previous section there is a 10 week plan in place to address the key decisions and outputs required.

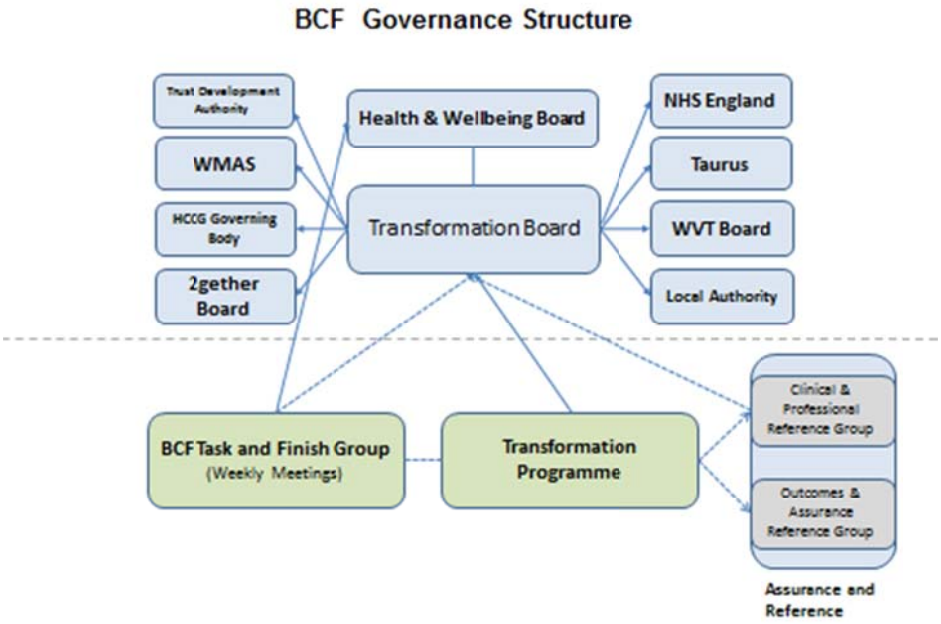
5. Risk Sharing & Contingency Agreements

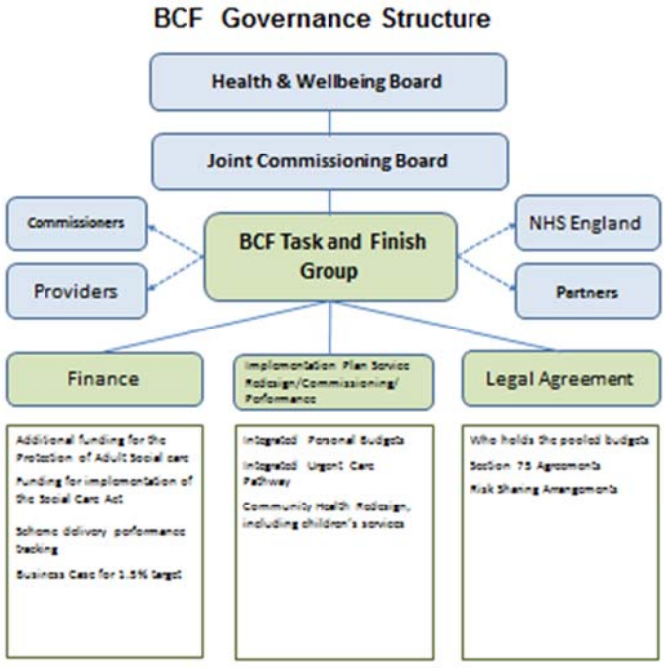
As noted this is a key area for focus within the 10 week Task and Finish Plan.

The High Level Gant Chart for this is shown below at paragraph 10.

6. Programme Management and Governance

The diagrams below illustrate how the 10 week Task and Finish Group described above work with the existing governance arrangements for BCF and the System Transformation Programme.





7. Scheme and Service Summaries

The Schemes submitted in Annex 1 of the original submission are Schemes in the BCF sense in that they are measured in terms of benefit and impact against the key targets such as reduction of emergency admissions.

The Service Delivery Summaries were submitted in order to show how the LA & CCG are working together to illustrate how monies within the BCF minimum fund are being spent and to what benefit.

We are regularly refreshing these documents as our projects (including service redesign) and schemes are reviewed, reshaped and become more integrated and so documents submitted on the 19th September are already out of date. We will submit a refresh at a later date (we expect that there will be a further BCF plan submission requirement this autumn).

The table at Appendix 3, illustrates the schemes and summaries and which of the BCF conditions they specifically support.

8. Performance Fund

The proposal is that the performance fund is set at a level of 1.5% i.e. £289,628. Following discussion with the BCF National Support Team, this approach has been accepted as a rational and pragmatic approach to the challenges at play in Herefordshire. Factors which have influenced this view include:

Emergency activity in Herefordshire 2013/14 - 2014/15

Herefordshire benchmarks low in terms of access rates to urgent care and in particular in relation to conditions amenable to ambulatory care. This suggests that primary and community care services are already managing a higher proportion of patients who are at risk of deterioration and admission than is the case in other communities.

Readmission rates are also low, suggesting that management of patients is appropriate on discharge. Our acute provider, Wye Valley Trust, is the smallest DGH in England, and in comparison with 9 other Trusts with a similar A&E footfall, the Trust has: the smallest number of beds per 1000 population; a low A&E to admission conversion rate, and a low general acute and medical bed base. Average length of acute stay at WVT benchmarks well and there have been reductions in length of stay at Community Hospitals.

Demand has increased – the Herefordshire Operational Resilience and Capacity Plan outline the agreed proposals to mitigate this growth in the short and medium term. As part of this, the CCG is proposing to move to an outcomes based contract for urgent care in October 2015.

- A&E Attendances – There has been a year on year growth of 1,640 (3.6%) from 2012/13 to 2013/14.

- A majority of the increase since 2012/13 (1,368 i.e. 83.4%) is over 65's.There was a 2% increase in the 2013/14 conversion rate for over 65s, whilst under 65s increased by 1%. The over 65s attending A&E have a 49% chance of being admitted, whilst for under 65s the chance falls to 18%.

- Ambulance – The number of conveyances is up by 6% from 2012/13 to 2013/14.

- Analysis of attendances by over 65s per GP practice has provided a list of top ten practices where work is to be undertaken to understand possible changes in patient presentation and referral patterns. This work will dovetail with other frail elderly pathway initiatives.

- The GP Led Walk in Centre (provided by Primecare) saw a drop in activity in 13/14. However in the first part of 14/15 there has been a significant increase in the activity and Primecare is also reporting a greater acuity in the patients attending.

- In terms of flow of Primecare patients to A&E, the Walk in Centre has reported an increase of 32% year on year with an average of 30 patients per month in 13/14. March 2014 recorded a significant increase to 49 patients referred into A&E from the Walk in Centre.

- During the first 4 months of 2014/15, NHS 111 data has shown an increasing trend in ambulance, A&E and other services signposted. This confirms other data showing an increase in emergency activity and acuity.

- In the early part of 2013/14, admissions via A&E at WVT were significantly lower than 2012/13. However in August and from November onwards there was a marked increase. This in part is attributable to the increased A&E attendances activity, but also the reported increase in the acuity of presenting patients' conditions.

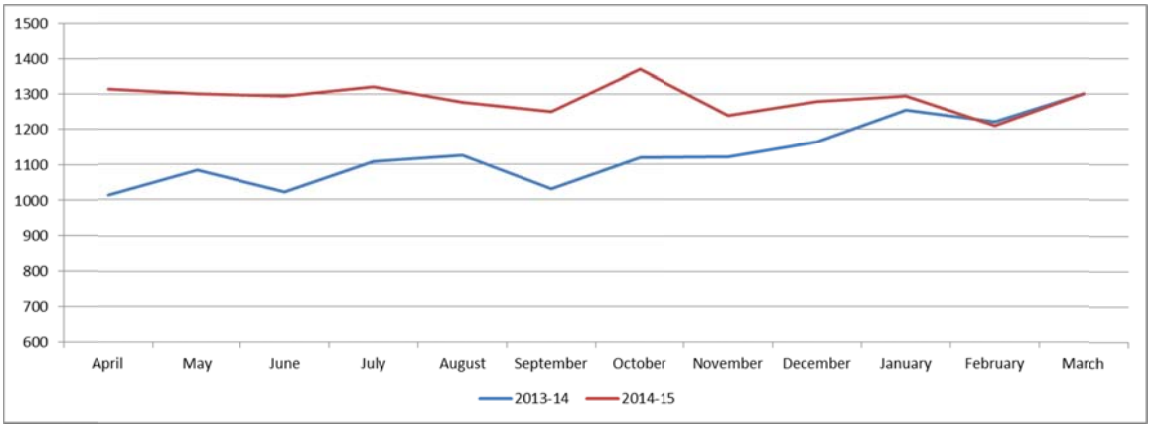
- Virtual wards were implemented as a pilot across the 8 Hereford City practices in October 2013, with two components: risk stratification and hospital at home. To June 2014, hospital at home had supported early discharge for 174 patients, and admission avoidance for 135 patients, mainly avoiding what would have been short stay admissions.

- Implementation of the RAAC scheme (Rapid Access to Assessment and Care), commenced in January 2014 with the "discharge to assess" component. By June 2014 this had taken 51 patients out of Wye Valley Trust. An additional 32 patients were supported through earlier discharge by spot purchase of additional capacity during periods of increased emergency pressures.

Year on year comparison of activity between 2013/14 and 2014/15 shows a projected increase of approximately 8.25%. The figures below exclude maternity and dental emergency admissions.

Outturn 2013/14	11,565
Projected outturn 2014/15	12,519
Increase:	**954**

Acute Emergency Admissions (non-elective admissions)



There has been a step change in emergency admissions that started in October 2013 and levelled out at a higher rate in March 2014. This appears to relate to the introduction of the CAU, and reflects appropriate management of short stay patients although with higher numbers of patients being admitted for short stay admissions. The introduction of the CAU is recognized best practice and was a recommendation from ECIST.

Additional bedded capacity is being introduced by the Trust to support the delivery of an appropriate quality of care. This will take the form of an additional temporary ward which it is planned to be operational by November. The Trust needs to reduce its use of escalation capacity in inappropriate areas – e.g. use of CAU overnight.

The Trust describes the need to pull back to a reasonable level of occupancy prior to beginning to make additional gains in bed use.

The Case for Change within the BCF submission includes a summary of the roles and aspirations of the System Resilience Group, the linkages to the system wide Transformation Programme, with diagrammatical representation of the current and aspirational systems.

9. Ten Week Task and Finish Plan

Attached as Appendix 2 of the report.