Herefordshire Integration and Better Care Fund

Narrative Plan 2017/19

FINAL

Contents

1. Introduction

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

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

2. Background and context to the plan

The Herefordshire Integration and BCF plan 2017/19 demonstrates the progress made during 2016/17, details key milestones for 2017/19 and describes the future vision for the county. This plan is a key component of, and wholly consistent with, the system-wide transformation of Herefordshire's health and social care economy that is being taken forward under the One Herefordshire initiative and the Herefordshire and Worcestershire Sustainability and Transformation Partnership.

We have a long history of joint working in Herefordshire that has enabled us to develop a good understanding of how we can work more effectively together. We recognise that for some of our most important issues, such as mental health and wellbeing, children's health and older people's health and wellbeing, we can accelerate improvements by working together with a common purpose, drawing on and providing support to the voluntary and community sector.

To drive more transformational and sustainable integration, Herefordshire has moved to an alliance contract which sees a set of separate providers, Wye Valley NHS Trust, 2gether Foundation Trust and Taurus Healthcare, enter into a single agreement with the CCG to deliver services, where the commissioner(s) and the providers within the alliance share risk and responsibility for meeting the terms of a single system-wide arrangement.

This shifting of more accountability onto the providers through contractual models will in due course lead to greater interdependencies and risk for providers. The providers will be best placed to develop interorganisational forums and processes for shared decision-making and holding each other to account. In Herefordshire, this is being developed through the community redesign programme, which is underpinned by a set of principles which seek to reinforce the view that:

- '*Your own bed is best'*.
- Care is provided by the *right professional* with the *right skills* providing the *right care* in the *right place at the right time*.
- Delivery occurs in *four localities* which provide a framework for populations of *c30k or greater*, create sustainable resources and are *wrapped around and functionally integrated with primary care* populations.
- Establishes a service that is responsive to the needs of the local population, reduces duplication and ensures community services and primary care work as one team, responsively supporting each other at the point of care.
- Promotes and embeds our commitment to ensure parity of esteem between physical and mental health

To support this redesign, the culture and practice within adult social care services are undergoing a major change in order to respond to demographic and financial pressures. This includes an end-to-end redesign of the adult social care pathways to ensure that appropriate and proportionate services are delivered to customers to meet their identified outcomes in a timely manner. Equivalent initiatives are being taken forward within the community healthcare services, with strong links between these parallel programmes.

Whilst Herefordshire is undertaking a transformational change in community health and social care services, we continue to face a number of significant challenges in ensuring people maintain a good level of wellbeing and are able to access care and support when they need it.

Rurality: The level of rurality and sparsely populated communities cause challenges for the delivery of public services. Herefordshire has 189,000 residents and 82,700 homes dispersed across 842 square miles. The county has the fourth lowest population density in England, with over half of all residents living in areas classified as rural, with two in five living in the most rural villages and dispersed areas. Furthermore, those aged 65 years and older are more likely to live in the rural areas, creating particular challenges with the delivery of services where travel times and access issues, such as public transport, is a barrier.

Demography: Herefordshire has one of the highest proportions of people over the age of 65 in the country and the figure is growing faster than in most other areas. In addition to this general trend, the number of people aged over 75 and over 85 is increasing at a much more rapid rate and people in these age ranges tend to be much more likely to need formal care. Furthermore, although life expectancy has been increasing, the number of years of healthy life that a person can expect has not been growing at the same rate. This means that there has been, and continues to be, a significant rise in the number of older people living with disabilities, in both relative and absolute terms.

Workforce: Not only does the demographic character of the county mean we have a larger number of people requiring care than other areas, but the number of people of working age who might provide that care is smaller than in other areas. As the economy in Herefordshire develops, there is increasing competition in the market place for staff. Social care has traditionally not enjoyed high levels of status or pay, so it can often prove difficult to recruit and retain staff. There are particular difficulties in recruiting nurses for nursing homes, yet demand for nursing home care is growing faster than any other area.

3. The local vision and approach for health and social care integration

The Integration and BCF plan is fully aligned with the joint **local vision** for the county, as described within the One Herefordshire report:

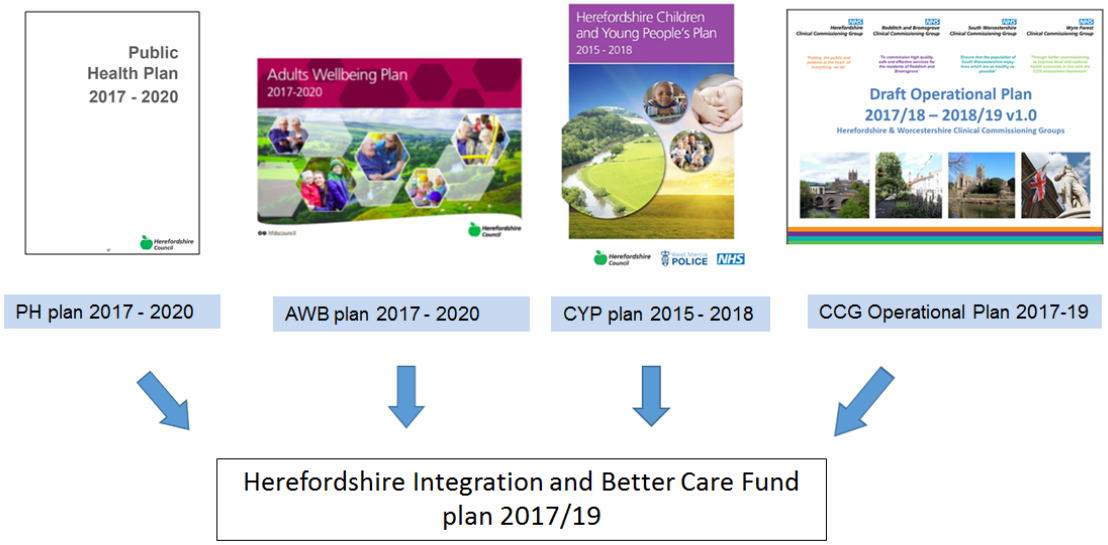
"The vision for the local health and care system in Herefordshire is one where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people".

Sustainable services are those delivered via a model of care which ensures that they can be delivered in a clinically viable, safe and effective manner at the scale to which they are required locally and within the financial resources available to the system as a whole.

Herefordshire will commission and provide services from a population basis, not an organisation basis. Services will be focussed at the General Practice (delivered at scale), locality or county basis. Where this brings benefit, certain services may be commissioned on the basis of the STP footprint. All service providers in a defined area will be commissioned to improve the health outcomes of that area, applying the combined workforce to best effect in order to deliver theses outcomes.

The Integration and BCF plan is aligned to a number of other key operations plans:

Key Operational Plans



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

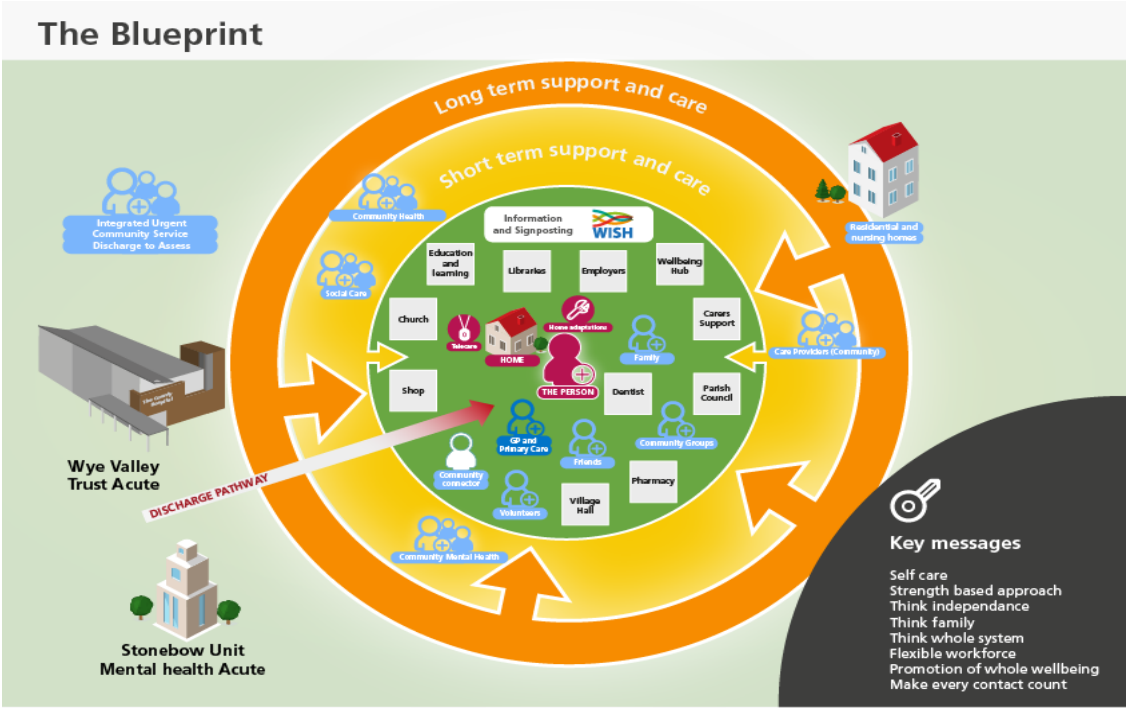
At a strategic level, the Integration and BCF plan intends to support the One Herefordshire alliance in achieving the following aims:

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

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

The Joint Blueprint

The joint blueprint below demonstrates the adoption of the vision described above. Our philosophy is centred on the interconnected principles of information, prevention and enablement. The essence of this approach is that it is better if people are able to maintain a good level of wellbeing, drawing on their community, on an ongoing basis. Nonetheless, we recognise that people will at times experience situations where they are unable to cope on their own, even with the support of their local networks. Information and prevention are the central features here. In these circumstances, our joint philosophy is based on the belief that the best approach is to focus on helping people to regain as much control over their own lives, as quickly as possible. Ways of working that are grounded on the principle of enablement form the foundation of this.



For new customers contacting the adult social care “front door” (Access and referral team), services will be redesigned to give improved and consistent information, advice and guidance to support people more effectively to live independently within their communities. For customers requiring additional support, ART will have a range of improved referral options aimed at ensuring that customers receive the right level and type of support at the time of need. The redesign and changes to practice will increase capacity within the adult social care short term care and urgent care pathways. This will ensure that adult social care can respond more effectively to meet acute need in areas such as adult safeguarding and community crisis.

To prepare for the changes the entire cohort of front line social care staff have undertaken an intensive strengths based training programme which will allow staff to work more effectively with customers to determine an outcome that draws on the customer’s strengths and assets.

In addition to the pathway redesign, Rapid Response and Reablement services will be expanded and merged to become a redesigned “Home First” service. The Home First service will work closely with frontline health services and will have an integrated, therapy led approach. The service and new pathway will be more responsive to customers living at home who find themselves in crisis and will work with community health services to avoid hospital admissions where possible. In addition, the redesigned services will see an increase in the numbers of customers in Herefordshire offered a reablement package and will significantly speed up hospital to home discharges, thereby reducing the numbers of delayed transfers of care. The new pathway and Home First services will be phased in from the end of August 2017 with an expectation that all services will be live by the middle of November 2017.

4. Progress so far

The following tables provide a progress update in relation to the Integrated Action plan, as detailed in section 4 of the 2016/17 BCF plan.

SCHEME: MINIMUM PROTECTION OF ADULT SOCIAL CARE	
Strategic objective: *To maintain the existing levels of NHS (section 256) investment in social care in order to enable the council to support services which meet the wider strategic objectives of the BCF.*	
Planned Developments 2016/17	**Progress achieved 2016/17**
Implementation of redesigned social care teams into locality / complex care teams	During 2016, social care operational teams were re-organised into locality and complex care teams, enabling the concentration of expertise into dedicated teams. This work has since been built upon with the design, testing and implementation of a strengths based assessment process and new assessment pathway for customers, which enables practitioners to better target care and limited resources.
Review and redesign of reablement services to align with the wider development of community health, mental health and social care services.	The existing reablement service contract ended on 31 July 2017. During 2016/17, a review of reablement services was completed and the approach to in-source the reablement provision to Herefordshire Council was approved. This change in service delivery will allow for alignment with the council's existing rapid response service to allow flexibility within the two service areas for movement of staff and service users, whilst streamlining service delivery, improving efficiencies and increasing capacity in the market.
Redesign of the RAAC provision to enable a community based support service offering both "step up" and "step down" provision	During 2016/17, the existing rapid access to assessment and care (RAAC) provision was reviewed and an Intermediate Rehabilitation Service (IRS) pilot was introduced. The aim of the scheme was to deliver rehabilitation to those who would otherwise face unnecessarily prolonged hospital stays, inappropriate admission to acute inpatient care or long term residential care. The focus of the scheme was active therapeutic interventions, with the aim to maximise the independence of individuals. The service provided the opportunity for admission avoidance and also to facilitate earlier hospital discharge.
Implementation of the Joint Carers Strategy	A joint Carers Strategy between the council and the CCG has been signed off and is the process of being implemented.
Reduced delays in transfer of care (DToC) from community settings to the most appropriate setting to support individual needs	DToC presented significant issues throughout the health and social care system in Herefordshire during 2016/17. A number of schemes were delivered to help address the pressures, including earlier identification of potential discharges, rapid access to assessment and care (RAAC), brokerage, additional support to self-funders and to care homes. The council and CCG are actively working together to monitor and reduce the levels of DToC and ensuring that new schemes are developed and implemented, where appropriate. A number of reporting mechanisms were introduced during 2016/17 and many initiatives have been implemented across the system which is demonstrated in section

SCHEME: MINIMUM PROTECTION OF ADULT SOCIAL CARE	
	6.4 – managing transfer of care.

SCHEME: CARE ACT IMPLEMENTATION	
Strategic objective: *To ensure that all duties under The Care Act 2014 are met.*	
Planned Developments 2016/17	**Progress achieved 2016/17**
Enhance content of IAS	The WISH (Wellbeing Information and Signposting Herefordshire) website was launched in early 2016 to provide information, advice and signposting for citizens in Herefordshire. Following a review of the website in November 2016, it was identified that further enhancements were needed to improve functionality, content and overall usability. The WISH Phase 2 project has been initiated to deliver the necessary improvements. This will be implemented during the second half of 2017/18.
Re-procure advocacy service	A competitive tendering process was undertaken during 2016/17. A contract has been awarded, which includes the provision of an independent mental health advocate.
Initial local area development of community links model	In 2016/17, a community based project was set up in the Leominster area to prototype a new approach to enhance opportunities that build communities and create a sustainable way of maintaining our knowledge of the services and opportunities which can help meet the needs of our social care customers. The successes of the first year of the project included the establishment and expansion of community opportunities through a seed funding grant, the connecting up of statutory agencies, community based organisations and businesses and the development of a comprehensive Community Menu for the area. This function will be expanded during 2017/18.

SCHEME: COMMUNITY HEALTH AND SOCIAL CARE SERVICES REDESIGN	
Strategic objective: *To deliver the right Community Health and Social Care services in the most appropriate way by reviewing the current menu and method or models of provision and implementing the* changes required to achieve the transformation aims and objectives.	
Planned Developments 2016/17	**Progress achieved 2016/17**
Full implementation of the joint service model for community health, mental health and social care services	Implementation has begun and the full service change will take place over the next two years. Wye Valley NHS Trust has reorganised its community services division and structured services in a locality model based around GP practices. Integration with mental health services and social care services is not as far forward, but continues to progress as part of the One Herefordshire programme and the Living Well At Home workstream
County wide roll out of the Virtual Ward and risk stratification model, identifying and supporting more individuals in community settings.	Virtual Ward has been rolled out county-wide. Risk Stratification is in place and is being re-purposed to focus on frailty in the Herefordshire population
Reduction in DToC from community settings through an	DToC has been a key focus of the A&E Delivery Board. In common with many authorities DToCs increased through the first three

SCHEME: COMMUNITY HEALTH AND SOCIAL CARE SERVICES REDESIGN	
increased focus and development of risk sharing arrangements across health and social care to support and incentivise improvement	quarters of 2016/17, reaching a high point in November 2016 before declining month on month for the rest of the year (see the JCB integrated performance report for detail).
Continuation of the short break provision for children and families	During 2016-2017, the council supported 151 disabled children with short breaks through commissioned services and direct payments. Planned work to recommission the short breaks offer was completed during early 2017, and will continue to be monitored to manage any market gaps. As part of the new offer from April 2017, the council has implemented a new targeted short breaks allowance scheme.
Rapid response service will continue at an enhanced level	The council's rapid response service continues to deliver crisis management domiciliary care to adults throughout Herefordshire, to support people in their own homes for a short term period. During 2016/17 additional resource was provided to ensure that the increasing levels of demand could be met. The service continues to successfully support timely hospital discharge.
Intermediate care strategy to be implemented with a focus on step up/step down provisions	The progress in the development of an Intermediate Care Strategy was limited during 2016/17. This strategy will be developed during 2017/18. The services to support this have continued including a rapid access to discharge beds (RAAC), a piloted service intermediate rehabilitation services and the redesign of reablement and rapid response into the 'Homefirst' service.
Commencement of engagement on redesign of the community hospital and intermediate bedded provision	Community Engagement was delayed in 2016/17 while the community services redesign was being developed with the One Herefordshire partners. It will now be taking place in July and August 2017 and consultation will commence in October.

SCHEME: DISABLED FACILITIES GRANT	
Strategic objective: *The purpose of the disabled facilities grant is the delivery of essential structural changes to enable people to remain in their own homes and avoid the need for admission to residential care*	
Planned Developments 2016/17	**Progress achieved 2016/17**
Establish a working group to review the DFG scheme	There was a steady increase over the year of the number of DFG referrals approved by the HIA and the number of DFGs completed reflected the additional work of the locum caseworker and locum surveyors, plus the work done by the team in managing contractor availability to make this possible. OT waiting times were significantly reduced during 2016-17. To help reduce waiting times further we have been undertaking a trial of "Trusted Contractors" with a small number of local experienced contractors for less complex adaptations requiring minimal surveying input.
Continue to work with Housing colleagues to ensure a joined up approach to improving outcomes across health, social	The Better Care Team has been working with the Housing Team on a Healthy Homes Project, which will include commissioning a stock modelling report. The project will produce an Outcomes Monitoring Framework, which will enable the identification of older and/or

care and housing.	vulnerable people living in housing, which is a serious and immediate risk to their health and safety, so that remedial, preventative action can be taken. This will help ensure that the need for expensive health and social care service interventions, arising from poor quality housing, is mitigated prior to crisis.

SCHEME: CARE HOME MARKET MANAGEMENT	
Strategic objective: *To deliver more effective market management across Herefordshire to enable the more cost effective purchasing of Residential and Nursing placements through both the council and Continuing Health Care (CHC).*	
Planned Developments 2016/17	**Progress achieved 2016/17**
Agree and implement unified contract in relation to residential, nursing and CHC placements.	The unified contract was implemented from 1st April 2017 following a Dynamic Purchasing System procurement to develop a framework for care home packages. This approach by the council and the CCG has meant that there is a now a simplified common set of the agreed terms and conditions covering all residential and nursing placements for adults.

5. Evidence base and local priorities to support plan for integration

Local Priorities

To support this BCF plan, evidence has been drawn from a range of sources including the Population of Herefordshire 2016 report[1] and Herefordshire Joint Strategic Needs Assessment (JSNA) 2017. This information provides an understanding of current and future trends in demographics, changes in unplanned care and the support provided by primary care and social care services. This evidence base is summarised below to clearly define and quantify the precise issues that Herefordshire faces which the BCF aims to address.

Herefordshire is a predominantly rural county, with the 4th lowest population density in England (0.86 persons per hectare). The **resident population is 189,300** [mid-2016 estimate]; a 0.5 per cent rise from mid-2015, and an eight per cent growth from 2001 (below the England and Wales population growth of 12 per cent 2001 to 2016). This growth has been entirely due to net in-migration, there were around 300 fewer births than there were deaths during the year whilst 1,200 people migrated from overseas and 300 people from other parts of the UK. The vast majority (95 per cent) of the county's land area is classified as rural according to Defra's 2011 rural/urban definition. It is situated in the south-west of the West Midlands region bordering Wales. The city of Hereford, in the middle of the county, is the centre for most

1 Population of Herefordshire: https://factsandfigures.herefordshire.gov.uk/media/48832/population-of-herefordshire-2016-v20.pdf

facilities; other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington. In relation to the geography and demography of the county, Herefordshire faces a specific set of issues:

- **The population is dispersed.** The population of Herefordshire is spread across the county; 42 per cent of residents live in areas classified as 'rural village and dispersed'. The rest of the population live in Hereford City (32 per cent) or one of the five market towns (22 per cent).
- Herefordshire continues to have a relatively **older age structure compared to England and Wales;** 24 per cent of residents (44,800 people) are aged 65+, compared to 18 per cent nationally[2].
- The **older population continues to grow at a disproportionately quicker rate than elsewhere.** Between 2001 and 2016, the number of people aged 65+ increased by 33 per cent (26 per cent nationally). The number aged 65-84 is projected to continue growing at a similar rate, whilst the number aged 85+ will rise even more rapidly.
- Across Herefordshire, although higher than national averages, **healthy life expectancies[3] for both males and females have not increased in line with average life expectancies**; people are living longer but not healthier lives. For those born in Herefordshire in 2012-14 the average life expectancy is 80.7 years for males, whilst for females it is 84.2 years. However, in 2012-15 the healthy life expectancy in Herefordshire was 67.1 years for males and 66.8 years for females.

Longevity is an important achievement; it is the culmination of advances in medical care, access to health care, healthier lifestyles and improved living conditions[4]. However, the disparity between longer life expectancy and accompanying good health has important implications for health and social care systems that must be considered as part of informed planning. Evidence shows an increasing incidence of multiple chronic conditions in the older population[5] as well as a growing number of older people living alone and declining informal care provision from family members[6]. The result is a rising demand in

2 ONS mid-year estimates 2016

3 Health expectancy combines life expectancy, population data and data on the health of a population to give an index of the expected remaining years of healthy life. Healthy Life Expectancy (HLE) is calculated by the Office for National Statistics (ONS) and defines healthy life as years in good or fairly good self-perceived general health.

4 Value for money in health spending, OECD, 2011: https://www.oecd.org/berlin/46201464.pdf

5 Anderson, 2011. 'The challenge of financing care for individuals with multimorbidities': http://www.oecd-ilibrary.org/social-issues-migration-health/health-reform/the-challenge-of-financing-care-for-individuals-with-multimorbidities_9789264122314-6-en

6 How can the settings used to provide care to older people be balanced?, Coyte, Goodwin and Laporte, 2008: http://www.euro.who.int/__data/assets/pdf_file/0006/73284/E93418.pdf

health care and social care services[7]. Evidence of these challenges and the impact on the health and social care services across Herefordshire is identifiable across a range of services.

Evidence Base

Social Care

In Herefordshire, approximately 2,500 people (2015/16) are in receipt of long-term support from adult social care at any one time, the majority of whom (1,700 people) are supported to live in their own homes. The remaining 800 people live in care homes. In addition, there are a substantial number of individuals who arrange and fund their own care, representing more than half of the total number of people in care homes.

Demand for social care is determined by a person's inability to undertake 'instrumental activities of daily living'. A fall, illness or other factor can compromise a person's ability to undertake these activities. Currently, an estimated 17,900 people aged 65+ in Herefordshire are unable to undertake at least one domestic task for themselves (e.g. shopping, washing up, cleaning windows inside, vacuuming floors, dealing with personal affairs, undertaking practical activities). An estimated 14,700 are unable to perform at least one self-care activity (i.e. bathe, shower or wash all over; dress/undress; wash hands and face; feed themselves; cut toenails; take medicines).

Domiciliary Care

Currently, around 800 people are in receipt of domiciliary care services across the county, the majority (75 per cent) of whom are aged over 65 years with a large proportion of clients aged over 85 years (42 per cent of the total).There is also a high proportion of female clients (two thirds), particularly in the older age groups. The Mosaic Public Sector profile is able to provide greater insight into the most common characteristics of people receiving domiciliary care:

- Elderly
- Reliant on state support and state pension
- Low income
- Living alone
- No car
- No longer able to look after their home
- Poor health
- High likelihood of emergency hospital admission
- Live in isolated rural communities

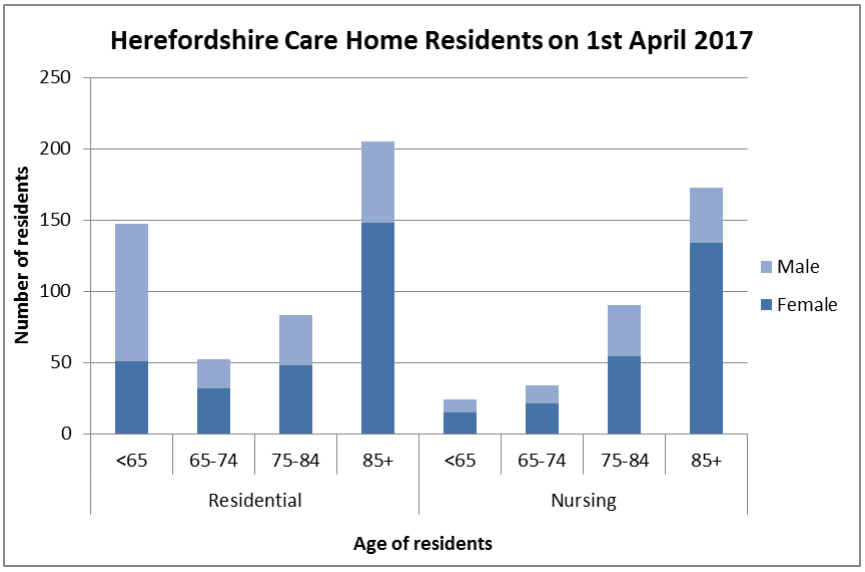
7 Goodwin et al. 2014. Providing integrated care for older people with complex needs: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/providing-integrated-care-for-older-people-with-complex-needs-kingsfund-jan14.pdf

The most common types of support provided can be differentiated by age groups; 91 per cent of clients aged over 50 years receive 'physical support', whilst half of clients aged below 50 years received support in relation to a learning disability.

Care homes

There are 54 nursing homes and 23 residential homes across Herefordshire. Data is recorded on the first of each month to gain an understanding of client profiles on that particular date. On 1 April 2017, there were 809 people living in care homes across Herefordshire who received funding through the council; 488 in residential homes and 321 in nursing homes.

The majority (79 per cent) of care home clients in Herefordshire were aged 65+ years and almost half were aged 85+ years. There was a larger proportion of females than males at every age group except the under 65's, in particular, the 85+ group which is 75 per cent female.



Health Care

GP Practice profiles

There are 23 GP practices in Herefordshire, each with an average of 7,697 people registered to them[8]. The most recent GP practise profiles released by Public Health England show the skew in Herefordshire's older age distribution registered at GP practices when compared to England as a whole. In Herefordshire, 23.9 per cent of people registered with local GP practises were aged 65+ years, whilst across England it was 17.2 per cent. As might be expected from those figures, in 2015/16, residents registered at Herefordshire GP practices also had a higher proportion (55.4 per cent) of longstanding health conditions than those registered across England (53.2 per cent).

8 Public Health England's *National General Practise Profiles*: http://fingertips.phe.org.uk/profile/general-practice/data#mod,2,pyr,2016,pat,153,par,E38000078,are,-,sid1,2000005,ind1,639-4,sid2,-,ind2,-

Hospital care

Wye Valley NHS Trust provides healthcare services at Hereford County Hospital and community hospitals in the market towns of Ross-on-Wye, Leominster and Bromyard.

The most recent provider level analysis for Hospital Admitted Patient Care Activity published by the NHS' Hospital Episode Statistics is for the period 2015/16, and includes the number and age of patients who finished consultant episodes in 2015/16. The data highlights a high proportion of patients aged 60 years or above (56 per cent), despite making up only 30 per cent (ONS 2016 mid-year population estimate) of the total population. Nationally, the proportion of patients aged 60+ was lower (48 per cent). People over the age of 60 are therefore on average twice as likely to require hospital treatment as are younger people.

A further important consideration for hospital care is the increasing occurrence of multiple chronic health conditions with age[7]; a higher number of admissions are more complex, requiring more treatments across the health and care system. Nationally, the top 2 per cent most complex patients are responsible for 16 per cent of spend on inpatients admissions, they are admitted on average seven times per year for three different conditions, 61 per cent of whom are aged 65 or over[9]. NHS Right Care published the Commissioning for Value Where to Look pack in January 2017, which provides local information on the top 2 per cent most complex patients using inpatient admissions, outpatient and A&E attendances data from across the county. Similarly to national figures, 62 per cent of the most complex patients in Herefordshire were aged 65 or over, costing around £5,555,000 in 2015/16.

For the majority of patients, once medically fit for discharge, they are able to leave hospital with the necessary care, support and accommodation in place. However, in some cases a delayed discharge occurs when a person cannot leave hospital because the care, support, accommodation or funding is not readily accessible by the date required to discharge. Depending on the circumstances of the delay, these can be characterised by NHS or Adult Social Care (ASC) responsible delays. Between March and July 2017, there were around 200 delays to discharge of at least one day from Hereford Hospital and local community hospitals. More than 90 per cent of Delayed Transfer of Care (DToC) patients were aged 65+ (66 per cent 80+, 29 per cent 90+) across the period with the median age being 85 years old; fragmented services are not meeting the needs of older people whose multiple complex conditions make them most vulnerable to problems with care co-ordination and transitions between services[10,11]

9 Commissioning for Value Where to Look pack, NHS Herefordshire CCG, 2017: https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/cfv-herefordshire-jan17.pdf

10 Understanding and improving transitions of older people: a user and carer centred approach, Ellins, Glasby, Tanner, McIver, Davidson, Littlechild, Snelling, Miller, Hall, Spence and the Care Transitions Project coresearchers, 2012: http://www.birmingham.ac.uk/Documents/news/SDOTransitions-Report.pdf

11 Ordering the chaos for patients with multimorbidity, Haggerty, 2012: http://www.bgs.org.uk/pdf_cms/reference/bmj_multimorbidity_chaos.pdf

Local integration

Fragmented care for older people who often require both health and social care services is perpetuated by organising and funding services separately[7]. A whole system transformation in the delivery of services is necessary to provide care co-ordinated around older people's needs and goals at the right time and right place[12]. The BCF programme aims to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.

There is no definitive model for providing integrated care for older people; the approach needs to be tailored to the local context[13]. Through the BCF programme, the aim is to drive local integration across Herefordshire to achieve a change at the local system level in which strategies and resources are shared through the use of a pooled budget. At the clinical and care team level, the aim is to share information more effectively and to change the way many services work in isolation. Through the proposals detailed in the BCF plan, Herefordshire will continue to drive the change towards these aims and a service better co-ordinated around patients needs, in particular older patients, will result. This integrated system will be better equipped to assess and meet a wide range of care needs and improve continuity of care[7] for an increasingly older population of Herefordshire.

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[12] A narrative for person-centred coordinated care, National Voices, 2013: https://www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care

[13] Making Integrated Care happen at scale and pace: lessons from experience, Ham and Walsh, 2013: https://www.kingsfund.org.uk/publications/making-integrated-care-happen-scale-and-pace

6. National Conditions

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

- Jointly agreed plan
- NHS contribution to adult social care is maintained
- Agreement to invest in NHS commissioning out of hospital services
- Managing transfers of care

6.1 National condition 1: Jointly agreed plan

The proposed content of the Herefordshire Integration and BCF plan for 2017/19 was presented to the Health and Wellbeing Board (HWB) on 7 September 2017, prior to the initial national submission deadline of 11 September 2017. The HWB have delegated authority to the council's Director for Adults and Wellbeing, the Director of Operations for the CCG and the chief finance officers for both organisations to approve the final content of the plan**.**

In agreeing the content and direction of the plan, the CCG and council commissioners have engaged with a range of health and social care providers in both the acute and private sectors and held a number of consultation workshops to inform the content. This has been done to ensure they are engaged with the plan, can influence the recommendations and understand the joint requirements to deliver the BCF plan insofar as they relate specifically to services they provide to the BCF partners. The CCG and council, as commissioners, and Wye Valley NHS Trust and 2gether NHS Foundation Trust, as providers, are all fully engaged in the alliance to deliver the One Herefordshire Plan and all are sighted on the role of the BCF within the wider transformation programme.

The Disabled Facilities Grant (DFG) has again been allocated through the BCF fund and therefore local housing authority representatives have been involved in developing and agreeing the plan. Herefordshire is a unitary authority which does not devolve DFG to a second tier authority. The management of the DFG sits within the local authority housing team in the adults and wellbeing directorate of the council, and is overseen by the head of prevention. This assists in ensuring that a joined up approach to improving outcomes across health, social care and housing is achieved. Many DFG referrals are received via social care staff and assessment of eligibility for DFG is consistent with delivering wider health and social care benefits, and keeping people safe in their own homes. The following section describes the key DFG achievements in Herefordshire in 2016/17 and details a clear spending plan.

A DFG plan has been developed and incorporated within appendix 1 which shows background information, overall funding, objectives and outcomes to be achieved.

6.2 National Condition 2: Social Care Maintenance

Adult social care services in Herefordshire will continue to be supported within the Integration and BCF plan 2017/19 in a manner consistent with 2016/17. Broadly, funding is assigned to the same service areas, although some areas have seen increases (due to in year pressures such as DOLS) or decreases following successful recommissioning of external services (e.g. carers), which have delivered the same level of service, or improved service outcomes for less. Funding is reallocated to make best use of the available funds to services which are aligned to supporting health outcomes.

As detailed within the submitted planning template, adult social care services in Herefordshire will continue to be supported within the BCF plan 2017/19 in a manner consistent with 2016/17 and within the confirmed increase in line with inflation.

In setting the level of protection for social care (PASC) the local area has ensured that any change does not destabilise the local social and health care system as a whole. As the funding for PASC shows an uplift compared to 2016/17 this has reduced the risk of destabilisation of social care services, but will slow down the pace of change.

The planning template, located at appendix 2, provides a comparison to the approach and figures set out in the 2016/17 plan. Herefordshire is not planning any significant changes from the schemes included in 2016/17, however the inflationary uplift will provide additional capacity to support the community services redesign and philosophy of 'own bed is best' and supporting people in the community rather than in bedded provision. The table below provides a brief summary of the changes in the key schemes within the PASC:

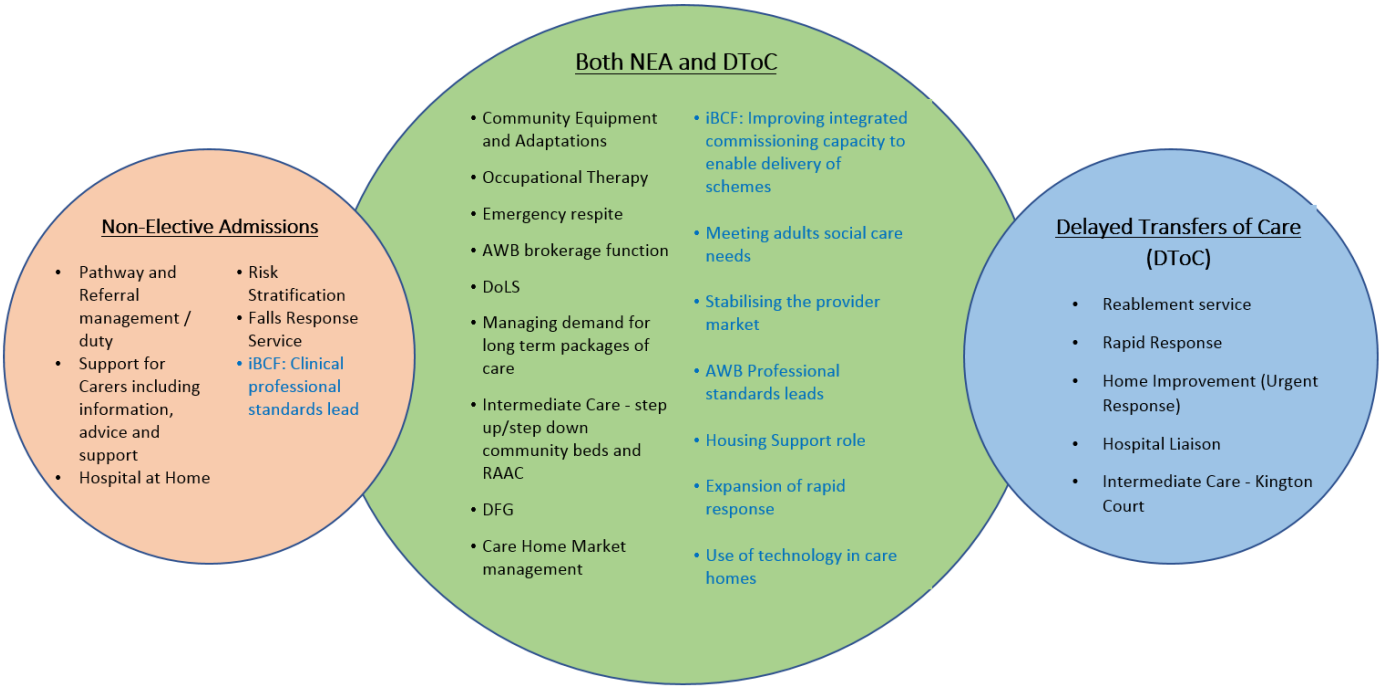
Scheme	Financial change from 16/17 to 17/18	Reason for change
RAAC	(94)	Reduction in budget to reflect historic underspend. Future system redesign.
Support for Carers	(244)	In line with commissioning intensions as detailed in Carers Strategy. Links to wider services- WISH/Community Connectors
Rapid Response	78	Funding level at 16/17 outturn. Increase in staffing levels to enable service to meet demand.
DoLS	175	Funding level at 16/17 outturn
Managing demand of long term packages of care	100	Funding level at 16/17 outturn. Increase due to demand challenges.

Changes in PASC 2018/19

The Learning Disabilities Health Service has been commissioned by the council since 2013 to provide health provision to support people with learning disabilities. The contract is due to cease on 31st December 2017 however the Council will extend this contractual arrangement with 2gether Foundation Trust to 31st March 2018 and will remain the lead commissioner for this period.

The service is a statutory function of the CCG and it is therefore the intention for the CCG to commence the lead commissioner arrangement from April 2018. The total funding for the service is £970k and this will be transferred from the Council to the CCG for the financial year 2018/19. However, both the Council and the CCG will commit resources to review all learning disability services, commissioned by either party or both parties, with an agreed detailed programme of work for this period to establish the future resources and services and the goal of implementing a joint commissioning arrangement. Agreement on the future vision and services will need to have been agreed by both parties by October 2018, which will be governed by the JCB. If agreement has not been reached by this time both parties will negotiate a recurrent contractual transfer arrangement (i.e. the Council will take on recurrent responsibility for certain existing non-NHS contracts from the CCG) to the value of £970k, to allow discharge of responsibility from the Council to the CCG for the provision of LD Health service from 1 April 2019. The CCG and the Council will thereafter be free to seek efficiencies in the services commissioned, having regard to the potential implications on wider services.

The services within PASC have been robustly reviewed to ensure that the elements which support social care are sustainable and do not allow for destabilisation of the market. These services have been aligned in discussion and agreement with the CCG. The diagram below identifies the schemes within the BCF and iBCF that contribute and support the reduction of DToC and/or NEA, as illustrated in the following diagram:



6.3 National Condition 3: NHS out of hospital services

Within Herefordshire, there is agreement that NHS commissioned out-of-hospital services and services that were previously paid for from funding made available as a result of achieving their non-elective admission reduction, continue in a manner consistent with those agreed in 2016/17. The community health scheme meets the requirement for allocation of at least £3,399k to be invested in NHS commissioned out of hospital services in 2017/18 and £3,463k in 2018/19. The funding has been allocated in full and not retained as part of a local risk sharing agreement. This funding is allocated to district nursing and other community based nursing. The specific detail is clearly set out within the summary and expenditure plan tabs on the BCF planning return template.

The non-elective target has been recently agreed as part of the CCG operational plans and has been updated with guidance from NHSE. Herefordshire system have agreed to this target and will not be having an additional target, and contingency funds will not be held as the BCF fund is fully allocated to existing schemes within Herefordshire, and no funds are available to be retained for a contingency.

As agreed by the One Herefordshire Alliance Executive, the vision for the local health and care system in Herefordshire is one where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people. Sustainable services are those delivered via a model of care

which ensures that they can be delivered in a clinically viable, safe and effective manner at the scale to which they are required locally and within the financial resources available to the system as a whole.

Building then on the learning from emerging models of care and the Primary Care Home model, the community redesign is to support people who are frail, who have complex needs or are in vulnerable circumstances, have their independence maximised through appropriate support, information and tools to empower them and their carers to be more in control of their care journey. The extended primary care team will work with individuals and their families to co-produce a single assessment and care and support plan to deliver timely, targeted, effective and co-ordinated care and support, and improve the health and wellbeing of those identified.

Four localities will be developed to create ownership and support improved outcomes across the system, which are both sensitive to the resource and needs of the local population but remain resilient in delivery. Organised at a county wide and locality level, localities will mirror General Practice arrangements, and would see the formation of wraparound services across the localities defined above.

Once locality teams are established, it is expected that county wide resources can be more closely aligned to locality working. The focus of the Provider Alliance will be to ensure that the teams operate effectively with wider community based resources, including adult social care (council & independent sector provision), voluntary sector enablers, third sector providers (including Hospice at home) and other specialist providers (including tertiary care) to support service users in;

- Staying well
- **Remaining at home**
- **Using community resources more effectively**
- Ensuring whole life planning

Such outcomes will require very different ways of working, and drawing on the learning from engagement events with community teams (including practice based planning), national learning and academic thinking, the Provider Alliance will seek to implement a comprehensive system change.

The BCF schemes are key enablers to the outcomes highlighted above and the sections below describe the development for 2017/19 for out of hospital services:

Remaining at Home

- Crisis prevention, crisis management and admission avoidance – Developing a single community based urgent care response, rapidly responding to crises and putting plans in place to ensure that our service users remain safe and only use urgent and emergency services if absolutely necessary. This is to be achieved through;

- Seeking to incorporate a Therapy led Reablement programme in support of admission prevention and rapid discharge.
- Incorporating the Hospital at Home functions; providing traditional ward based interventions to service users in their own home, including Intravenous antibiotics and fluids, supporting acute management of long term conditions and active treatment in end of life care alongside the resources of Hospice at Home.
- Utilising the emerging model for Urgent Care Coordination to provide a menu of options including to;
- Provide clear access to community NHS and community based resources which operate to keep patients out of hospital, prioritising ambulatory care assessment and;
- Be used to access bed based resources to enable 'step up' functions
- Care Navigation - It is proposed to use the ICP model to ensure a clear line of communication across the multidisciplinary team, and in supporting professionals to effectively communicate across the pathway, including the support to each GP practice in risk stratification and MDT working.
- Tele-metrics – Using existing schemes, monitoring biometric data provided directly by patients to inform rapid treatment change and admission prevention. It is recognised that such models will need to significantly increase, informed by the resources provided through the Local Digital Roadmap (LDR) planning.
- Nursing and residential home development – Seeking to reduce variance in care and performance, building on existing initiatives such as the 2gether Care Home Dementia support team, upskilling the independent sector workforce and developing more effective shared care pathways across physical and mental health provision, utilising the skills of the whole primary care and community team to inform standardised care home practices and reduce variation..
- Building on the success of the Taurus programme of training carers in dementia, and working with Herefordshire Carers Support to provide training and support in looking after their loved ones, which better reflects the proactive pathways and admission prevention. This complements the successful dementia/managing memory services delivered by 2gether Trust which works through a strong partnership they have developed with The Alzheimer's Society and has opened access to a range of community resources across Herefordshire
- Alongside our proposals for developing a robust acute/urgent care system we will ensure that urgent/crisis care for individuals experiencing mental health crisis will continue to be strongly supported by our Mental Health Crisis services recently rated as Outstanding by the CQC. Whilst these services received this rating we know that there is more to do and will be undertaking work to implement the requirements of the Mental Health Task Force in line with our STP development proposals. These developments will also support our Acute/Urgent care system as the Hospital Liaison services are strengthened as part of developing the Mental Health crisis concordat.

- Through the Primary Care Home model and community health redesign the NHS out of hospital service provision that is within the BCF will be part of the change along with all of the community services.

Using Community resources more effectively

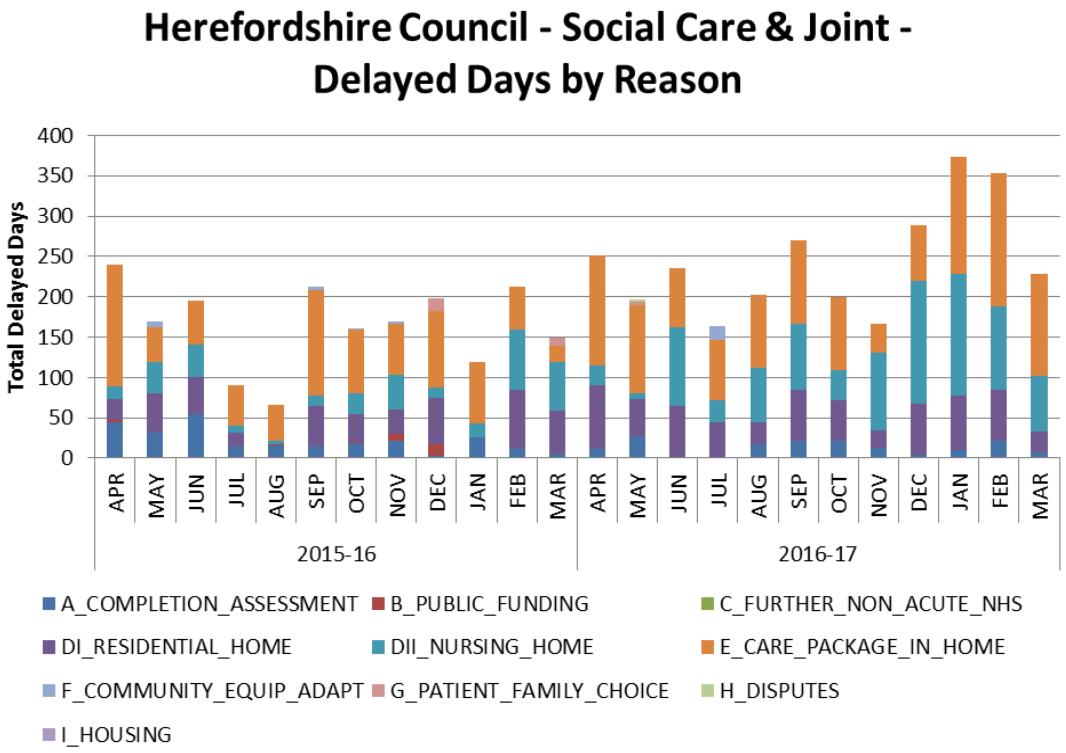
A co-designed model for intermediate care – Rapidly defining a model of intermediate bed based and non-bed based care that best utilises the extensive community hospital resources we have. This will include:

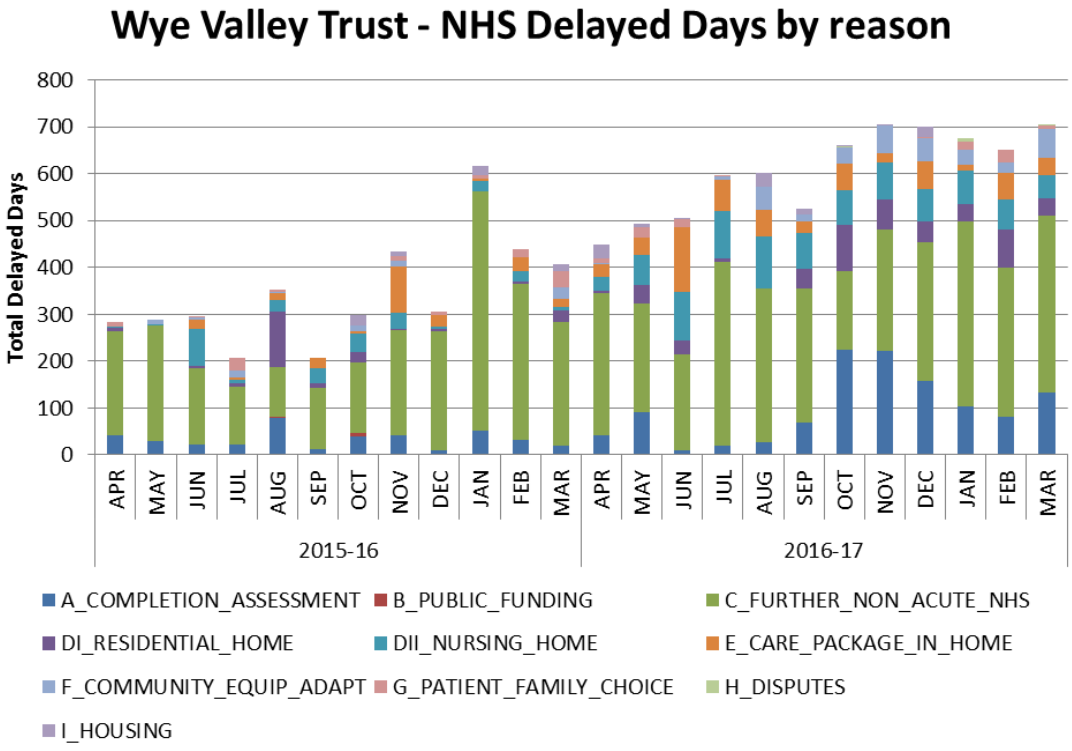
- Community Multi-Disciplinary Team supported admissions to bed based services (step up), including both the emerging Intermediate Rehabilitation Service and wider community beds to support ambulatory frailty assessment.
- Rapid discharge to 'your own bed' principles of management, with wraparound community support. This is intended to seamlessly interface with statutory Adult Social Care functions, and seek to drive improved collaborative relationships with care providers.
- Interlinked locality working between primary care, community and intermediate care teams.
- Harnessing the frailty pathway development work as the required resource to support clinically driven, practical change on behalf of 'Living well at home'.

6.4 National Condition 4: Managing Transfers of Care

Herefordshire have undertaken a number of engagement sessions with key stakeholders and providers on the implementation of the high impact change model. This involved identifying the system problem we are trying to address in Herefordshire against each of the eight high impact areas, understanding what we are currently commissioning to support these areas to them determine the future requirements. Through this process, it was identified that the areas focussed on transfers of care without addressing the need to prevent individuals being admitted into hospital. Therefore, an additional high impact change has been included, change '0' – 'Preventing Escalation of Need' - that focusses on prevention and early intervention to keep people in their own home whilst reducing demand on formal services.

Reducing delayed transfers of care (DToC) continues to be a challenge in Herefordshire. Partners are working closely together to implement changes and improve systems to enable reductions. Detailed analysis is undertaken on a regular basis to ensure that the reasons for delays are clearly understood and plans are put in place to aid progress.





The table below clearly articulates the eight high impact areas, identifying the problem, what we are currently doing and what we plan to do next split between the system response and schemes influenced by the BCF:

Improvement Plan - Delayed Transfers of Care

A. Mapping and action plan - High Impact Interventions

Section 11.4 shows the trajectory for Herefordshire and although we have agreed locally to the target we recognise that the required trajectory is very steep and that hitting it will require substantial performance improvements. The table below sets outs the improvement we will make:

Please note that the schemes identified in green relate to BCF and/or iBCF schemes. Those in orange represent system response.

BCF or iBCF schemes	**System response**

The problem	Where we are	What we intend to do next	Timescales
Preventing escalation of need Insufficient investment in preventative services to reduce the pressure, including integrated approach to risk stratification	• WISH – online and city centre hub • Falls service • Leominster community project • Warm homes initiative – boiler replacement programme	• Introduction of professional standards leads • Expansion of community connector roles • Development of an integrated risk stratification approach/tool	December 2017 December 2017 January 2018
Early Discharge Planning Lack of evidence of needs and analysis to understand the full problem in Herefordshire and out of county planning. However, evidence shows that patients are staying in hospital longer than necessary and bed blocking acute and community beds. This results in reduced mobility and independence.	• Risk Stratification, Care Plans and Enhanced Care Plans in place. Information Governance arrangements developing to enable further sharing across system. System membership of Acute Frailty Network. • Red and Green day pilot in place in Community Services across half of Community Hospitals and Intermediate Care facilities with rollout planned over summer. Red to Green day programme rolling out across acute wards. Daily system wide calls to review DTOCs in acute, community and intermediate care	• Analysis of data to ensure clear understanding of the reasons for delays. • Implementation of Red to Green day programme across acute wards. • Implementation of Red to Green day programme across community including intermediate and discharge beds • Information Governance arrangements in place to support information sharing • Support for self funders and OOC delays (iBCF) • Domiciliary providers to hold package for 2week when service users admitted to hospital being scoped	September 2017 September 2017 September 2017 September 2017 September 2017

	beds and 7 day LoS reviews occurring at each site.		
	• Three ASC workers in hospital – duty teams/hospital teams • Res/Nursing – placements remain open for 12 weeks but payment reduces over this time • Pathway redesign	• DTOC support • Development of Trusted Assessor role to support out of county patients. • Dedicated support for facilitating self funder discharges • Red 2 Green day programme implementation	September 2017 October 2017 January 2018 September 2017
Systems to monitor patient flows No integrated care record or patient tracking system. No links between hospital and social care tracking systems. Manual tracking is inefficient and resource intensive. It does not allow clarity on where issues and gaps are. Lack of tracking information.	• Daily system calls in place. Live bed state available within WVT. Daily sharing of SITREP information across key partners. Dashboard shared through A&E Delivery Board. Joint Discharge Pathway group in place with system wide involvement. Out of County relationships and regular calls established. New model of provision for Adult Social Care.	• Review and re-engineering of Care Co-ordination Centre to support accurate daily information shared across system. • Increased capacity and capability in Adult Social Care systems to support improved tracking and signposting.	October 2017 October 2017
	• Manual inputting from operations on tracking information such as DToC	• Exploring the Mosaic professional portal • Live GIS system to track capacity – availability dashboards for all staff • Rota software for Home First service, and the dom care market • Scoping PI software – pulling together ASC and health data	October 2017 January 2018 November 2017 January 2018
Multidisciplinary Discharge Teams including the Voluntary and Community Sector. The MDT (Huddle) is not embedded culturally and works on an ad hoc	• Daily calls in place with system wide multi-agency involvement to review all delays in acute, community and intermediate care facilities and agree on next actions. Red Cross engaged in Huddles in community site and planned rollout to include carers support. Social Workers based within	• Development of Trusted assessor roles with Care sector in Herefordshire. • Development of Trusted Assessor roles with Out of County commissioners (health and social care). • Development of consistent criteria for equipment with OOC commissioners.	February 2018 October – March 2018 October 2018

basis. Lack of engagement and market development with the community and voluntary sector to be part of these discussions. Scattergun approach when hospital at level 3 or 4.	acute trust working effectively. Lead from Powys based in Acute Trust supporting transfers	• Implementation of strength based assessment in social care	September 2017
	• Under the short term pathway ASC will be working with GP's and senior practitioner roles linking into the GP's.	• Making Every Contact Count – what could be put in place ahead of admissions? • Independent review for CHC assessments	October – March 2018 October 2017
Home First / Discharge to Assess Insufficient capacity to provide intensive wrap around care in the community including therapists and care workers. D2A methodology not embedded culturally. Staff are risk averse and over cautious resulting in disablement, not reablement.	• RAAC beds and Integrated Rehab. Service in place providing "step down and step up" from acute/community bedded setting. • Community hospital and intermediate care beds. • Review ("bed census") of beds across acute, community and intermediate care provision demonstrated 40% of patients could be cared for more appropriately outside of current (hospital) setting. • Limited reablement service moved into AWB team to support integration and market development.	• Active support for "own bed first" approach to discharge. • Development of Discharge to Assess/Intermediate care model building on reablement approach of IRS. Development of reablement culture and capacity across system. Recruit physio support to enhanced reablement service • Development of mental health provision for elderly.	Ongoing cultural change October 2017 November 2017
	• Reablement • IRS and RAAC beds	• Introduction of Home First service • Reablement training for the care market – cultural change programme for the care market	November 2017 From January 2018
Seven Day Services Lack of fully resources 7 day services in hospital and out of hospital. This has resulted in wasted resource in social care as staff working without referrals. Improved IT systems would help flow.	• Seven day provision of key services: reablement, falls, rapid response, social work assessment. Discussions underway with Care Home market to develop seven day response to transfers and returns. • 7 day access to primary care through Access hubs in place across county.	• Domiciliary providers to hold packages of care open if patient admitted to hospital being scoped	September 2017

	• Reablement, rapid response, IRS and social workers 7 days a week.	• Scoping new Adult Social Care strength based assessment model extends 7 day provision to allow assessment and placement.	November 2017
Trusted Assessors This has not been introduced due to lack of trust by partners.	• Limited arrangements in place.	• Development of Trusted Assessor role with Care sector • Development of Trusted Assessor role to support out of county patients.	February 2018 October – March 2018
	• Considering trusted assessor in appropriate format.	• Define the role of trusted assessor • Create role for development and training of trusted assessor.	September 2017 November 2017
Focus on Choice We do not engage with the voluntary sector to ensure that they play a robust part in this process. Hospital teams do not clearly explain peoples choices. No clear pathway of choice.	• Local Authority public facing Information hub in place – WISH - and linked into DoS. • Community Connectors model in place with opportunity for further development including learning from local pilot of impact (Leominster project) • Strong Voluntary Sector in Herefordshire with high percentage of population involved in volunteering • Adult social care re-engineering includes strengthening of connection to and support for self- care, choice and voluntary sector.	• Increased provision of community broker role. • Implementation of pathway roles in Adult social care model • Development of Primary Care Home projects working with community connectors.	September 2017 September 2017 October 2017
	• WISH • Strength based assessment embedded	• System message on choice and implications associated with these • Strength based assessment embedded • Deliver strength based training to providers • Community catalyst project	October 2017 September 2017 From January 2018 November 2017
Enhancing Health in Care Homes No strong care co-ordinator model	• "Red bag" scheme in place. • Active programme of support and education jointly between CCG and Local Authority. • Falls prevention scheme supporting Care	• Increased prevention advice to Care homes • Enhanced falls prevention technology scoping	December 2017 January 2018

to join up health, social care and providers. High level of admissions to hospital from care homes. Variable quality within the providers.	Homes.		
	• Falls prevention • Red bag scheme • Joint contract for Care Homes between CCG and Local Authority • Producing a needs analysis on nursing bed provision • Working with providers to change beds to nursing to create additional capacity for nursing provision (SHAW and Blanchworth) • Review of planning applications • Senior management meetings with providers of concern to improve quality, particular focus on homes with suspensions in place • Soft market test on block contract option for nursing placements.	• Clinical professional leads • Joint brokerage with the CCG • Scoping cloud based technology / enhancing health across the care sector • Evaluation of technology in care homes • PH input / advice to care homes e.g. nutrition, dehydration, postural support • Community support for stroke patients • Training for care home staff • Review of planning policies to create a corporate approach to new care home developments in the county. • A new market position to identify the gaps in the market to inform future business development. • Review of quality assurance process to improve intelligence data and response. • Scope care home development with housing/stakeholders • 1-2-1 visits with the nursing providers, council and CCG to discuss future developments. • Consider best practice and pilots.	December 2017 January 2018 March 2018 March 2018 September 2017 October 2017 December 2017 September 2017 September – January 2018 September – November September – ongoing September – January 018 September 2017

6.5 Continuing progress in other areas

Supporting progress on meeting the 2020 standards for seven day services

The One Herefordshire Programme, through its Urgent Care and Community Collaborative workstreams, together with schemes within the Better Care Fund, has continued to have a central focus on ensuring coherence across primary, community and secondary care, seven days a week.

Work has been ongoing to develop a Professional Facing Care Co-ordination Hub to deliver multi-disciplinary clinical inputs to support decision making and to co-ordinate and simplify:

- Emergency admissions and discharges
- Information and record sharing across providers, enabling front line staff to share records to improve the continuity of their care and work toward an integrated record for Herefordshire
- IT interoperability enabling direct booking of appointments across service providers
- Ensure access to most appropriate care that can prevent emergency admissions e.g. diagnostics, community services, social care
- Access to specialist opinion and advice (through regional procurement)
- Integration with GP out of hours services for improved efficiency
- Our continuing work with primary care and wider stakeholders to develop infrastructure to deliver 7 days services inc IT, workforce and estates

This approach is designed to prevent unnecessary non-elective admissions (physical and mental health) through the provision of an agreed level of infrastructure across out of hospital services 7 days a week and improved discharge planning.

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

- Increased capacity and capability over 7 days, at locality level, of primary care and community services central to the urgent care pathway

- Realignment of resources within Minor Injuries Units and the Walk-In Centre, to simplify access routes for the public, reduce service duplication, and realign workforce and skill sets to primary care and A & E.

- An Integrated NHS111/GP Out of Hours service has been commissioned across the West Midlands, on behalf of 16 CCGs which includes Herefordshire. Each CCG in the West Midlands has an opportunity to influence how the NHS 111 service works in their area and we will be ensuring that NHS 111 will be integrated with Herefordshire's urgent care services.

- A public facing "virtual assessment" function across the whole pathway of care, to move towards "talk before you walk", across primary care, NHS 111, WMAS and the "front door" of A & E.

- The brokerage function within the Adults Wellbeing directorate for the local authority provides 7 days a week support to enable hospital discharges

- Enhanced capacity has been provided to hospital social care management function 7 days a week

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

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

Since April 2016, every local area has been required to deliver, monitored by the Transformation Through Technology Group (TTTG):

- A Footprint detailing the partners and the governance arrangements to drive the local health and care system to become paper-free at the point of care.

- A baselined and benchmarked process towards becoming paper-free at the point of care using a new Digital Maturity Self-Assessment Tool.

- A digital roadmap outlining the steps (operational and strategic) to be taken towards being paper-free at the point of care.

The major recommendation from the workstream is that Herefordshire should implement a shared care record, with data being supplied from providers once appropriate systems are in place. This would provide a platform that improves the quality of care, the information available to professionals and

clinicians and community workers and should, with appropriate business change, reduce time in hospital, support living at home longer, improve outcomes for patients and reduce costs.

A service re-design management sub-group has been established called the Transformation Through Technology Group (TTTG) since 2016, to support the delivery of the Digital Road map in Herefordshire. Initial membership of the group includes representation from the CCG, local authority and key providers including WVT, 2G, WMAS, St Michaels Hospice and Taurus Healthcare. The digital roadmap is the key deliverable for the TTTG to ensure that Herefordshire have interoperability of systems by 2020 at patient points of care across both health and social care. The digital footprint was agreed as 'Herefordshire' and submitted to NHS England in December 2015. The TTTG have submitted their Digital maturity Index returns on schedule in January as required by NHS England.

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

It is recognised that there is a requirement for appropriate Information Governance controls to be in place for information sharing in line with the revised Caldicott principles and guidance (available by the IGA). The council has achieved 74% of the current IG toolkit submission and is at least level 2 in all areas and the Herefordshire CCG 91% with at least level 2 in all areas. A Herefordshire memorandum of understanding on information sharing is in place and local data sharing agreements amongst partners are in the process of being developed. All staff receive mandatory training in information governance as part of each organisations IG toolkit and IG compliance. Specific multi-agency face-to-face training is in the planning stages for roll-out during the remainder of 2017 and into 2018.

The CCG and Council have also been working on an overall data sharing agreement with regards to the enhanced summary care record. Taking this forward Taurus, the GP consortium covering most Herefordshire practices, has been commissioned to undertake the data sharing agreements and on-going management of them.

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

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

A joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care, there will be an accountable professional

We have an Integrated Urgent Care Pathway project in place, which is a joint project between the Local Authority and Wye Valley NHS Trust. This utilises the existing community health and locality social care teams to maximise opportunities to avoid admissions into the acute hospital and promote early supported discharge/discharge to assess. This project continues to develop the footprint for multi-disciplinary working utilising lead professionals (Key Workers) and Trusted Referrer and Trusted Assessor roles across multiple Health and Social Care teams.

Our strategic objective is to minimise admissions and spend within acute settings and to invest in the community health and social care services in order to meet the system objectives of safely and effectively maintaining independence within the community for vulnerable adults.

The pathway's aim is to provide a rapid response to urgent care requirements in the right place at the right time, maximising the person's independence within the community setting by deploying an optimal skill mix to ensure that the response provided is appropriate and proportionate to the assessed needs. The default position is, wherever possible and safe, for the person to be supported to remain at, or return to their home.

To support dementia services in our community we have memory clinic nurses in primary settings which support diagnosis and provide case management. In addition they also provide integrated planning across primary and secondary care settings. We also have Alzheimer's Society link workers to integrate with community services and maintain social inclusion. They also link into the Hospital at Home scheme, district nurses, community matron and therapists. This approach has been developed using risk stratification tools.

Agreement on the consequential impact on the providers that are predicted to be substantially affected by the plans

Providers have been fully briefed on the projects included within the BCF that impact on them. We continue to work with our providers to support delivery of the key elements of the One Herefordshire projects and where appropriate, changes are reflected in our contractual relationship with providers. Providers have played an active role in our development workshops especially in proposed changes to the expanded use of Telecare within care home settings.

Key providers are full members of the One Herefordshire programme of work, to which the BCF plans are integral. This has ensured that providers are engaged with, and co-produce, transformation and service redesign plans at an early stage (though if re-procurement of a service is required, appropriate conflicts of interest safeguards are in place).

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

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

The impact of local plans has been agreed with relevant health and social care providers. The CCG's contract with its main acute provider (Wye Valley Trust) includes QIPPs and contractual changes that reflect the implementation and extension of schemes that are supported through the BCF – e.g. extension of the Virtual Wards across the whole county. Activity and performance trajectories are modelled, alongside financial impact and these are taken into account through contract negotiations. A clear provider engagement plan will be included within the BCF 2017/19.

The largest pool within the BCF plan for Herefordshire is for the joint contracting and commissioning of residential and nursing placements. The unified contract was developed during 2016/17 and the consequential impact on the implementation and delivery of the contract has been monitored and reported on a regular basis. A large engagement process has been undertaken with the market, during which contract principles and changes have been considered.

There is ongoing public, patient and service user engagement in the planning process by partners, through our usual activities. We have recently reconfigured and re-contracted for our local Healthwatch service to ensure that our plans are subject to appropriate public and partner scrutiny. In addition, CCG and council provide regular updates to governing body, Cabinet and members as part of the routine governance and assurance processes.

Falls Response Service

The Falls Responder Service provides a 24/7 mobile response to adults who have fallen in their home environment and are uninjured. The team are trained to safely move an individual who articulates that they are uninjured, provide a welfare check, provide signposting to sources of support, notify the GP and refer (with consent) to the Falls Prevention Team for follow up clinical assessment and intervention. A

follow up telephone call is made to each individual 24 hrs after the responder visit to clarify impact post fall.

Since the introduction of the Falls responder service monthly analysis of WMAS conveyances to Hereford County Hospital which are coded as 'Fall' (as a percentage of all WMAS conveyances) are measured as a 12 month rolling average, this indicates a reducing trend for falls conveyances. The falls responder data also indicates that the number of WVT admissions per month with a falls diagnosis measured as a 12 month rolling average indicates an overall decline in the number of admissions. Monthly data analysis indicates that the responder service is delivering the projected system benefits alongside positive patient feedback.

7. Plan: schemes and spending

The table detailed below provides an overview of the schemes included within both the BCF and iBCF for 2017/19 and identified key developments for be achieved during 2017/19.

Please note that a detailed spending plan for each of the BCF and iBCF are located in the appendices of this document:

National Metric	Contributing scheme	Funding source	Key developments 2017/19
Non-elective admissions (NEA)	**Pathway and referral management**	BCF	ASC pathway and front door redesign - there will be continued development of aligned working arrangements and implementation of the strengths based assessment process. Workforce and market development support has also been commissioned to address the workforce issues within the market.
	Support for Carers, including information, advice and support	BCF	**Implementation of the Carers Strategy** - The implementation of the Strategy will continue to be monitored to ensure that it continues to fit with Herefordshire Council's Health and Wellbeing Strategy and Adults Wellbeing Plan. **Enhance content of Information, Advice and Support -** The work for Phase 2 commenced in 2016/2017 and this will continue to be developed and aligned to the commissioning intentions and prevention priorities. **Re-procure advocacy service -** This service will continue to be monitored and reviewed to ensure that it provides an effective and efficient service. Mental health services including advocacy will be reviewed by our newly recommissioned Healthwatch service during 2017-18. The findings of this review will help inform our continued development of these services.
	Hospital at Home	BCF	There will be a continuing focus on the delivery of the Virtual Ward concept. This will include the roll out of enhanced telecare support enabled by the

			development of the 'Faster Shire' Broadband programme across the county.
	Risk stratification	BCF	Continued roll-out of the risk stratification tool
	Falls Response Service	BCF	Continue to monitor service and measure impact of Falls scheme during 17/19.
	Short break provision for children and families	BCF	The newly commissioned services for short breaks will continue to be reviewed. The success of the new targeted short breaks allowance scheme will also be reviewed.
	iBCF: Clinical professional standards lead	iBCF	To support care homes throughout Herefordshire to reduce admissions to hospital and improving the care standards within the care homes.
Delayed Transfers of Care (DToC)	**Reablement service**	BCF	The service will be delivered by the council from 1 August 2017, with the redesigned model 'Home first' being implemented from the beginning of November 2017. The increased capacity within the service will support transfer of care and people to remain within their own homes.
	Rapid response service and expansion of service	BCF/iBCF	The continuing success of this programme is central to our ability to manage and influence a wide range of targets such as DToCs as well as meeting our own ambitions to increase the number of people able to remain independent in their homes within their communities. This service will be aligned and incorporated into the 'Homefirst' service.
	Home Improvement (Urgent Response)	BCF	Continue to deliver and manage demand.
	Hospital liaison	BCF	Continue to deliver and manage demand.
	Intermediate Care – Kington Court	BCF	Existing contract due to end 31 March 2018. Engagement process to be completed to inform future commissioning decisions.
Both NEA and DToC	**Community Equipment and Adaptations**	BCF	Existing contract due to end March 2018. Extension options to be investigated and future commissioning options to be scoped during 2017/18.

	Occupational therapy	BCF	Continue to fund staffing structure to support the delivery of the DFG.
	Emergency respite	BCF	Continue contribution to respite costs - estimate 15% emergency to prevent admissions to hospital.
	AWB brokerage function	BCF	Continue to facilitate securing placements / dom care to facilitate hospital discharges.
	DoLS	BCF	The number of referrals for DoLS has increased in Herefordshire, in line with the national trend. Herefordshire is currently experiencing a back log in cases, which is slowly decreasing. During 2017/18 the service will continue to manage demand through careful triaging of referral to ensure that those most at risk are assessed as quickly as possible.
	Managing demand for long term packages of care	BCF	Continue to manage demands for long term packages of care.
	Intermediate Care – step up/step down community beds and RAAC	BCF	It has been agreed that a review of RAAC provision is required during 2017/18. The current RAAC framework is due to end in November 2017 a review is being undertaken to reshape the service to support the community redesign model and systems demands.
	DFG	BCF	The Key DFG Objectives for 2017/19 include: o OT Assessments to be completed within 28 days of receipt of referral o the recruitment of staff including the recruitment of additional 1.5 FTE locum Surveyors and 1 FTE caseworker o Increased Support to Self-funders o Better Support to Clients with Dementia & their Carers o Extension of Hospital Discharge Project o Development of the Trusted Contractor Project The increased funding for DFG in 2017/18 provides the potential to deliver additional adaptions. Based on central government estimates this may lead to the delay of residential admissions of up to 30 people (10% per CSR

			projections). In addition, the Healthy Homes Project will enable the identification of older and/or vulnerable people living in housing, so that where needed remedial, preventative action can be taken. The Project which will be in two phases covering 2017/19 will also generate statistical information about housing conditions and the health and wellbeing of older and/or vulnerable residents to inform local housing, health and social care strategies.
	iBCF – Improving integrated commissioning capacity to enable delivery of schemes	iBCF	Adding additional capacity into the system to project manage key changes such as iBCF and community services redesign. Introduction of a BCF contract and performance management function to monitor the performance and impact of investments, drive efficiencies within integrated services, adding capacity to develop further integrated ways of working and pilots funded through the BCF programme.
	Meeting adults social care needs	iBCF	The council and CCG will continue to work together to monitor and reduce the levels of DToC and ensuring that new schemes are developed and implemented, where appropriate. The development of a locally based system of Community Brokers to identify and promote local provision and support mechanisms is underway. These posts will increase the amount of provision and support available to enable DToC cases to be kept to a minimum.
	Stabilising the provider market	iBCF	
	AWB Professional standards leads	iBCF	Introduce lead professionals to drive up the quality of the social care workforce to enable a strengths based approach and reducing the reliance on health and social care services.
	Housing Support role	iBCF	Introduction of role to aid transition from enhanced housing benefit to new supported housing model.
	Use of technology in care homes	iBCF	Initial assessment of use of technology in care homes to identify best areas for future investment / training / support. Baseline information gathering to

			determine investment in homes that requirement improvement to avoid admissions and improve quality.
Both NEA and DToC	**Full implementation of the joint service model for community health, mental health and social care services**	BCF and iBCF	Full service change will be in place by 2019. The local NHS Trust (Wye Valley) will re-organise its community services division and structured services focusing on GP practice hubs. Other local provision including community hospitals will also be reviewed and reshaped as required. There will be closer integration between mental health services and social care services as this is central to the work of the One Herefordshire programme and the Living Well At Home workstream
	Admiral dementia nurses	iBCF	Introduce Admiral dementia nurses to provide additional support in the community and in care homes and community hospitals. Improve care for Dementia- reduce admissions, lower length of stay, improved discharges
Admissions to Residential care homes	**Care Home Market management**	BCF	Management of market to ensure improved care planning and avoidable admissions, to improve self-care and self-management, and to enable choice to minimise avoidable admissions
	Continuation of unified contract in relation to residential, nursing and CHC placements.	BCF	The effectiveness of the contract will continue to be monitored throughout 2017/19 and the contract will support with joint market development between the council and CCG, joint quality assurance process and initiative to reduce hospital admissions such as the red bag scheme.
			Implementation of the schemes detailed above, and the delivery of the joint blueprint, will support individuals to remain in their own communities for longer is expected to impact upon the demand for permanent admissions to residential care homes.
Effectiveness of Reablement	**Redesign and implementation of Home First service**	BCF	The service will be delivered by the council from 1 August 2017, with the redesigned model 'Home First' being implemented from the beginning of November 2017. The increased capacity within the service will support transfer of care and people to remain within their own homes.

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

The Herefordshire BCF plan maintains the schemes identified in the 2016/17 BCF submission and therefore an assessment of the impact of these changes on these services is minimal. The funding for the protection of social care includes increased support to demand management in response to the increased in long term packages of care, DOLS increase and increase in rapid response.

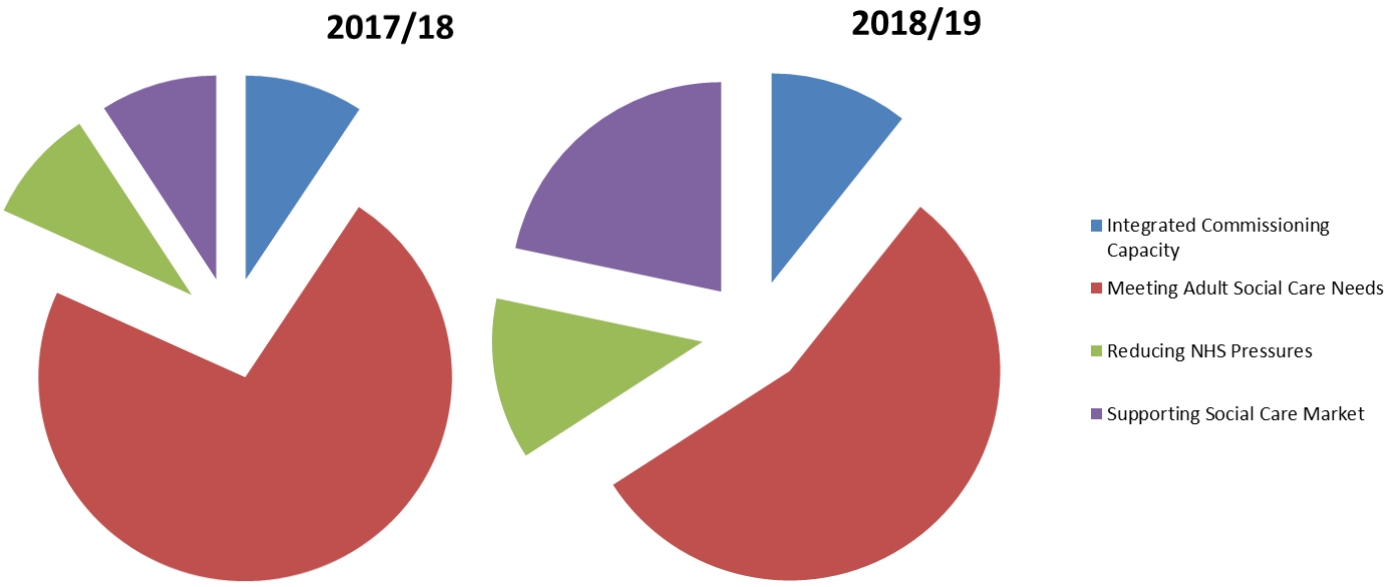
The investment in the falls response service has proved very successful since its commencement and has delivered more than double the target savings. This scheme is jointly funded by the CCG, council and the provider.

8. Overview of funding contributions

The table below provides a brief summary of the Herefordshire's financial allocation for 2017/19.

Better Care Fund 2017-19	**2016/17 £'000**	**2017/18 £'000**	**2018/19 £'000**
Planned Social Care Expenditure	5,052	5,142	5,240
NHS Commissioned Out of Hospital Care	6,698	6,818	6,947
Minimum Revenue Fund	**11,749**	**11,960**	**12,187**
Disabled Facilities Grant	1,558	1,706	1,853
Sub Total Minimum BCF	**13,308**	**13,665**	**14,040**
iBCF	**0**	**3,573**	**4,722**
Minimum Fund including iBCF	**13,308**	**17,238**	**18,762**
Additional Pool – Care Home Market Management			
Council Contribution	19,468	20,147	20,530
CCG Contribution	9,272	8,594	8,757
Total Additional Pool	**28,739**	**28,741**	**29,287**
Total BCF	**42,047**	**45,979**	**48,049**

Further detail on how this funding is being allocated can be found within the planning template (located at appendix 2) of this document. This details what proportion of each funding stream is made available to social care and also provides a detailed breakdown of the agreed iBCF spend. Please note that this funding has not been used to offset against the contribution from the CCG minimum fund. The following diagram illustrates how the iBCF funding has been allocated against the 3 grant conditions, plus a local condition of increasing integrated commissioning capacity:



Two transformation pools have been agreed within the iBCF, to which the following principles will be applied:

Principles of the transformation pool 1
• Building on existing or new schemes – quicker/bigger • Key criteria: support transfers of care; reducing length of time in hospital, and also preventing admission through in-reach to ED (linking with the new streaming service) • Engage with the market next week on options and how they would support the criteria (bids from the market)
Principles for Transformation Pool 2
• 200k in year 1 (2017/18) and 400k in year 2 (2018/19) • Focused on supporting the shift from bedded care to “own bed” based care • Building increased capacity and capability in community and primary care (within the context of

Primary Care Home)

- Measured through clear reductions in total length of stay in hospital and intermediate care beds
- Investments in providers to be non-recurring to support the transition period (with “transition” being up to 6 months in duration.
- Proposals developed and implementation overseen through the panel approach agreed for Transformation Pool 1, reporting to the Operating Model Working Group and through there to the Joint Commissioning Board and Provider Alliance Board.

9. Programme Governance

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

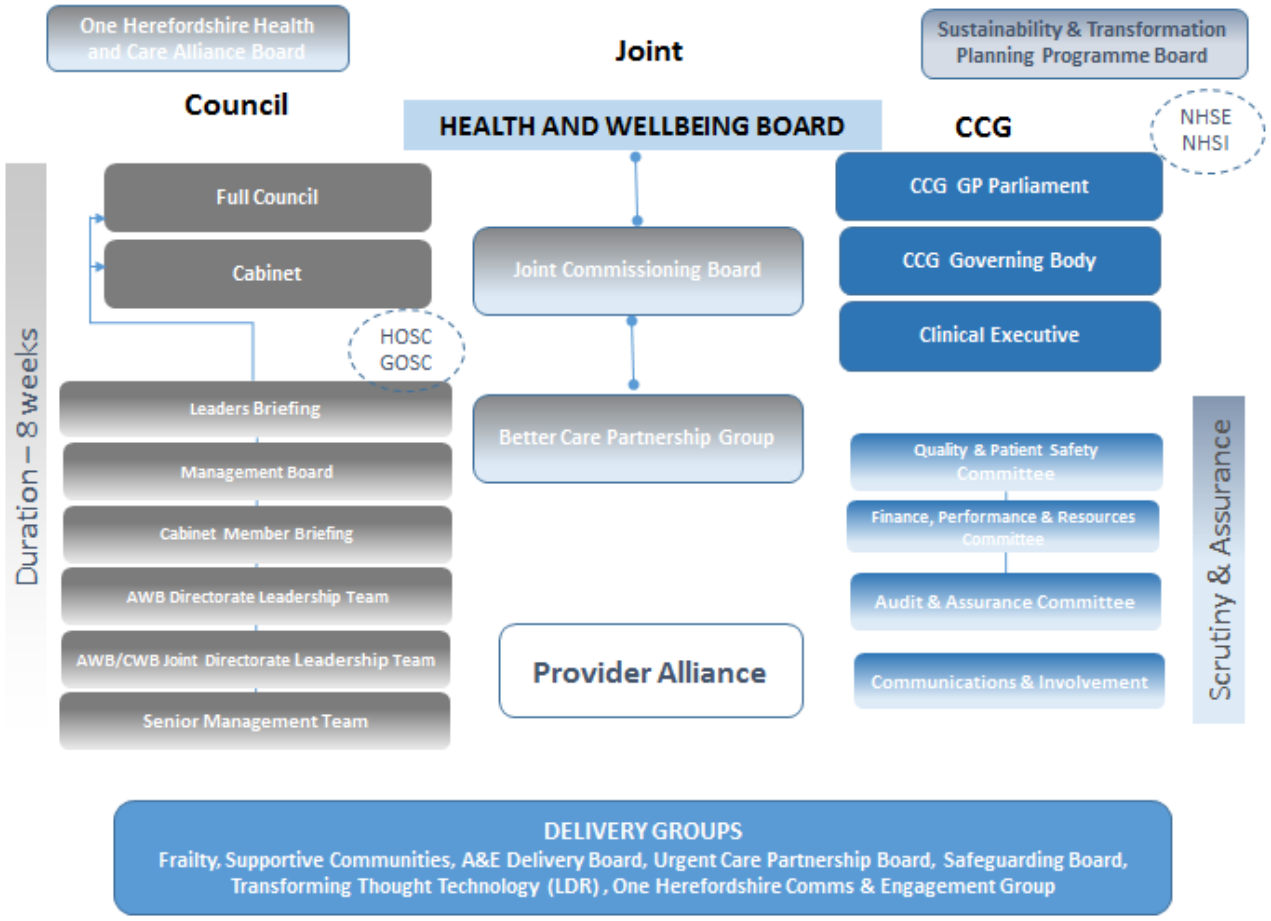
The Better Care Partnership Group (BCPG), which reports to the Joint Commissioning Group, includes representation from provider organisations and is responsible for overseeing implementation of the action plan and for the continuing review and development of the fund.

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

The BCPG is a dedicated multi-agency group which supports focus and progression of the Better Care Fund and acts as the key problem solving vehicle and is accountable to the Joint Commissioning Board. The JCB receives a monthly highlight report from this group with key decisions and issues being escalated to the board for resolution as appropriate.

An integrated performance report has been developed and is shared with the Joint Commissioning Board on a monthly basis. In addition, during 2016/17, the BCPG worked to further develop and implement scheme level performance monitoring. On a monthly basis, the group monitor scheme outcomes and escalate any concerns to the JCB, as well as other appropriate mechanisms e.g. the A & E delivery board, WVT contract monitoring board, AWB directorate leadership team etc. The BCPG is also the forum used to share and discuss national and regional learning, for example from the regional commissioning network, ADASS, ECIP or NHSE.

The programme governance arrangements detailed above are in place to support joint working and to enable a move to increasing alignment of our commissioning arrangements, including development of joint strategies and commissioning arrangements, in particular in relation to adult community health and social care services including personal budgets, support to carers, care home market management, mental health and learning disabilities.



All 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, and demonstrate that we are paying 'due regard' in our decision making in the design and delivery of services.

It is not envisaged that the content of this plan 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. 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 will by improving the health and wellbeing of people in

Herefordshire by enabling people 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.

10. Assessment of Risk and Risk management

A fully populated and comprehensive risk log is located within the appendices of this plan. This has been developed in partnership with all key stakeholders and provides a description of how risks will be managed operationally. The table below details the high level risks identified and the actions in place to mitigate.

Risks	Mitigations
All partners do not agree plan, including funding	Critical friend has been offered to support negotiation.
Impact of not achieving DToC target leading to potential reduction of iBCF funding for 2018/19	Partners working together to develop and implement system changes to address DToC
Increasing financial pressures on all partners	Working together to implement system change to manage demand
Fail regional assurance process	Working through guidance and KLOEs to ensure robust response and detailed plan is submitted.

The BCF plan for 2016/17 contained a risk share arrangement for pool 2 which was a variation to the original risk share arrangement in the first year of BCF. The risk share was for one year to allow for clients to be reassessed determining their eligible need with the risk share supporting each organisation if the risk was transferred between the CCG and LA.

The delivery of service innovation with the implementation of the unified contract for the residential and nursing commissioning of placements and assertive reviews for continuing healthcare provision were key deliverables for this risk and benefit share arrangement. Partners have worked together to consider the use of a local risk sharing agreement with respect to a number of key areas, including DTOC. Following clear consideration partners have concluded that a risk share, in relation to DTOC, NEA and schemes contained within pool 1 of this plan would not be of benefit to either party at this time. In regards to pool 1, as previously mentioned, partners are currently working together to review and redesign the Intermediate Care Scheme (previously delivered through the RAAC framework).

11. National Metrics

The following section provides an overview of 2016/17 performance and an update in relation to the following metrics:

- Non-elective admissions
- Admissions to Residential care homes
- Effectiveness of Reablement
- Delayed Transfers of Care (DToC)

11.1 Non Elective Admissions (NEA)

The NEA targets included within the Herefordshire CCG operational plan, as detailed within the planning template, have recently been reviewed and resubmitted.
The revised planned Non-Elective Admissions are based on the trend in actual admissions throughout 2016/17 and is derived from 2016/17 actual out-turn activity plus activity in April and May 2017. The NEA plan figures are modelled on actual activity and trend over time adjusted for demographic changes and the impact of planned schemes to reduce NEA, including those set out in section 7.

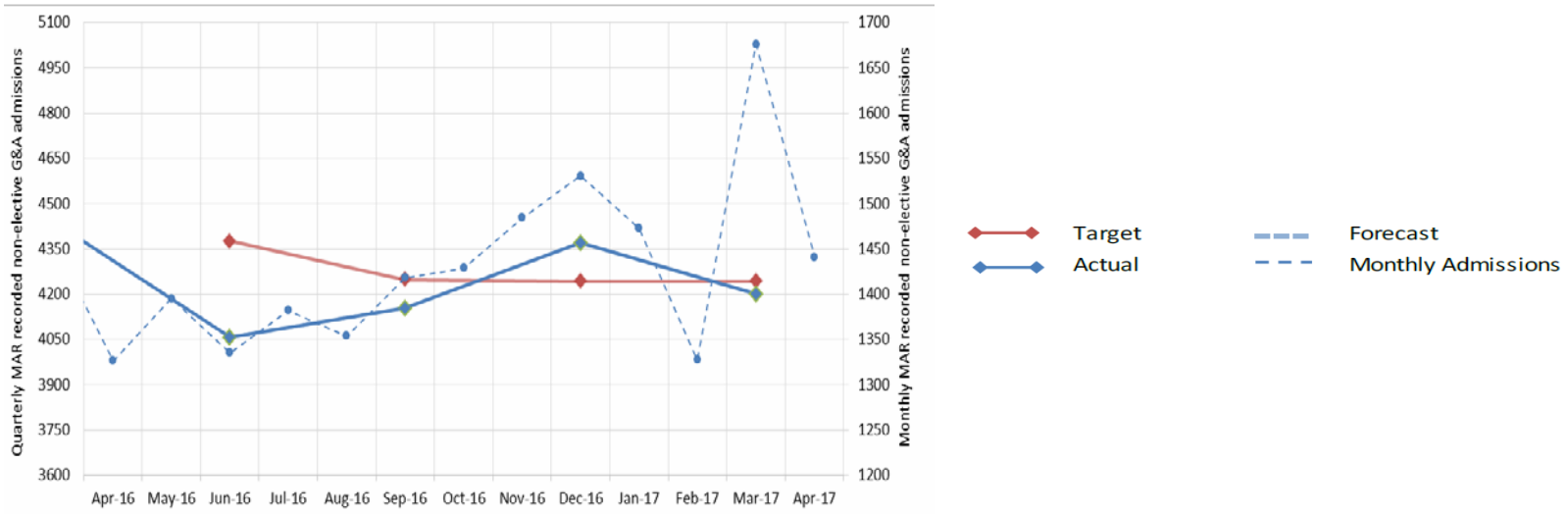
The BCF Planning Template shows an earlier version of Herefordshire's NEA plans- the figures presented above represent the most recent CCG plan submission of 30th August.

Please note that those in the planning template will be adjusted to reflect as detailed below. The Joint Commissioning Board have considered applying a further reduction in NEA, additional to those in the CCG operating plan, however have concluded that this is not required at this time.

Metric: Non Elective Admissions								
2016/17 target		**HWB NEA plan** (after reduction)	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**	
			4,306	4,235	4,527	4,614	17,682	

2016/17 performance

	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17
Actual	**4,057**	**4,154**	**4,370**	**4,201**



2017-19 target

Total NEA	**2017/18 plan**	**2018/19 plan**
	19,226	**19,129**

2017/18				**2018/19**			
Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
4,682	**4,594**	**4,958**	**4,992**	**4,658**	**4,570**	**4,933**	**4,968**

11.2 Admissions to Residential care homes

Metric:

2016/17 target

491.8

2016/17 performance

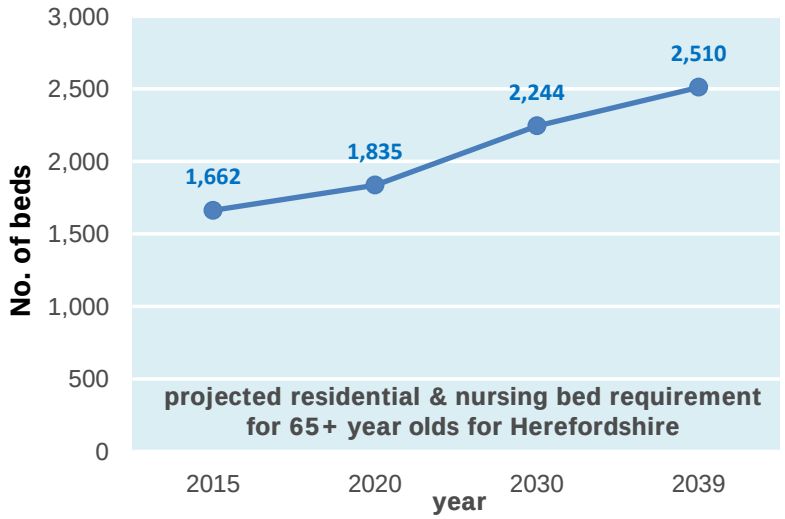
Permanent Admissions to Residential & Nursing Care													
		April	May	June	July	August	September	October	November	December	January	February	March
65+ Admissions (Month Alone)	2014/15	32	35	31	32	10	16	22	16	20	23	24	11
	2015/16	22	22	13	21	7	19	12	16	14	12	19	9
	2016/17	26	24	20	21	26	30	30	29	19	18	28	14
	2017/18	25	17	15									
65+ Rate (YTD)	2014/15	71.6	149.9	219.3	290.9	313.3	349.1	398.4	434.2	478.9	530.4	584.1	655.3
	2015/16	50.9	101.9	132.0	180.6	196.8	240.8	268.6	305.6	338.0	365.8	409.8	430.7
	2016/17	59.2	113.8	159.4	207.2	266.4	334.7	403.0	469.0	512.2	553.2	616.9	648.8
	2017/18	56.9	95.6	127.2									
18 - 64 Admissions (Month Alone)	2014/15	1	3	2	1	4	1	1	1	0	1	1	0
	2015/16	0	0	2	0	0	2	1	1	0	1	0	2
	2016/17	2	2	1	0	1	0	0	2	0	2	0	1
	2017/18	0	2	3									
18 - 64 Rate (YTD)	2014/15	0.9	3.7	5.6	6.5	10.3	11.2	12.1	13.1	13.1	14.0	14.9	14.9
	2015/16	0.0	0.0	2.8	2.8	2.8	4.6	5.6	8.3	9.3	10.2	11.1	11.1
	2016/17	1.9	3.7	4.6	4.6	5.6	5.6	5.6	7.4	7.4	9.3	9.3	10.2
	2017/18	0.0	1.9	4.6									

2017-19 target

The 2017-19 targets detailed below are based upon an average over the last 3 years:

2017/18	2018/19
550.5	549.8

The target has been set based on the average number of new placements made last year and proportioned across the year. Analysis of future demands for residential care show increasing demands for nursing provision with continuing demographic pressures. The implementation of the joint blue print, with a key focus upon supporting people in their own homes, the development of the Home First service and the introduction of strength based assessments will assist in managing the increasing demands.



11.3 Effectiveness of Reablement

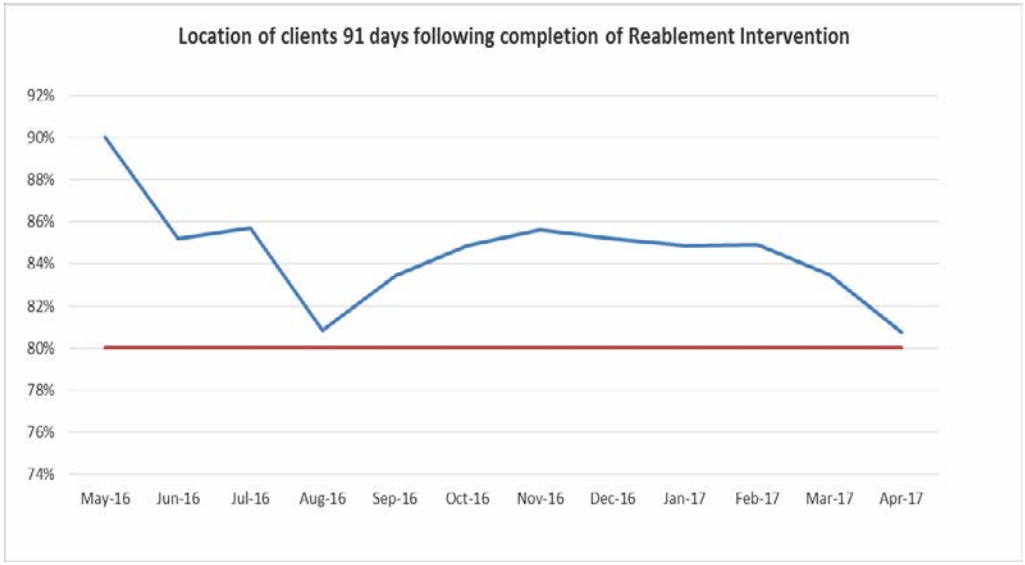
Metric:

2016/17 target	80%

2016/17 performance and update

Location of clients at 91 day review following completion of Reablement Intervention

	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
At home	32	24	3	46	43	24	23	22	34	22	27	21
No response			4		11	1						
Hospital, Deceased, Care	3	3		3	2	1	1	2	4	4	10	2
Other	1			2	1		1	3	3		1	3
Percentage at home 91 days	90.0%	85.2%	85.7%	80.8%	83.4%	84.9%	85.6%	85.2%	84.9%	84.9%	83.5%	80.8%

	
2017-19 target	85% The reablement target has been increased to 85% for 2017-19, this is due to the increase in capacity from the remodelled Homefirst service that will be in place from November 2017. The expectation will be for the service to increase efficiency and capacity therefore more people will be supported to reach their potential. Although the service was reaching this target in some months during the year, we have remained at this target level to allow for the transition and implementation of the new service. This will be reviewed next year with an expectation to increase if target is being met.

11.4 Delayed transfers of care (DToC) plan

Herefordshire have agreed the trajectory below however it is recognised that the required target is very steep and that hitting it will require substantial performance improvements.

Metric:

2016/17 target

Q1	Q2	Q3	Q4
608.4	605.8	743.5	512.6

2016/17 performance and update

	2014/15	2014	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
Target	814	795	720	800	680	700	720	790	932	928	1,139	790
Denomi	150,90	150,90	150,90	151,87	151,87	151,87	151,87	153,00	153,00	153,00	153,00	153,96
Actual	**814**	**1,085**	**843**	**915**	**932**	**928**	**1,139**	**1,226**	1,714	1,602	2,227	2,182
Target	539	527	477	527	448	461	474	516	609	607	744	513
Actual	**539**	**719**	**559**	**602**	**614**	**611**	**750**	**801**	**1,120**	**1,047**	**1,455**	**1,417**

2017-19 target

As detailed within the planning template, DToC targets for 2017-19 are as follows:

	17-18 plans				18-19 plans			
	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Quarterly rate	1113.5	820.8	663.8	649.4	652.7	659.8	659.8	646.2
Numerator (total)	1,716	1,265	1,023	1,007	1,012	1,023	1,023	1,007
Denominator	154,110	154,110	154,110	155,058	155,058	155,058	155,058	155,829

The following table provides a detailed breakdown of this target, into monthly targets for NHS attributed, social care attributed and joint attributed delayed days:

Delayed Transfers of Care- Herefordshire- Total Delayed Days- Local Authority- All DToCs (Acute & Non-Acute)

NHS Attributed Delayed Days	17-18 plans											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
DToC Per Month	469.0	337.0	457.0	373.0	289.0	205.0	211.8	205.0	211.8	213.1	192.5	213.1
Avg DToC Per Day	15.6	10.9	15.2	12.0	9.3	6.8	6.8	6.8	6.8	6.9	6.9	6.9
DToC per 100k 18+ Popn	304.33	218.7	296.5	242.0	187.5	133.0	137.5	133.0	137.5	137.5	124.2	137.5
Avg DToC per Day per 100k 18+ popn	10.1	7.1	9.9	7.8	6.0	4.4	4.4	4.4	4.4	4.4	4.4	4.4

Social Care Attributed Delayed Days	17-18 plans											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
DToC Per Month	153.0	159.0	141.0	141.5	137.3	128.8	133.1	128.8	133.1	133.1	120.2	133.1
Avg DToC Per Day	5.1	5.1	4.7	4.6	4.4	4.3	4.3	4.3	4.3	4.3	4.3	4.3
DToC per 100k 18+ Popn	99.8	103.7	92.0	92.3	89.5	84.0	86.8	84.0	86.8	86.8	78.4	86.8
Avg DToC per Day per 100k 18+ popn	3.3	3.3	3.1	3.0	2.9	2.8	2.8	2.8	2.8	2.8	2.8	2.8

Jointly Attributed Delayed Days	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

All Attributed Delayed Days	17-18 plans											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
DToC Per Month	622.0	496.0	598.0	509.8	421.7	333.5	344.7	333.5	344.7	346.8	313.2	346.8
Avg DToC Per Day	20.7	16.0	30.0	16.4	13.6	11.1	11.1	11.1	11.1	11.2	11.2	11.2
DToC per 100k 18+ Popn	405.7	323.5	390.1	330.8	273.6	216.4	223.6	216.4	223.6	223.6	202.0	223.6
Avg DToC per Day per 100k 18+ popn	13.5	10.4	13.0	10.7	8.8	7.2	7.2	7.2	7.2	7.2	7.2	7.2

12. Approval and sign off

On 7 September 2017 the Herefordshire Health and wellbeing board delegated authority to the director for adults and wellbeing at Herefordshire Council, the chief officer at the CCG and the chief officers of the council and CCG, to finalise the BCF 2017/19 submission to NHS England.

Appendix 1 – DFG plan 2017/19

Herefordshire Disabled Facilities Grant Funding (DFG) 2017/2019

Background

The Disabled Facilities Grant is a mandatory grant provided under the Housing Grants, Construction and Regeneration Act 1996. Following amendment to the act the Disabled Facilities Grant is now the only remaining mandatory Housing grant available under this act.

Under the Act, the Council's Housing Authority has a duty to administer the Disabled Facilities Grants and must take advice from the Council's Social Services Authority as to what is considered "necessary and appropriate" in accordance with criteria given within the Act.

The in-house Home Improvement Agency (HIA) undertakes the Council's "Housing Authority" role in administering the grant and the Occupational Therapy Team within the Council provide the advice about what is "necessary and appropriate" for provision.

The Council's **Occupational Therapy Team** also assists the Council to meet its responsibilities for clients and carers under the Care Act 2014 by providing assessments, advice and guidance for maintaining wellbeing, safety and independence in the home, and/or making recommendations for provision of equipment and minor adaptations. Where people have eligible needs the equipment and minor adaptations are procured by the OT Team via the Integrated Community Equipment Store and the Home Improvement Agency Technicians, or recommendations passed to Registered Housing Providers for provision.

The Council's in house **Home Improvement Agency (You at Home)** has an additional wider role in fulfilling the Council's duties under the Regulatory Reform Order (Housing Assistance) 2002 for the provision of wider housing related support. This includes administration of the following types of support which is also currently made available via the DFG funding allocation in accordance with the Council's "Home Adaptations and Assistance Policy 2016-19":

- Relocation Assistance
- Emergency Repayable Grant
- Discretionary Disabled Facilities Grant
- Discretionary Fast-track Adaptations
- Professional and Technical Advice
- Handyperson Service

DFG Funding

The known and estimated future DFG grant allocations are shown in the table below:

	15/16 Actual	16/17 Actual	17/18 Actual	18/19 Estimate	19/20 Estimate

	£'000	£'000	£'000	£'000	£'000
DFG	866	1,558	1,706	1,870	1,980
Social Care Capital	490	N/A	N/A	N/A	N/A
Total Capital	**1,356**	**1,558**	**1,706**	**1,870**	**1,980**

As a result of the additional investment in 2016/17 additional resources were recruited / engaged on a locum basis in year which enabled significant improvements to be made in year to reduce waiting lists and increase DFG grant approvals and completed DFG adaptations.

Key Outcomes Delivered in 2016/17

- OT waiting lists were reduced from 797 people waiting (01/04/16) to 207 people waiting (04/05/17). The number of DFG Referrals received per month increased over the year from 23.7 in Quarter 1 to 34.7 in Quarter 4.
- A total of **378 referrals** were received during the year.
- The average number of DFGs approved during the year increased from 10 per month Quarter 1 to 19.7 per month Quarter 4.
- A total of **183 DFGs were approved** during the year.
- The average number of DFGs completed increased from 11 per month in Quarter 1 to 30.3 per month in Quarter 4.
- A total of **178 DFGs were completed** during the year.

The final quarter demonstrated that there was a steady increase over the year of the number of DFG referrals approved by the HIA and the number of DFGs completed. This reflected the additional work of the locum caseworker and locum surveyors, plus the work done by the team in managing contractor availability to make this possible. The average number of referrals received showed an increase from the first quarter reflecting the increased number of OT assessments completed during the year by use of the external agency, in-house seconded staff, and operation of the assessment clinics.

DFG plan 2017/19

DFG Outcomes expected for 2017-18:

- By end March 2018, 100% of OT DFG Assessments will be completed within 28 days of receipt of referral
- The number of DFGs completed during the year will increase from 178 (2016-17) to minimum of 200 (2017-18)
- The number of DFGS approved during the year will increase from 183 (2016-17) to minimum of 230 (2017-18)
- Programme in place to increase the % of adaptations costing less than £15k from 61% (2016-2017) to 85% in 2018-19
- Programme in place to increase the number of people supported with information and advice
- Increase the number of people supported with adaptations/technology essential for safe hospital

discharge from 236 to 250

- Introduction of pilot project to focus on supporting people at the time of hospital discharge with wider housing related issues.

Key Objectives for 2017/18 include:

- OT Assessments completed within 28 days of receipt of referral
- Increased staffing to ensure service is able to provide support to a greater number of people and progress supported required more quickly
- DFG recommendations progressed to completion in timely fashion
- Increased Support to Self-funders
- Better Support to Clients with Dementia & their Carers
- Extension of Hospital Discharge Project
- Trusted Contractor Project

Appendix 2 – Herefordshire planning template submission

BCF 2017-19 Planning Template - H

Appendix 3 – Risk register

BCF risk register - v0.3 - FINAL.xlsx