Herefordshire Council

Agenda

Health and wellbeing board

Date:	**Tuesday 5 March 2019**
Time:	**3.00 pm**
Place:	**Committee Room 1, Shire Hall, St. Peter's Square, Hereford, HR1 2HX**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Ben Baugh** Tel: 01432 261882 Email: ben.baugh2@herefordshire.gov.uk

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Agenda for the Meeting of the Health and wellbeing board

Membership

Chairperson	Councillor JG Lester	Herefordshire Council
	Chris Baird	Director for children and families
	Ingrid Barker	2gether NHS Foundation Trust
	Russell Hardy	Wye Valley NHS Trust
	Jo Melling	NHS England
	Councillor P Rone	Herefordshire Council
	Ian Stead	Healthwatch Herefordshire
	Councillor EJ Swinglehurst	Herefordshire Council
	Dr Ian Tait	NHS Herefordshire Clinical Commissioning Group
	Simon Trickett	NHS Herefordshire Clinicial Commissioning Group
	Stephen Vickers	Acting Director for Adults and Communities
	Karen Wright	Director of Public Health

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

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

3. DECLARATIONS OF INTEREST

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

4. MINUTES 7 - 12

To approve and sign the minutes of the meeting held on 1 October 2018.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.

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

www.herefordshire.gov.uk/getinvolved

The deadline for the receipt of a question from a member of the public is Wednesday 27 February 2019 at 5.00 pm.

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6. QUESTIONS FROM COUNCILLORS

To receive any written questions from councillors.

The deadline for the receipt of a question from a councillor is Wednesday 27 February 2019 at 5.00 pm.

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7. UPDATE ON THE DELIVERY OF DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2017 RECOMMENDATIONS 13 - 20

To provide a update on the implementation of the recommendations of the director of public health annual report 2017 as agreed at the October 2018 health and wellbeing board meeting.

8. FUTURE ARRANGEMENTS AND PRIORITIES FOR THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 21 - 26

To agree future arrangements for the delivery of, and outputs from, Herefordshire's joint strategic needs assessment (JSNA).

9. BETTER CARE FUND QUARTER 2 AND 3 REPORT 2018/19 27 - 66

To review the better care fund 2018/19 quarter two and three national performance report, as per the requirements of the programme.

10. HOMELESS LINK HEALTH NEEDS AUDIT 67 - 112

To inform the board of the results of Herefordshire's Homeless Link Health Needs Audit and to consider the recommendations arising from the audit.

11. HEREFORDSHIRE AND WORCESTERSHIRE DEMENTIA STRATEGY 2019-2024 113 - 166

To review Herefordshire and Worcestershire dementia strategy and endorse the high level actions set out for 2019-2024.

12. PROVISIONAL MEETING DATES FOR 2019/20

The following provisional meeting dates for 2019/20 are suggested:

Monday 8th July 2019, 2.30pm

Monday 14th October 2019, 2.30pm

Monday 9th December 2019, 2.30pm

Monday 10th February 2020, 2.30pm

Monday 20th April 2020, 2.30pm

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- Inspect minutes of the council and all committees and sub-committees and written statements of decisions taken by the cabinet or individual cabinet members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting (a list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
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The chairperson or an attendee at the meeting must take the signing in sheet so it can be checked when everyone is at the fire assembly point.

Herefordshire Council

Minutes of the meeting of Health and wellbeing board held at The Council Chamber - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Monday 1 October 2018 at 9.30 am

Present: **Cllr JG Lester (Herefordshire Council) (Chairman)**
Dr I Tait (NHS Herefordshire Clinical Commissioning Group) (Vice Chairman)

Jo Alner	NHS England
C Baird	Director for children and families
P Rone	Herefordshire Council
S Vickers	Acting director for adults and communities
K Wright	Director of Public Health

In attendance: **Councillors PA Andrews**

Officers: **John Coleman, Alistair Neill, Amy Pitt and Alison Talbot-Smith**

159. APOLOGIES FOR ABSENCE

Apologies were received from Ingrid Barker, Russell Hardy, Jo Melling, Ian Stead, Councillor EJ Swinglehurst and Simon Trickett.

160. NAMED SUBSTITUTES (IF ANY)

Christine Price attended for Ian Stead, Jo-Anne Alner attended for Simon Trickett and Duncan Sutherland attended for Ingrid Barker.

161. DECLARATIONS OF INTEREST

There were no declarations of interest.

162. MINUTES

Resolved that:

the minutes of the meeting held on 13 February 2018 be agreed as a correct record and signed by the chairman.

163. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

164. QUESTIONS FROM COUNCILLORS

There were no questions from councillors.

165. BETTER CARE FUND QUARTER 1 REPORT 2018/19

The head of partnerships and integration introduced the report and highlighted the key points. She noted that partners had agreed to invest improved better care fund (iBCF) funds in a number of new areas including a trusted assessor scheme, discharge to

access model and to support improvements in the quality of care in care homes. It was recognised that substantial performance improvements were required to meet the new target in relation to Delayed Transfers of Care (DToC).

The case studies circulated as a supplement to the agenda papers were reviewed as examples of the impact the additional funds were expected to have.

In discussion of the report the board noted that:

- there was no single area of weakness in Herefordshire care homes, key themes identified in inspections of homes were around recruitment and retention of staff, leadership and management not having a full understanding of what was required, poor care planning and the environment of some homes;
- a nurse led, rapid improvement team employed by the CCG had been set up to provide hands on support and early intervention;
- care homes in Herefordshire were generally run by smaller providers and work was taking place to improve partnership working and mentoring for weaker providers;
- where homes were judged to be failing a condition could be imposed requiring that they work with an improvement partner;
- the case studies provided were helpful in translating the work being undertaken to real life situations.

It was resolved that:

a) **the better care fund (BCF) 2018/19 quarter one report, at appendix 1, as submitted to NHS England was reviewed;**
b) **the integration and BCF plan 2018/19 refresh, at appendix 2 and 3, as submitted to NHS England be approved; and**
c) **the board determined there were no further actions it wished to recommend to secure future improvement in efficiency or performance at this time.**

166. CHILDREN AND YOUNG PEOPLE'S PLAN 2018 - 2023

The director for children and families introduced the draft plan and highlighted the improvements made and achievements over the life of the previous plan. Many children and young people had been involved in developing the new plan. Consultation was now taking place and it was hoped that the final version of the plan would be approved by Herefordshire Council at the full council meeting in February 2019.

The children's commissioning and contracts lead explained the engagement work that had taken place with children, young people, providers and parents in drafting the new plan. Efforts had been made to make the plan as concise and easy to read as possible. The plan had moved towards an outcomes based approach and four key pledges:

- be safe from harm;
- be healthy;
- be amazing; and
- feel part of the community.

In discussion of the draft plan the board noted:

- it was important to join up work with children and work with adults to focus on whole family issues;
- that the importance of making every contact count (mecc) should be highlighted;
- that 'family first' was a local name for an approach to working with troubled families, with an expanded outcomes framework;

- that the plan could be aligned with the local maternity services plan and that contact between the authors of the two plans should be encouraged;
- that mental health was an important element, work was taking place with partnerships and would feed in to the plan and be translated to concrete actions;
- that individuals from a travelling background had the poorest outcomes in Herefordshire and that particular efforts should be made to target and engage with this group;
- that care should be taken when presenting figures in the plan as fact if they were not, for example the number of children and young people requiring support with their mental health or emotional resilience was an estimate based on national statistics, it was agreed that this would be reworded;
- that schools would have a significant role to play in implementing the plan, it was noted that action plans would be developed under the main plan and that schools would be one of the partners involved;
- that members of the board should take the outcomes in the plan back to their respective governance structures, publicise the plan as much as possible, ensure the outcomes were embedded in their own areas of work and regularly referred to;
- that the plan should be more explicit about partnership work, but it was noted that the plan should not become too large a document;
- that board members should identify barriers to the success of the plan and use their strategic weight to remove these.

Actions identified by the board included:

- board members to take the strategic priorities identified in the plan and work to deliver them through the governance structures of their respective organisations;
- board members to reference and encourage discussion of the strategic priorities identified in the plan in forums not specifically dealing with children and families to identify opportunities for indirect contributions to achieving outcomes; and
- board members to publicise the plan and the outcomes achieved through it.

It was resolved that:

(a) The Health and Wellbeing Board's comments on the attached draft as set out in the minutes of the meeting be fed back in order to inform development of the final version of Herefordshire's final Children and Young People's Plan; and

(b) The Health and Wellbeing Board considered its key role and identified necessary action it should take in helping to achieve the proposed priorities.

167. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2017

The director of public health introduced her annual report for 2017. Directors of Public Health have a statutory duty to produce an independent annual report on the health of their population. This report sits alongside the Joint Strategic Needs Assessment (JSNA). The director highlighted that:

- the health and wellbeing of the population was generally improving although there were some areas of concern;
- the areas of concern had been picked up in other related plans;
- the key areas for action were obesity in both adults and children, children's mental health, developing a strategic and coordinated approach to embedding community focused and strengths based approaches and how to build the resilience of health and social systems;

- there was a need to look at priority groups across all plans and strategies and to embed health in all policies for example strengthening licensing conditions around fast food outlets and alcohol free zones;
- there was a need to strengthen the embedding of making every contact count (MECC), for example anyone having contact with a family could have a conversation about access to dentists and reducing consumption of sugary drinks to promote good oral health;
- an oral health plan and healthy weight plan were being developed;
- building individual, family and community resilience would underpin efforts to improve childhood mental health;
- the ageing well plan would look at sustainable health and welfare and what could be done around environmental changes and MECC with an aim to have people living in good health longer;
- the strategic prevention board, which included representatives from the council, CCG and HVOSS would be working to embed prevention, this needed support from the health and wellbeing board.

In discussion of the report board members noted that:

- organisations represented on the board should seek to support their own staff to live healthy lives and take a lead in embedding the practices recommended;
- work was going on both locally and nationally with supermarket chains to promote fresh food and change how sweets were marketed;
- care should be taken in the tone of communications and there should be a focus on practical things that could be done, it was recognised that there was no single solution to the issues but a lot of individual steps would contribute to overall improvement;
- communication should be consistent and marketed in a non-preachy way;
- environmental health would be included in future reports, the JSNA breakdown at local community level would identify particular areas to target and the Hereford City Plan would also be considered;
- it was important to link together strategies and identify barriers;
- key messages should be included in induction for new staff members in organisations represented on the board, including MECC training;
- positive examples should be used in communications as case studies;
- there was a need to work at grass roots level and give ownership to local communities;
- business cases for projects such as the Hereford bypass should reflect the potential savings from improved public health;
- that the board should consider a future workshop on environmental health impacts.

Actions identified by the board included:

- looking at the policies and practices in place within board member's own organisations to support the health and wellbeing of staff members and their families;
- improving communication of the areas of concern and focus in the report;
- ensuring relevant members of staff undertake 'making every contact count' training;
- encouraging staff to highlight examples of successful projects which could be used as case studies in communications;
- exploring pooling resources for outreach workers;
- highlighting the potential health benefits of infrastructure projects when creating business cases and the savings that these can generate; and
- Identifying health impacts of environmental pollution / air quality as a topic for a future workshop.

It was resolved that:

(a) The Health and Wellbeing Board provides leadership to the process of implementing the recommendations of the Director of Public Health Annual Report by communicating the key messages of the report to their constituent members; and

(b) The Health and Wellbeing Board receives quarterly reports from the Director of Public Health on the progress being made in leading the implementation of the recommendations and as part of this process considers how it will support the Director of Public Health in overcoming barriers that may arise.

The meeting ended at 11.18 am **Chairman**

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Tuesday 5 March 2019**
Title of report:	**Update on the delivery of Director of Public Health Annual Report 2017 recommendations**
Report by:	**Director of public health**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

The purpose of this paper is to provide an update on the implementation of the recommendations of the Director of Public Health Annual Report 2018 as agreed at the October 2018 health and wellbeing board meeting.

This report summaries the progress in implementing the recommendations of the Director of Public Health Annual Report 2018. The detail behind the updates in set out in other plans, which will be presented to the board for assurance on an annual basis.

The report identifies that in January 2019 NHS Long Term Plan (NHSLTP) was published. This report strengthens the requirements for the system and in particular the NHS to strength its role in both prevention and reducing health inequalities. The impact of the NHS LTP is referred to as part of the report.

The report concludes that whilst progress is being made against the recommendations, there is a need for health and wellbeing board partners to be held more to account for supporting the priorities. The plan is that this is addressed through the prioritisation and planning workshop taking place before the health and wellbeing board meeting.

Further information on the subject of this report is available from
Karen Wright, email: Karen.Wright@herefordshire.gov.uk

Recommendation(s)

That:

(a) The health and wellbeing board considers its own role in taking forward the priorities.

Alternative options

1. The health and wellbeing board may identify additional and alternative approaches to delivering against the recommendations when discussing the progress.

Key considerations

2. In January 2019, the NHS Long Term Plan was published. This plan has identified the need to strengthen the focus on prevention and reducing inequalities. The plan supports the need to prioritise the areas of work identified below. In order to ensure a robust and planned approach the CCG organised a series of 'Hot House' workshops on behalf of One Herefordshire. The targets, plans and programmes of work resulting from this process will be aligned to the priorities below as appropriate.

3. The health and wellbeing board identified the following actions in relation to the implementation of the DPH Annual Report at the October 2018 meeting:

   - looking at the policies and practices in place within board member's own organisations to support the health and wellbeing of staff members and their families;
   - ensuring relevant members of staff undertake 'making every contact count' training;
   - encouraging staff to highlight examples of successful projects which could be used as case studies in communications;
   - exploring pooling resources for outreach workers;
   - highlighting the potential health benefits of infrastructure projects when creating business cases and the savings that these can generate;
   - identifying health impacts of environmental pollution / air quality as a topic for a future workshop.

4. The updates set out below regarding progress towards implementation of the Director of Health Annual Report 2018 recommendations and the actions identified in the October 2018 health and wellbeing board meeting have been lead in the main by the council and are reported into the Strategic Prevention Board. In the next quarter, the health and wellbeing board should expect to receive updates from partner organisations against the priorities.

5. The Director of Public Health Annual Report sets out the following recommendations. Progress against each of the recommendations are set out below.

6. **Recommendation 1: Strengthen our approach to embedding health in all policies, strategies and commissioned services.**

7. In the Local Authority, work has been undertaken with planning to identify how spatial planning can improve health in Hereford through the area plan. In partnership with the planning department, policy is currently being drafted for several areas including

increasing tree cover in key areas of the city to impact on respiratory illness. The benefit of a supplementary planning document for takeaways is currently being considered.

8. Scoping work has also commenced to identify the best mechanism to help local parishes to include planning for health within their neighbourhood plans.

9. Initial engagement with licensing has been started as part of the Alcohol Needs Assessment process. This has identified short term actions that can be facilitated by public health, to enable licensing to utilise already available and functioning systems to improve health.

10. Scoping work is planned to map and prioritise further aspects of health in all policies, in order to target efforts to achieve the greatest impact. This will be reflected in the Economic Development Strategy being produced by the Herefordshire Council.

11. The council have been continuing to implement programmes of work to promote staff health and wellbeing including the flu vaccination programme and active travel programmes. There will be an increased focus on staff health and wellbeing in the next quarter.

12. A date has yet to be identified to organise a health and wellbeing board workshop focussed on air pollution.

13. **Recommendation 2: Work with Herefordshire's health and wellbeing board and other partners to develop a comprehensive oral health plan to tackle issues of poor oral health in children. A key priority will be to completing an oral health needs assessment and identifying the range of options that would best suit Herefordshire. This would include looking at fluoridating the mains water supply.**

14. The promotion of oral health, through evidenced based interventions is now embedded in to public health nursing service and the Children's Centres. The oral health needs assessment has been initiated, this process will completed by May 2019. Recommendations from the Scrutiny Spotlight on child dental health and obesity is being developed into an action plan working with partners from across the council and with external partners.

15. **Recommendation 3: Work with Herefordshire's health and wellbeing board and other partners to develop and implement a healthy weight plan which focuses on reducing obesity in children. A key priority will be to use current data to target our work with communities, schools and parents.**

16. A weight management programme has been developed with the public health nursing service for families with children identified as obese or severely obese through the national child health measurement programme - we have more children who are obese or severely obese than children who are overweight in the county in year 6. The programme is being offered to parents currently, with the first course beginning at the end of February. Recommendations from the Scrutiny Spotlight on child dental health and obesity are being implemented in through a partnership approach with colleagues from across the council and with external partners.

17. A school based programme will be implemented with environmental health and schools to assess school meal provision. A bid for transformation funding for a community based approach to reducing childhood obesity was not successful, but partners of the bid are keen to take the piece of work forward, which includes insights work with communities to

identify barriers to change and opportunities for positive health behaviour. This work is complementary to the Spotlight recommendations.

18. **Recommendation 4: Work with partners to develop a co-ordinated approach which focuses on what people can do to take care of themselves and build individual and community resilience. The key priorities will be aligning the developing approaches already in place to ensure people are connected to local assets and frontline staff are equipped with the skills and confidence to work with communities and Make Every Contact Count.**

19. The Council has committed to developing a Community Strategy which will support the strengths based working and increased focus on working with communities through a range of approaches. This includes the proposed roll out of the 'Let's Talk Community Hubs'. Locality profiles are being enhanced to assist local communities in identifying local needs, assets and prioritisation of local programmes of work. A second parish councils' event has been organised to support parish councils in considering their local approaches to working with local communities to build resilience.

20. The models of locality working across the One Herefordshire continues to develop and will support the approach of focusing on priority areas and connecting residents with the local community offer to improve health and wellbeing.

21. With respect to MECC, the online training package is finally able to be hosted on an open access site. Whilst this is an operational issue, this has presented a significant challenge in this and other authorities to the industrial scale roll out of MECC across the health, social care and wider system. The CCG, Taurus and Wyre Valley Trust have responded to the escalation of MECC as a strategic priority, however support is needed from 2gether NHS Trust, who have yet to identify a lead for MECC. Herefordshire Council are both prioritising MECC for Adult Social Care staff and a system is being put in place to record MECC conversations for the purposes of evaluation.

22. **Recommendation 5: Work with our partners to develop an ageing well plan, which responds to the findings in the ageing well needs assessment and the deep dive analysis of the problems of cardiovascular disease and hypertension**

23. The Ageing Well Plan is under development at the moment. Components of work have been undertaken which will contribute to the plan as a whole. This includes work to understand stroke prevention activities across the STP and in Herefordshire; falls prevention pathway and strength and balance classes; technology enabled care and communities and community link roles. This will be complete by June 2019.

24. **Recommendation 6: Develop the Healthy Living Network (HLN) to enable community and voluntary organisations, businesses, partners and residents to champion actively health and wellbeing improvements in their area.**

25. Voluntary organisations, businesses and community groups have all signed up to be part of the Healthy Living Network, actively promoting health and wellbeing messages within their community and helping to build social networks for support. Throughout 18/19 the HLN has recruited 39 different organisations and groups from which 75 people have been trained at level 1 and 9 at level 2. In January, the network members came together to showcase the work that has taken place. Looking forward the network will aim to further establish itself within the community through supporting community networks and recruiting more network members.

26. **Recommendation 7: Work with schools and early years settings to better understand the underlying issues impacting on children's mental health and self-esteem and embed evidenced based interventions to promote resilience and good relationships.**

27. Mental Health First Aid training is now offered to secondary schools as part of a free national training initiative. Multi-agency training and trainer-training in the Solihull parenting programme is being rolled out across the county, together with free online courses for parents being made available. The programme focuses on developing attachment, resilience and confidence. Mental health issues that are indicated at the two and a half year check are referred for an early help assessment and liaison is undertaken between health visiting and the early years setting to review referral and support – the Solihull programme is also a key element of support offer.

28. **Recommendation 8: Develop a sustainable health and social care service in Herefordshire by maximising the opportunities to reduce demand on services in the first instance.**

29. We continue our wide remit of public health contributing across the system to improve the health of the population, through population level approaches (for example, development of a multiagency domestic abuse strategy; key involvement in development of locality profiles; work with gypsy, Roma and traveller communities and others to reduce inequalities in immunisation rates) and individual programmes aimed at identifying those at high risk and behaviour change (for example, through delivery of the healthy lifestyle trainer service, NHS health checks, substance misuse commissioned services)

30. The strengths based model of working introduced through adult social care, has demonstrated its impact to date in reducing demand on social care and will further developed over the next few months as part of the locality based model of working.

Community impact

31. In accordance with the council's adopted code of corporate governance, the council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining the right mix of these is an important strategic choice to make to ensure intended outcomes are achieved. The council needs robust decision-making mechanisms to ensure our outcomes can be achieved in a way that provides the best use of resources while still enable efficient and effective operations. Decisions made need to be reviewed periodically to ensure that achievement of outcomes is optimised.

32. In accordance with the NHS constitution, the NHS pledges to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered, and adherence to the principles within the NHS constitution ensure that the values of the NHS are maintained.

33. The Director of Public Health Annual Report recommendations specifically identify priority areas which can have a positive impact on looked after children and/or care leavers. These include improving mental health and resilience of children, strengthening the community focussed and strengths based approaches, improving oral health and developing a healthy weight plan. The recommendation of strengthening how we embed health in all policies will provide a more rigorous approach to ensuring the impacts of policy, strategy and commissioning decisions on health are considered.

Equality duty

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

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

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

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

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

35. This report identifies the need to effectively tackle inequalities and to reach our most vulnerable communities. This will support public authorities in exercising their equality duties.

Resource implications

36. The resource implications of the report are in the main staff time to develop the new approaching to working. These areas of work are prioritised within the Public Health Team, but will need the support of partner organisations. The resource implications of specific programmes will be costed and businesses cases developed on an ongoing basis. The Local Authority currently receives the Public Health Ringfenced Grant which will support the implementation of the recommendations, however the grant settlement for 2020/21 will not be announced until Spring 2019 and there is some uncertainty about the future of the grant and the future arrangements for commissioning public health services.

Legal implications

37. The Health and Social Care Act 2012 (s30) added in a new s.73A to the National Health Service Act 2006 requiring the appointment of a Director of Public Health. Under subsection s.73B (5), the Director is required to prepare an annual report on the health of the people in the area of the council and the council is required to publish this report.

38. Under the NHS Act 2006 as amended by the Health and Social Care Act 2012, councils are required to take particular steps in exercising public heath functions.

39. The terms of reference of the health and wellbeing board are set out in the council's constitution.

40. The recommendations in the report are in accordance with the legislation.

Risk management

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

Risk / opportunity	Mitigation
Insufficient resource and partner agency support to deliver the recommendations set out in the Director of Public Health Annual Report. Lack of public support to the implement health improvement programmes Opportunity to develop more effective community focussed models of working focussed on areas of inequality. Risks of demand outstripping the supply of community support. Lack of public and or political support for adding fluoride to the water.	Partners reprioritise areas of work to create the capacity needed. Target work in areas of greatest priority. Implement evidenced based practice based on local insight from priority groups where possible. Develop our approach based on evidence which consider all the elements of community focussed working, including building community capacity. Involve voluntary sector partners in the development of the approach. Follow the PHE toolkit which sets out a clear process for assessing the feasibility of fluoridation, developing the business case and consulting with the public to fulfil the legal duties of the council.

Consultees

None.

Appendices

None.

Background papers

None identified.

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Tuesday 5 March 2019**
Title of report:	**Future arrangements and priorities for the joint strategic needs assessment (JSNA)**
Report by:	**Director of public health**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

To agree future arrangements for the delivery of, and outputs from, Herefordshire's joint strategic needs assessment (JSNA). To consider the priorities for analysis and understanding for 2019/20 and beyond.

One of the statutory functions of the health and wellbeing board is to produce a joint strategic needs assessment of the health and well-being needs of Herefordshire and its residents. The recommendations in this report aim to ensure that the JSNA is fit-for-purpose and responsive to the intelligence needs of the board and its member organisations. A key aim of the revised process and outputs is to ensure that the JSNA is used to inform strategic planning, commissioning and partnership working designed to improve the health and wellbeing of Herefordshire residents and reduce inequalities.

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

Recommendation(s)

That:

(a) The board approves the proposed move to a three-yearly summary, supplemented by a live JSNA in the form of the new Understanding Herefordshire website and quarterly bulletins;

(b) The board agrees the key areas for analysis and intelligence for the 2019/20 JSNA, having regard to the outputs of the workshop to be held on 5 March and reported verbally to the board; and

(c) The director for public health be authorised, following consultation with the CCG Chief Officer and relevant cabinet members, to determine in-year changes to the key areas for analysis and intelligence.

Alternative options

1. There are no alternative options to the production of a joint strategic needs assessment. It is the joint statutory responsibility of Herefordshire Council and Herefordshire Clinical Commissioning Group to undertake one on behalf of the health and wellbeing board.

2. There is no prescribed format or approach, and different boards choose to produce them in different ways. Some produce a full annual report, whilst others take a more thematic approach – for example, focusing on a particular topic once every few years. Some publish reports on their websites, whilst others have automated and interactive online local information systems.

3. The main alternative to the recommended changes would be to continue with the current outputs. This is not recommended however as it does not represent the most effective use of officer time in the production or the governance arrangements. Furthermore, it is not delivering the most effective, timely, or fit-for purpose JSNA.

Key considerations

Current process and outputs

4. Herefordshire's approach to its JSNA has been to produce a summary report which is refreshed every year based on the latest indicators of health and the wider determinants of wellbeing. This summary is known as 'Understanding Herefordshire'.

5. Herefordshire Council's intelligence unit produces the annual summary, with input from other teams across the council and its partners. The JSNA Steering Group determines topics for inclusion and the structure of the report, and reports to the health and wellbeing board. Contributors to the 2018 JSNA included Herefordshire CCG, 2gether NHS Foundation Trust, Wye Valley NHS Trust, Healthwatch Herefordshire, Herefordshire Carers Support and West Mercia Police.

6. The summary is published on the 'Facts and Figures about Herefordshire' website, along with the supporting evidence in the form needs assessments, technical reports and/or raw data. This underlying evidence base is updated regularly throughout the year as new data become available, but the summary report is static – meaning that it can become outdated almost as soon as it is published.

7. The annual report is resource intensive to produce, and by the strategic nature of much of the information it contains (for example earnings, house prices, deprivation), there is little significant change year-on-year.

Proposed changes

8. Given these considerations this paper recommends several changes to the outputs and, for information, describes the changes to the process.

9. These proposals have been agreed in principle by the JSNA Steering Group and the multi-agency Strategic Prevention Board.

10. Process

    i) The JSNA Steering Group is dissolved. In-year strategic direction will be provided through multiagency partnership meeting that includes representation from Herefordshire CCG, all directorates of Herefordshire Council and other partners as appropriate.

    ii) An annual update and forward work plan will be discussed with Herefordshire Council Management Board and Herefordshire Clinical Commissioning Group Clinical Executive Board in addition to the formal governance through the health and wellbeing board.

    iii) A new JSNA Delivery Group will be established, comprised of those responsible for the production of evidence and intelligence across the whole system – including the council, CCG, healthcare providers, the police, and the voluntary sector. This group would undertake the work necessary to deliver the JSNA, and act as a network to share intelligence, expertise and opportunities to improve the evidence base.

11. Outputs

    iv) The JSNA becomes a live resource rather than a static report. This will be achieved through the new 'Understanding Herefordshire: people and places' website and brand. The website will be jointly Herefordshire Council and CCG branded, but with its own brand design style to make clear the evidence and reports that form the JSNA.

    v) The annual report is replaced with a three-yearly summary of the health and wellbeing of Herefordshire and its residents, supplemented by quarterly intelligence bulletins to provide more timely updates of work being done by all partners. This would also free up resources for more thematic work.

Priorities

12. In addition to routine updates such as population change, causes of mortality, and economic indicators, the focus of the JSNA for 2018/19 has included:

    - domestic violence and abuse analysis to inform the multiagency Domestic Abuse Strategy (complete)
    - understanding the care market, including self-funders, domiciliary care, future need for care homes (complete)

- children's integrated needs assessment, which included HWBB priority areas of child obesity and dental health and an in-depth analysis of (completed draft awaiting sign-off)
- locality profiles, to include community asset mapping and dwelling-led population forecasts (templates to be shared with locality teams in February)
- complementary ward profiles to be available for councillors following May elections
- alcohol needs assessment to inform alcohol harm reduction strategy (due by March)
- vulnerable persons housing needs assessment (due by May/June)

13. The priorities for the JSNA for 2019/20 and beyond will be discussed in detail at a workshop immediately prior to the HWBB meeting. The outcome of those discussions will be reported verbally to the HWBB.

Community impact

14. The JSNA provides an overview of Herefordshire's population and communities' profiles. It informs the development of the council's Health and Wellbeing Strategy and contributes evidence to a wide range of council and health strategies, such as the Children and Young People's Plan, to improve outcomes for residents of Herefordshire.

15. The NHS constitution, the Herefordshire Clinical Commissioning Group constitution and the council's constitution all contain commitments to transparency, accountability and principles of good corporate governance. Being clear about the reasons for decisions is a key element of these shared principles and the JSNA provides the underpinning data.

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

Equality duty

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

18. Section 149 of the Equality Act 2010 imposes a duty on the council to have due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic (i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation) and persons who do not share it.

    By providing analysis on the characteristics of the population wherever possible, and comparing experiences and outcomes of people with different characteristics, the JSNA supports the council in discharging its duty under the Act and will help deliver the three aims of the duty:

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

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

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

19. In addition, the NHS Long Term Plan aims to reduce inequalities in health. The JSNA should provide a robust evidence base of these inequalities on which to benchmark improvements.

Resource implications

20. The recommendations have no direct financial implications, but the JSNA should play a significant role in guiding the allocation of resources by all partners in their commissioning plans. This underlines the importance of having a robust and timely evidence base.

21. The proposed changes to the process and outputs represent a more effective use of human resources, by focusing on producing evidence for greatest impact.

Legal implications

22. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing boards regarding Joint Strategic Needs Assessments.

23. The health and wellbeing board has a statutory function to prepare a health and social care Joint Strategic Needs Assessment for the county, and must have regard to guidance issued by the Secretary of State.

24. Department of Health Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies 2013 states that JSNAs are continuous processes, and are an integral part of CCG and local authority commissioning cycles. Health and wellbeing boards will need to decide for themselves when to update or refresh JSNAs or undertake a fresh process to ensure that they are able to inform local commissioning plans over time. They do not need to be undertaken from scratch every year; however boards will need to assure themselves that their evidence-based priorities are up to date to inform the relevant local commissioning plans. To be transparent and enable wide participation, boards should be clear with their partners and the community what their timing cycles are and when outputs will be published.

25. The constitution at paragraph 3.5.32(a) provides that the health and wellbeing board is to develop a Joint Strategic Needs Assessment.

26. Recommendations in the report ensure that the board complies with its legal duties and acts in accordance with the constitution and terms of reference for the board.

Risk management

27. There is a reputational risk to the council if it fails to discharge its public health duties, specifically requirements around production of a JSNA, as set out in the Health and Social Care Act 2012.

28. In the absence of a robust JSNA, decisions on the allocation of resources would not necessarily be based on the best available evidence. This may result in resources not being directed to the areas of highest priority.

Consultees

None

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

Appendices

None

Background papers

None identified

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Tuesday 5 March 2019**
Title of report:	**Better Care Fund Quarter 2 and 3 report 2018/19**
Report by:	**Director of adults and communities**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

To review the better care fund 2018/19 quarter two and three national performance report, as per the requirements of the programme. In summary, the report identified the following points:

- Herefordshire is currently on track to meet the ambition rate for the national metric for non-elective admissions;
- achieving the ambition rates for the proportion of older people who were still at home 91 days after discharge from the reablement service and delayed transfers of care both continue to pose significant challenge to partners;
- partners continue to work together to progress integration plans and jointly agreed funding allocations are in place for the improved better card fund, which meet the grant conditions and align to the national high impact change model, as required.

Recommendation(s)

That:

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

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

efficiency or performance.

Alternative options

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

Key considerations

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

3. As detailed in both the quarter two and three reports, recent performance indicates that Herefordshire is on track to meet the ambition for the national metric of reducing the rate of non-elective admissions. A number of key schemes continue to be delivered to assist in supporting individuals at home and avoiding admissions, where possible, including Hospital at Home, Falls Response service and Home First.

4. Achieving the ambition rate for delayed transfers of care (DToC) continues to pose a challenge to all partners across the health and social care system in Herefordshire. Whilst partners have agreed to align DToC targets to the national ambitions, it is recognised that achieving this will require substantial performance progress.

5. To support DToC improvements, partners are working together to deliver the high impact change model action plan, as required. Achieving progress in each of these areas will assist in improving flow throughout the system and achieving DToC reductions. Key actions within this include the introduction of the Trusted Assessor model, the appointment of an Integrated Discharge Lead to support a joint hospital discharge pathway and the development and implementation of discharge to assess provision.

6. In addition to the above, a DToC peer review is scheduled to take place during quarter four that will assist partners in identifying and developing areas for improvement.

7. Capacity within the care home market in Herefordshire continues to impact upon the ability to achieve the ambition rate of permanent admissions into residential care, specifically in relation to complex nursing care provision. Partners continue to support individuals in the community and facilitate independence, therefore reducing the rate of admissions into residential and nursing care. The adult social care pathway redesign has been implemented and is delivering a strength-based approach and a robust placement panel process is in place to consider and provide alternatives, where possible.

8. Home First, the redesigned community reablement service delivered by the local authority, continues to experience recruitment challenges, which impacts upon the service capacity available. The year to date performance of the proportion of older people who were still at home 91 days after discharge from the reablement service was 71.4% at the end of December 2018, against an ambition of 80%. The service continues to develop and deliver the service review implementation plan.

9. Throughout quarters two and three partners have continued to discuss and develop integration arrangements. Further progress has been made in relation to a number of key

integration work areas. Herefordshire's Integrated Urgent Care Model - a multi agency delivery group has been established to lead on the implementation of a number of key schemes within this model. This includes the Integrated Discharge Team Function and Integrated Community Capacity Function.

10. As described within the report at appendix one, the Integrated Discharge Team will be made up of a group of professionals from both Social Care and Health who will work together to ensure the safe and timely discharge of patients. The Integrated Discharge Team will provide a service where the main aims are:

    a. that discharge planning begins at the point of admission to the hospital;

    b. The outline assessment of complex patients' needs prior to discharge is undertaken;

    c. to provide ward staff with support, education and training regarding discharge planning of both simple and complex patient discharges;

    d. to work collaboratively with community agencies such as Continuing Health Care, Therapists, Social Services and Community Matrons to ensure that patient needs have been correctly assessed and is appropriately met on discharge;

    e. to ensure the development of existing discharge services and transfer of care into community settings by developing key relationships with community services; and

    f. to develop and produce discharge information and literature for our patients regarding the discharge process to assist them and prevent delays in their discharge.

Community impact

11. The BCF plan is set within the context of the national programme of transformation and integration of health and social care. The council and CCG continue to work together to deliver on the key priorities within the plan to achieve savings and improve the delivery of services in order to achieve the priorities of the health and wellbeing strategy in the most cost effective way.

Equality duty

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

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

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

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

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

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

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

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

Resource implications

16. The finance position of the better care fund represents the forecast outturn at month 9 (December 2018), the most recent month available.

17. Overall the schemes that comprise the section 75 agreement have a net overspend of £1,406k (2.6%), chiefly due to a forecast overspend in the in-county care packages and the Integrated Community Equipment Store.

18. The table below shows a summary forecast outturn at month seven (December 2018) for the schemes that comprise the section 75 agreement. A more detailed forecast for each pool within the section 75 agreement is available upon request.

Section 75 Agreement Finance Summary 2018/19 **Forecast Out-turn at Month 9 (December)**	**Plan**	**Forecast Spend**	**Forecast (Under) / Over Spend**	**% (Under) / Over Spend**
	£'000	**£'000**	**£'000**	
Spending on Social Care Services (PASC)	4,760	4,718	(42)	(0.9%)
Spending on Social Care Services (Care Act)	479	479	0	0.0%
Sub-Total- Spending on Social Care from Minimum Mandatory Fund	**5,240**	**5,198**	**(42)**	(0.8%)
NHS Commissioned Out of Hospital Care	6,947	6,947	0	0.0%
Sub Total- Mandatory Minimum BCF Contribution from CCG	**12,187**	**12,145**	**(42)**	**(0.3%)**
Disabled Facilities Grant (Capital)	1,853	1,853	0	0.0%

Total Pool 1- Mandatory Better Care Fund Contributions	**14,040**	**13,998**	**(42)**	**(0.3%)**
Herefordshire CCG Funded Packages	9,564	9,574	10	0.1%
Herefordshire Council Funded Packages	21,359	23,151	1,791	8.4%
Total Pool 2- Additional Better Care Fund Contributions	**30,923**	**32,725**	**1,801**	**5.8%**
Improving Integrated Commissioning Capacity	226	240	13	5.9%
Meeting Adult Social Care Needs	3,285	3,276	(8)	(0.3%)
Reducing Pressures on the NHS including Supporting Hospital Discharge	971	1,024	52	5.4%
Supporting Local Social Care Provider Market	200	159	(41)	(20.3%)
Total Pool 3- Improved Better Care Fund (IBCF)	**4,722**	**4,699**	**(23)**	**(0.5%)**
Children's' Commissioning Unit	80	80	0	0.0%
Children's' Short Breaks	440	440	0	0.0%
Children's' Complex Needs Solutions	3,493	2,653	(840)	(24.0%)
Children's' Safeguarding Board	214	214	0	0.0%
Total Pool 4- Children's' Services	**4,227**	**3,387**	**(840)**	**(19.9%)**
Integrated Community Equipment Store	1,000	1,510	510	51.0%
Total Pool 5- Integrated Community Equipment Store	**1,000**	**1,510**	**510**	**51.0%**
Total Section 75 Agreement	**54,913**	**56,319**	**1,406**	**2.6%**

Legal implications

19. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to

instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding. The council is legally obliged to comply with grant conditions, which have been complied with.

Risk management

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

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

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

23. Partners continue to work together to ensure sufficient schemes are in place and that the risks identified are mitigated.

Consultees

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

Appendices

Appendix 1 – Better care fund quarter two 2018/19 report

Appendix 2 – Better care fund quarter three 2018/19 report

Background papers

None.

Better Care Fund Template Q2 2018/19

Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements for 2017-19 which supports the aims of the Integration and BCF Policy Framework and the BCF programme jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of the BCF quarterly reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)

2) To provide information from local areas on challenges, achievements and support needs in progressing integration and the delivery of BCF plans
3) To foster shared learning from local practice on integration and delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform delivery improvements

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

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

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

For 2018-19, reporting on the additional iBCF Grant (funding announced in the 2017 Spring Budget) is included in the BCF quarterly reporting as a combined template to streamline the reporting requirements placed on local systems. The BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately.

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

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

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: A jointly agreed plan
Please note: This also includes confirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflation
National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 2017-19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
Please note that while NEA activity is not currently being reported against CCG Operating Plans (due to comparability issues relating to specialised commissioning), HWBs can still use NEA activity to monitor progress for reducing NEAs.
- Delayed Transfers of Care (DToC): The BCF plan targets for DToC should be referenced against your current provisional trajectory. Further information on DToC trajectories for 2018-19 will be published shortly.
The progress narrative should be reported against this provisional monthly trajectory as part of the HWB's plan.

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

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

4. High Impact Change Model

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

The maturity levels utilised on the self assessment dropdown selections are based on the guidance available on the published High Impact Changes Model (link below). A distilled explanation of the levels for the purposes of this reporting is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area

Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement

Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

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

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

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

Please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making the HICM self-assessment, which could be useful in informing future design considerations.

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

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

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

Hospital Transfer Protocol (or the Red Bag Scheme):
- The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
- Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
- Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.
- Further information on the Red Bag / Hospital Transfer Protocol: A quick guide has been published:
https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx
Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team through england.ohuc@nhs.net. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

5. Narrative

This section captures information to provide the wider context around health and social integration.
Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Please tell us about an integration success story observed over reported quarter highlighting the nature of the service or scheme and the related impact.

6. Additional improved Better Care Fund

For 2018-19 the additional iBCF monitoring has been incorporated into the BCF form. Please fill this section in if you are responsible for the additional iBCF quarterly monitoring for your organisation, or geographic area.
To reflect this change, and to align with the BCF, data must now be entered on a HWB level.

For Quarter 2, the iBCF section of the form covers questions relating to external provider fees only. Specific guidance is provide on the iBCF tab.

Better Care Fund Template Q2 2018/19

1. Cover

Version 1.0

Please Note:
- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. ***Narrative sections of the reports will not be published.*** *However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.*
- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

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

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

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0
6. iBCF	0

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | Local Government Association | NHS England

[<< Link to Guidance tab]

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75 Pooled Budget

^^ Link Back to top

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics

^^ Link Back to top

	Cell Reference	Checker
NEA Target performance	D11	Yes
Res Admissions Target performance	D12	Yes
Reablement Target performance	D13	Yes
DToC Target performance	D14	Yes
NEA Challenges	E11	Yes
Res Admissions Challenges	E12	Yes
Reablement Challenges	E13	Yes
DToC Challenges	E14	Yes
NEA Achievements	F11	Yes
Res Admissions Achievements	F12	Yes
Reablement Achievements	F13	Yes
DToC Achievements	F14	Yes
NEA Support Needs	G11	Yes
Res Admissions Support Needs	G12	Yes
Reablement Support Needs	G13	Yes
DToC Support Needs	G14	Yes

Sheet Complete:	Yes

4. High Impact Change Model ^^ Link Back to top

	Cell Reference	Checker
Chg 1 - Early discharge planning Q2 18/19	F12	Yes
Chg 2 - Systems to monitor patient flow Q2 18/19	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q2 18/19	F14	Yes
Chg 4 - Home first/discharge to assess Q2 18/19	F15	Yes
Chg 5 - Seven-day service Q2 18/19	F16	Yes
Chg 6 - Trusted assessors Q2 18/19	F17	Yes
Chg 7 - Focus on choice Q2 18/19	F18	Yes
Chg 8 - Enhancing health in care homes Q2 18/19	F19	Yes
UEC - Red Bag scheme Q2 18/19	F23	Yes
Chg 1 - Early discharge planning Q3 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q3 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q3 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q3 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q3 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	H12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	H13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	H14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	H15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	H16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	H17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	H18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	H19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	H23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	I14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I17	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	I18	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I19	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I23	Yes
Chg 1 - Early discharge planning Challenges	J12	Yes
Chg 2 - Systems to monitor patient flow Challenges	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J14	Yes
Chg 4 - Home first/discharge to assess Challenges	J15	Yes
Chg 5 - Seven-day service Challenges	J16	Yes
Chg 6 - Trusted assessors Challenges	J17	Yes
Chg 7 - Focus on choice Challenges	J18	Yes
Chg 8 - Enhancing health in care homes Challenges	J19	Yes
UEC - Red Bag Scheme Challenges	J23	Yes
Chg 1 - Early discharge planning Additional achievements	K12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K15	Yes
Chg 5 - Seven-day service Additional achievements	K16	Yes
Chg 6 - Trusted assessors Additional achievements	K17	Yes
Chg 7 - Focus on choice Additional achievements	K18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K19	Yes
UEC - Red Bag Scheme Additional achievements	K23	Yes
Chg 1 - Early discharge planning Support needs	L12	Yes
Chg 2 - Systems to monitor patient flow Support needs	L13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L14	Yes
Chg 4 - Home first/discharge to assess Support needs	L15	Yes
Chg 5 - Seven-day service Support needs	L16	Yes
Chg 6 - Trusted assessors Support needs	L17	Yes
Chg 7 - Focus on choice Support needs	L18	Yes
Chg 8 - Enhancing health in care homes Support needs	L19	Yes
UEC - Red Bag Scheme Support needs	L23	Yes

Sheet Complete:	Yes

5. Narrative

^^ Link Back to top

	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

6. iBCF

^^ Link Back to top

	Cell Reference	Checker
1. Average amount paid to external providers for home care in 2017/18	C19	Yes
1. Average amount expected to pay external providers for home care in 2018/19	D19	Yes
1. Uplift if rates not known	E19	Yes
2. Average amount paid for external provider care homes without nursing for clients aged 65+ in 17/18	C20	Yes
2. Average expected pay for external provider care homes without nursing clients aged 65+ in 2018/19	D20	Yes
2. Uplift if rates not known	E20	Yes
3. Average amount paid for external provider care homes with nursing for clients aged 65+ in 2017/18	C21	Yes
3. Average expected to pay for external provider care homes with nursing for clients aged 65+ in 18/19	D21	Yes
3. Uplift if rates not known	E21	Yes

Sheet Complete:	Yes

^^ Link Back to top

Better Care Fund Template Q2 2018/19

2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Herefordshire, County of

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

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q2 2018/19

Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	On track to meet target	Achieving the NEA is challenging to partners throughout the system.	A number of key schemes continue to be delivered to assist in supporting individuals at home and avoiding admissions, where possible. Including Hospital at Home, Falls Response service and Home First.	No support needs identified
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	Capacity within the care home market within Herefordshire continues to challenge partners, specifically in relation to complex nursing care provision.	Partners continue to support individuals in the community and facilitate independence, therefore reducing the rate of admissions into residential and nursing care. ASC pathway redesigned has been implemented and is delivering a strength based approach. A robust placement panel process is in place to consider and provide alternatives, where possible.	No support needs identified
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	The Home First service, delivered by the local authority, continue to experience recruitment challenges, which impacts upon the service capacity available. The YTD performance is currently 69.0%, against an ambition of 80%	During Q2 capacity improvements have been achieved due to the introduction of a new rota system. The service continues to develop and deliver the service review implementation plan. The new rota system went live on 1 October 2018 and we currently have the highest number of staff since the service commenced, with only 4 vacancies. The expectation is that the service will increase the number it supports from 35 to 70 by the end of October 2018.	No support needs identified

Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	Achieving the DToC target continues to pose a challenge to all partners. A number of key actions will be coming on line during Q3 but partners would welcome peer review of our plans to make sure they are robust as possible.	Partners continue to work together to deliver the HICM. Achieving progress in each of these areas will assist in improving flow throughout the system and achieving DToC reductions. A Trusted Assessor model will be implemented in Herefordshire from January 2019, an Integrated Discharge Lead post will be in place from December 2018 and D2A pathways continue to be developed.	Support to be requested from ADASS

Better Care Fund Template Q2 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Herefordshire, County of

Challenges Please describe the key challenges faced by your system in the implementation of this change
Milestones met during the quarter / Observed Impact Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change
Support Needs Please indicate any support that may better facilitate or accelerate the implementation of this change

		Maturity Assessment					Narrative			
		Q4 17/18	Q1 18/19	Q2 18/19 (Current)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Plans in place	Established	Plans in place	Established	Established		Further work required to ensure that the whole system is aware of the EDD and are committed to working together to achieve.	Integrated Urgent Care Delivery Group established. This multi agency group is leading on a number of schemes, including the development and implementation of an Integrated Discharge Team. A key aim of this integrated team will be to ensure that discharge planning begins at the point of admission to the hospital.	No support needs identified
Chg 2	**Systems to monitor patient flow**	Not yet established	Plans in place	Not yet established	Plans in place	Established		DToC analysis is completed on daily basis to understand causes of delays and identify bottlenecks.	Stranded Patients reviews carried out to further inform understanding of barriers.	No support needs identified
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Plans in place	Plans in place	Established	Mature		Currently the WVT complex discharge team and ASC hospital liaison discharge team work together closely, however they are not aligned.	Partners continue to work together to implement an Integrated Discharge Team. This team will be made up of a group of professionals from both Social Care and Health who are co-located at Hereford County Hospital and collaboratively work together to ensure the safe and timely discharge of patients.	No support needs identified
Chg 4	**Home first/discharge to assess**	Plans in place	Plans in place	Plans in place	Established	Mature		The Home First service, delivered by the local authority, continue to experience recruitment challenges, which impacts upon the service capacity available.	During Q2 capacity improvements have been achieved. The service continues to develop and deliver the service review implementation plan.	No support needs identified

Chg 5	**Seven-day service**	Plans in place	Plans in place	Not yet established	Plans in place	Established		Several areas of service provision are not delivered on a seven day basis e.g. community therapy services, which can often cause delays. However, seven-day services are being delivered where relevant, appropriate and demand evident.	Seven day provision continues to be delivered for key services, including Home First, Hospital at Home and Falls Response Service. Seven-day services are being delivered where relevant, appropriate and demand evident.	No support needs identified
Chg 6	**Trusted assessors**	Not yet established	Plans in place	Plans in place	Plans in place	Established		Overcoming barriers to implementation - building trust and ensuring model is right for Herefordshire.	A multi agency steering group, including care home market providers, has been established. The group is responsible for developing and implementing the Trusted Assessor model in Herefordshire.	No support needs identified
Chg 7	**Focus on choice**	Plans in place	Plans in place	Plans in place	Established	Mature		Comprehensive review of existing choice directive and processes – anticipate conclusion in coming month.	The redesigned ASC pathway continues to be delivered, which has a clear focus upon client choice and strength based assessments and voluntary sector support offer - including Community Broker	No support needs identified
Chg 8	**Enhancing health in care homes**	Plans in place	Established	Plans in place	Established	Mature		Several providers within the Care Home sector do not engage on a regular basis which can cause difficulties and delays in implementation of developments.	Clinical Professional Standards Lead continues to support care homes throughout Herefordshire with the aim to reduce admissions to hospital and improve the care standards within the care homes. Evidence of reducing admissions from care homes available.	No support needs identified

Hospital Transfer Protocol (or the Red Bag scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q4 17/18	Q1 18/19	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs
UEC	**Red Bag scheme**	Established	Established	Established	Established	Mature		Raising awareness of the scheme within the Acute Trust continues to be a challenge. The project team are planning a relaunch with marketing materials to address this.	A relaunch of the scheme is currently being planned and will be delivered during Q3. This is make improvements and to futher promote the scheme.	No support needs identified

Better Care Fund Template Q2 2018/19

5. Narrative

Selected Health and Wellbeing Board: Herefordshire, County of

Remaining Characters:	18,884

Progress against local plan for integration of health and social care

As reported in quarter one, partners across the Health and Social care system in Herefordshire remain comitted to working together to deliver a system 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.

Throughout quarter two partners have continued to discuss and develop integration arrangements. Further progress has been made in relation to a number of key integration work areas, including the following:

* Herefordshire's Integrated Urgent Care Model, including Integrated Hospital Discharge and Integrated Community Capacity Function - Integrated Discharge Lead post will be in place from December 2018

* Discharge to Assess (D2A) - expected to be implemented December 2018 (This may change due to negotiations with the provider)

* High Impact Change Model implementation - ongoing throughout 2018/19

* Trusted Assessor (TA) - to be implemented from January 2019 onwards

Further information is provided in the section below.

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Remaining Characters:	18,606

Integration success story highlight over the past quarter

Herefordshire's Integrated Urgent Care Model - a multi agency delivery group has been established to lead on the implementation of a number of key schemes within this model. This includes the Integrated Discharge Team Function and Integrated Community Capacity Function.

The Integrated Discharge Team will be made up of a group of professionals from both Social Care and Health who will work together to ensure the safe and timely discharge of patients. The Integrated Discharge Team will provide a service where the main aims are:

1. That discharge planning begins at the point of admission to the hospital.
2. The outline assessment of complex patients' needs prior to discharge is undertaken
3. To provide ward staff with support, education and training regarding discharge planning of both simple and complex patient discharges.
4. To work collaboratively with community agencies such as Continuing Health Care, Therapists, Social Services and Community Matrons to ensure that patient needs have been correctly assessed and is appropriately met on discharge.
5. To ensure the development of existing discharge services and transfer of care into community settings by developing key relationships with community services.
6. To develop and produce discharge information and literature for our patients regarding the discharge process to assist them and prevent delays in their discharge.

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

Better Care Fund Template Q2 2018/19

6. Additional improved Better Care Fund

Selected Health and Wellbeing Board:	Herefordshire, County of
Additional improved Better Care Fund Allocation for 2018/19:	£ 2,496,032

These questions cover average fees paid by your local authority (including client contributions) to external care providers.

We are interested only in the average fees actually received by external care providers from local authorities for their own supported clients (including client contributions). The averages should therefore exclude:

-Any amounts that you usually include in reported fee rates but are not paid to care providers e.g. the local authorities' own staff costs in managing the commissioning of places

-Any amounts that are paid from sources other than the local authorities' funding (including client contributions), i.e. you should exclude third party top-ups, NHS Funded Nursing Care and full cost paying clients.

The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

This single average should include fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.

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

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

If you are unable to provide rates for both 2017/18 and 2018/19, please ensure that you provide the estimated percentage change between 2017/18 and 2018/19 in the table below. Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	2017/18	2018/19	If rates not yet known, please provide the estimated uplift as a percentage change between 2017/18 and 2018/19
1. Please provide the average amount that you paid to external providers for home care in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per contact hour, following the exclusions as in the instructions above)	£15.90	£16.29	
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions as in the instructions above)	£ 491	£ 518	
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions in the instructions above)	£ 681	£ 721	
4. If you would like to provide any additional commentary on the fee information provided please do so. Please do not use more than 250 characters.			

Better Care Fund Template Q3 2018/19

Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements for 2017-19 which supports the aims of the Integration and BCF Policy Framework and the BCF programme jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of the BCF quarterly reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)

2) To provide information from local areas on challenges, achievements and support needs in progressing integration and the delivery of BCF plans
3) To foster shared learning from local practice on integration and delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform delivery improvements

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

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

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

Quarterly reporting for the 'improved Better Care Fund' (iBCF grant) will be required in Q4 18/19 and is not required for the current quarter Q3 18/19.

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

3. The checker column will appear "Red" and contain the word "No" if the information has not been completed. Clicking on the corresponding "Cell Reference" column will link to the incomplete cell for completion. Once completed the checker column will change to "Green" and contain the word "Yes"
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net.
3. When submitting your template, please also copy in your Better Care Manager.

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: A jointly agreed plan
Please note: This also includes confirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflation
National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 2017-19, planned targets have been agreed for these metrics.

This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
Please note that while NEA activity is not currently being reported against CCG Operating Plans (due to comparability issues relating to specialised commissioning), HWBs can still use NEA activity to monitor progress for reducing NEAs.
- Delayed Transfers of Care (DToC): The BCF plan targets for DToC should be referenced against your current provisional trajectory. Further information on DToC trajectories for 2018-19 will be published shortly.
The progress narrative should be reported against this provisional monthly trajectory as part of the HWB's plan.

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

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

4. High Impact Change Model

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

The maturity levels utilised on the self assessment dropdown selections are based on the guidance available on the published High Impact Changes Model (link below). A distilled explanation of the levels for the purposes of this reporting is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area

Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement

Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

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

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

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

Please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making the HICM self-assessment, which could be useful in informing future design considerations.

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

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

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

Hospital Transfer Protocol (or the Red Bag Scheme):
- The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
- Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
- Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.
- Further information on the Red Bag / Hospital Transfer Protocol: A quick guide has been published:
https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx
Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team through england.ohuc@nhs.net. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

5. Narrative

This section captures information to provide the wider context around health and social integration.
Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Please tell us about an integration success story observed over reported quarter highlighting the nature of the service or scheme and the related impact.

Better Care Fund Template Q3 2018/19

1. Cover

Version 1.01

Please Note:
- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. ***Narrative sections of the reports will not be published.*** *However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.*
- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

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

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

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | Local Government Association | NHS England

[<< Link to Guidance tab]

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75 Pooled Budget

^^ Link Back to top

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics ^^ Link Back to top

	Cell Reference	Checker
NEA Target performance	D11	Yes
Res Admissions Target performance	D12	Yes
Reablement Target performance	D13	Yes
DToC Target performance	D14	Yes
NEA Challenges	E11	Yes
Res Admissions Challenges	E12	Yes
Reablement Challenges	E13	Yes
DToC Challenges	E14	Yes
NEA Achievements	F11	Yes
Res Admissions Achievements	F12	Yes
Reablement Achievements	F13	Yes
DToC Achievements	F14	Yes
NEA Support Needs	G11	Yes
Res Admissions Support Needs	G12	Yes
Reablement Support Needs	G13	Yes
DToC Support Needs	G14	Yes

Sheet Complete:	Yes

4. High Impact Change Model ^^ Link Back to top

	Cell Reference	Checker
Chg 1 - Early discharge planning Q3 18/19	F12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19	F14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19	F15	Yes
Chg 5 - Seven-day service Q3 18/19	F16	Yes
Chg 6 - Trusted assessors Q3 18/19	F17	Yes
Chg 7 - Focus on choice Q3 18/19	F18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19	F19	Yes
UEC - Red Bag scheme Q3 18/19	F23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	H12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	H13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	H14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	H15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	H16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	H16	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	H17	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	H18	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	H23	Yes
Chg 1 - Early discharge planning Challenges	I12	Yes
Chg 2 - Systems to monitor patient flow Challenges	I13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	I14	Yes
Chg 4 - Home first/discharge to assess Challenges	I15	Yes
Chg 5 - Seven-day service Challenges	I16	Yes
Chg 6 - Trusted assessors Challenges	I17	Yes
Chg 7 - Focus on choice Challenges	I18	Yes
Chg 8 - Enhancing health in care homes Challenges	I19	Yes
UEC - Red Bag Scheme Challenges	I23	Yes
Chg 1 - Early discharge planning Additional achievements	J12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	J14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	J15	Yes
Chg 5 - Seven-day service Additional achievements	J16	Yes
Chg 6 - Trusted assessors Additional achievements	J17	Yes
Chg 7 - Focus on choice Additional achievements	J18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	J19	Yes
UEC - Red Bag Scheme Additional achievements	J23	Yes

Chg 1 - Early discharge planning Support needs	K12	Yes
Chg 2 - Systems to monitor patient flow Support needs	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	K14	Yes
Chg 4 - Home first/discharge to assess Support needs	K15	Yes
Chg 5 - Seven-day service Support needs	K16	Yes
Chg 6 - Trusted assessors Support needs	K17	Yes
Chg 7 - Focus on choice Support needs	K18	Yes
Chg 8 - Enhancing health in care homes Support needs	K19	Yes
UEC - Red Bag Scheme Support needs	K23	Yes

Sheet Complete:	Yes

5. Narrative

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	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

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Better Care Fund Template Q3 2018/19

2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Herefordshire, County of

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

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q3 2018/19

Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	On track to meet target	Achieving the NEA is challenging to partners throughout the system.	A number of key schemes continue to be delivered to assist in supporting individuals at home and avoiding admissions, where possible. Including Hospital at Home, Falls Response service and Home First.	No support needed identifed.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	Capacity within the care home market within Herefordshire continues to challenge partners, specifically in relation to complex nursing care provision.	Partners continue to support individuals in the community and facilitate independence, therefore reducing the rate of admissions into residential and nursing care. ASC pathway redesigned has been implemented and is delivering a strength based approach. A robust placement panel process is in place to consider and provide alternatives, where possible.	No support needed identifed.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	YTD to the end of Dec 71.4%. This is an uplift from the end of Nov (78.6% in December alone).	The Home First service, delivered by the local authority, continue to experience recruitment challenges, which impacts upon the service capacity available however improvements have been made during Q3. Further service developments are due to be completed in Q4.	No support needed identifed.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	Achieving the DToC target continues to pose a challenge to all partners. An LGA DToC Peer Review is scheduled to take place during Q4.	Partners continue to work together to deliver the HICM. Key areas of development for Herefordshire currently include Trusted Assessor model, Integrated Hospital Discharge function and implementation of D2A pathways - plans for all of these areas have progressed during Q3.	Please note that an LGA DToC Peer Review is scheduled to take place during Q4.

Better Care Fund Template Q3 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Herefordshire, County of

Challenges Please describe the key challenges faced by your system in the implementation of this change
Milestones met during the quarter / Observed Impact Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change
Support Needs Please indicate any support that may better facilitate or accelerate the implementation of this change

						Narrative			
		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Established	Plans in place	Plans in place	Plans in place		Further work required to ensure that the whole system is aware of the EDD and are committed to working together to achieve.	The multi agency Integrated Urgent Care Delivery Group continues to lead on a number of schemes, including the development and implementation of an Integrated Discharge Team. A key aim of this integrated team will be to ensure that discharge planning begins at the point of admission to the hospital.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 2	**Systems to monitor patient flow**	Plans in place	Not yet established	Plans in place	Plans in place		DToC analysis is completed on daily basis to understand causes of delays and identify bottlenecks.	Stranded Patients reviews are being carried out on a regular basis to further inform understanding of barriers. In addition an ASC Urgent Care huddle is taking place on daily basis.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Plans in place	Plans in place	Plans in place		Partners across the health and social care system work together where possible. Although teams are not necessarily co-located partners recognise the importance of aligning and working together.	The recruitment process for an Integrated Hospital Discharge manager has been completed and the post is due to commence during February 2019. MDT meetings occur across all of the community hospital sites which also includes an external provider.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 4	**Home first/discharge to assess**	Plans in place	Plans in place	Established	Mature		The Home First service, delivered by the local authority, continue to experience recruitment challenges, which impacts upon the service capacity available, however improvements have been made during Q3.	During Q3 further capacity improvements have been achieved. The service continues to develop and deliver the service review implementation plan.	Please note that a DToC Peer Review is scheduled to take place during Q4

Chg 5	**Seven-day service**	Plans in place	Not yet established	Plans in place	Plans in place		Several areas of service provision are not delivered on a seven day basis e.g. community therapy services, which can often cause delays. However, seven-day services are being delivered in some areas e.g. Homefirst	Seven day provision continues to be delivered for key services, including Home First, Hospital at Home and Falls Response Service. Seven-day services are being delivered where relevant, appropriate and demand evident.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Plans in place	Plans in place		Overcoming barriers to implementation - building trust and ensuring model is right for Herefordshire.	During Q3 the host employer for a trusted assessor post has been secured and the recruitment process for 2 FTE has commenced. Interviews are due to take place during Q4. The implementation group continue to meet to further develop the TA model for Herefordshire.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 7	**Focus on choice**	Plans in place	Plans in place	Established	Established		Comprehensive review of existing choice directive and processes – anticipate conclusion shortly.	The redesigned ASC pathway continues to be delivered, which has a clear focus upon client choice and strength based assessments and voluntary sector support offer - including Community Broker	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 8	**Enhancing health in care homes**	Established	Plans in place	Plans in place	Plans in place		Several providers within the Care Home sector do not engage on a regular basis which can cause difficulties and delays in implementation of developments.	The recruitment process for the Integrated Care Home Clinical Lead has been completed and the post commenced on 2 Jan 2019. This post will lead on the alignment of the Herefordshire Council and Herefordshire CCG Quality and Compliance teams. In addition 3 clinical Care Home practioners have been recruited and will commence during Q4 and a multi-agency team will in place from Q4.	Please note that a DToC Peer Review is scheduled to take place during Q4

Hospital Transfer Protocol (or the Red Bag scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q1 18/19	**Q2 18/19**	**Q3 18/19 (Current)**	**Q4 18/19 (Planned)**	**If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.**	**Challenges**	**Achievements / Impact**	**Support needs**
UEC	**Red Bag scheme**	Established	Established	Established	Mature		Providers have been taking part in the scheme however unfortunately a number Red Bags have been misplaced during the 'red bag journey' within the acute setting.	A relaunch of the Red Bag Scheme in Hereforshire was completed during Q3. This included circulation of briefings and promotional materials across a number of sites in order to promote to professionals. Literature has also been developed for clients and families/carers. Plans are in place for further awareness training with provided for Q4.	None identified.

Better Care Fund Template Q3 2018/19

5. Narrative

Selected Health and Wellbeing Board: Herefordshire, County of

Remaining Characters:	18,804

Progress against local plan for integration of health and social care

As reported in previous quarters, partners across the Health and Social care system in Herefordshire remain comitted to working together to deliver a system 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.

Throughout quarter three partners have continued to discuss and develop integration arrangements. Further progress has been made in relation to a number of key integration work areas, including the following:

* Herefordshire's Integrated Urgent Care Model, including Integrated Hospital Discharge and Integrated Community Capacity Function - Integrated Discharge Lead post will be in place from February 2019.

* Discharge to Assess (D2A) - a transition period for the pathway 3 provision has commenced. This will be fully implemented from March 2019 onwards. This pilot scheme is due to run until March 2020.

* High Impact Change Model implementation - ongoing throughout 2018/19

* Trusted Assessor (TA) - to be implemented from quarter 4 onwards.

Further information is provided in the section below.

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Remaining Characters:	19,103

Integration success story highlight over the past quarter

Integrated Community Capacity (ICC) Function

During Q3 partners have commenced more detailed discussions regarding the development of an Integrated Community Capacity Function. The integrated/aligned teams will provide daily community capacity information to inform the MDT and IDT of the availability of health and social care services in the community. The aim of the ICC will be:

• to provide timely community capacity information to the Huddle and IDT to ensure the appropriate decision is made for discharges
• to support with avoiding admissions to hospital
• to support with timely discharges from hospital
• to support with improving the length of stay

The aligning of the teams who inform the capacity and information will comprise of:

* Homefirst
* Hospital at Home
* Community Matrons
* Community occupational therapists and physiotherapists
* Community hospitals
* AWB brokers

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Tuesday 5 March 2019**
Title of report:	**Homeless Link Health Needs Audit**
Report by:	**Consultant in public health and housing strategy officer**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

The purpose of this report is to:

i. Inform the board of the results of Herefordshire's Homeless Link Health Needs Audit.
ii. Approve the recommendations arising from the audit.

The Homeless Health Needs Audit is an audit toolkit developed by the Department of Health and pilot areas, updated by Public Health England. It provides a framework for gathering and using this information to assess local need and improve healthcare services, using the direct experiences of people who are homeless.

The audit was identified as an action under Herefordshire's Homelessness Prevention Strategy 2016-2020, Objective 3: Help improve the health and wellbeing of homeless people and those who are at risk of homelessness.

The audit was undertaken for the first time in Herefordshire between December 2016 and February 2018. 102 audits were completed through face-to-face interview by Home Group, Supported Housing for Young People Project (SHYPP) and Herefordshire Council's Outreach Service.

Further information on the subject of this report is available from
Sandie Rogers, Tel: 01432 383531, email: Sandie.Rogers@herefordshire.gov.uk and Rebecca Howell-Jones, email: Becky.Howell-Jones@herefordshire.gov.uk

The vast majority of respondents were white British males. The average age was 34.5 years. Participants were sleeping in a hostel or supported accommodation (42%), in emergency accommodation (23%), rough on the streets or in a park (15%) or on someone's sofa/floor (14%). Backgrounds in institutions, including prison, local authority care and mental health admissions were common.

Overall the data showed that participants' physical and mental health, on all dimensions, was extremely poor compared to that of the population as a whole. Key health and service use findings were:

- 56% of respondents reported a physical health problem. Common physical health problems included joint/bone/muscle problems, dental problems, eyesight/eye problems and asthma.
- Overall 76% of respondents reported a mental health problem/behaviour condition. Just under half of those with a mental health problem felt that they were not receiving treatment that they would benefit from, this included respondents with severe mental health conditions and common mental health conditions.
- Drugs and alcohol use was common but not universal: 43% of respondents did not use drugs, 15% used cannabis only and 42% used Class A, prescription or other non-cannabis drugs. A quarter of respondents identified themselves as having a drug problem or being in recovery.
- Use of acute care services was common and frequent. Mental health problems and self-harm/attempted suicide contributed to approximately 40% of A&E, ambulance and hospital admissions. Violence and accidents were the main reason for approximately 30% of use of these acute services. Over three-quarters of respondents were registered with a GP and 29% with a dentist.
- Uptake of preventative health interventions was low in this population, for example <10% of respondents had the flu vaccine last year.

The report recommends a strategic commitment to improving the health of homeless population, evidenced through health and wellbeing board (HWBB) sign-up to the Charter for Health for Homelessness. The Charter commits the HWBB to identifying need, providing leadership and commissioning for inclusion. Furthermore, the audit report recommends the HWBB partners work together to improve access to mental health, primary and secondary health care and preventative services.

Recommendation(s)

That:

(a) The health and wellbeing board sign up to the 'Charter for Homeless Health' and implement its commitments, including identifying need, providing leadership and commissioning for inclusion;

(b) The health and wellbeing board members review within their organisations access to services, including mental health services, primary and secondary health care and preventative services for homeless people with the aim to improve health and reduce first-line use of A&E and ambulance services;

(c) The health and wellbeing board seeks assurance from lead agencies (including Herefordshire Council, Herefordshire Clinical Commissioning Group, Wye Valley NHS Trust and 2gether NHS Trust) on the actions they are taking to address this inequality

and considers these in a future session together with local consideration/adoption of the national memorandum of understanding on health and housing "Improving health and care through the home: A National Memorandum of Understanding"; and

(d) The Homeless Health Needs Audit be undertaken again in 3 years' time (2022; completing the audit cycle) and reported to the HWBB .

Alternative options

1. The board could decide not to agree some or all of the recommendations.

2. The board could decide not to sign-up to the Charter for Homeless Health. It is a statutory responsibility to produce a Joint Strategic Needs Assessment (JSNA) to improve the health and wellbeing of the local community and to reduce inequalities. Furthermore, without taking a leadership role or working with partners to ensure commissioning meets the needs of this vulnerable population it will be difficult for the HWBB to demonstrate they understand the link between homelessness and health and wellbeing and are working to address it, in line with Ministry of Housing, Communities and Local Government (MHCLG) Rough Sleeping Strategy, August 2018.

3. The board could decide not to work together to improve access to services for the homeless population. This would result in continued high demand and use of emergency and acute services by this population at high cost to both the individuals and the system.

4. The board could decide not to complete the audit cycle. This would result in a lack of up-to-date data on this population and mean any improvements could not be measured.

Key considerations

5. Homeless Link's Homeless Health Needs Audit was first developed in partnership with the Department of Health. It was updated in 2015, with funding from Public Health England.

6. The audit aims to:

    - Increase the evidence available about the health needs of people who are homeless and the wider determinants of their health.
    - Bring statutory and voluntary services together to develop responses to local priorities and address gaps in services.
    - Give people experiencing homelessness a stronger voice in local commissioning processes.
    - Help commissioners understand the effectiveness of their services.

7. That rough sleepers and single homeless people with complex needs experience considerable health inequalities is evidenced by the greatly reduced average life expectancy compared with general population. Men sleeping on the streets have an average life expectancy of 47 years whilst for women it is even lower at 43 years. These figures compare to 79.5 and 83.1 years average life expectancy for males and females in the general population respectively.[1] The Health Needs Audit provides a way to better understand the physical and mental health and wellbeing of Herefordshire's rough sleeping and single

[1] Public Health Matters, The inequalities of homelessness – how can we stop homeless people dying young? Public Health England, February 2018.

homeless people with complex needs, as well as access to and use of health related services.

8. The Audit consists of 42 questions including background information, physical and mental health, drug and alcohol use, access to services and staying healthy. The audit tool is given in appendix 2.

9. 102 health needs audits were completed in Herefordshire between December 2016 and February 2018, which is a considerable achievement given the comprehensive nature of the audit and the resulting time needed for questions and answer completion. Audits were undertaken through face-to-face interview by Home Group, Supported Housing for Young People Project (SHYPP) and Herefordshire Council's Outreach Service.

10. This is the first time that the Homeless Health Needs Audit has been undertaken in Herefordshire. The audit was used to capture the health needs of people who were/are sleeping rough, sofa surfing, otherwise chaotically housed or living in specialist supported accommodation and the collected data provides a significant evidence base of their physical and mental health needs. Completing the audit cycle by repeating the audit in three years' time will enable an analysis of whether or not the health outcomes for single homeless people in Herefordshire have improved during this time.

11. The following summarises some of the key findings from the report:

Background information:

i. The majority of respondents were male (82%), white British (92%) and the average age was 34.5 years. Participants were sleeping in a hostel or supported accommodation (n=43; 42%), in emergency accommodation (n=23, 23%), rough on the streets or in a park (n=15, 15%) or on someone's sofa/floor (n=14, 14%). Six percent of respondents did not have recourse to public funds.

ii. Backgrounds in institutions, including prison, local authority care and mental health admissions were common. The majority of respondents identified the cause of their most recent homelessness to be related to loss of their individual personal support networks: parents/carers or other relatives/friends being unable or unwilling to accommodate or breakdown of a relationship (non-violent). Mental or physical health problems were reported as a reason by 13% of respondents, drug and alcohol problems by 12% and domestic abuse or violence for nearly 10%.

Health needs:

iii. **Physical health:** The most common physical health problems identified were joint/bone/muscle problems (26%), dental problems (19%), eyesight/eye problems (16%) and asthma (16%).

iv. **Mental health**: Results of the Herefordshire audits show that participants experience high levels of stress, anxiety and other signs of poor mental health. Overall 76% of respondents reported a mental health problem/behaviour condition. Dual diagnosis (severe mental health issue and substance misuse) was reported by 18% (18 people, 78% of whom were told in the last 12 months); 14% reported psychosis (of whom 71% were told in the last 12 months). Just under half of those with a mental health problem felt that they were not receiving treatment that they would benefit from, this included respondents with severe mental health conditions and common mental health conditions.

v. **Drugs and alcohol**: 43% of respondents did not use drugs, 15% used cannabis only and 42% used Class A, prescription or other non-cannabis drugs. 25 people identified themselves as having a drug problem or being in recovery, of which 32% felt they would benefit from more treatment. Approximately half of respondents drank frequently (from almost every day to once or twice a week). Those that drink, drink on average 10.7 units on a typical day.

vi. **Access to services:** 78% of respondents were registered with a GP and 29% with a dentist. Use of acute care services was common, and frequent. Mental health problems and self-harm/attempted suicide contribute to approximately 40% of A&E, ambulance and hospital admissions. Violence and accidents were the main reason for approximately 30% of use of these acute services.

vii. **Staying healthy:** Basic nutrition in this population was identified as a problem with only 19% of respondents reporting an average of 3+ meals per day (81% had one or two meals a day). Uptake of preventative health interventions was low in this population, for example <10% of respondents had the flu vaccine last year.

12. Recommendations from the audit:

a. St Mungo's Charter for Homeless Health has been established as a means to galvanise change, and reduce some of the worst health inequalities in society, through health and wellbeing boards. The Charter itself is short and contains only the following commitments:

i. Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

ii. Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

iii. Commission for inclusion: We will work with the council and clinical commissioning group to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

b. Through endorsing sign up and commitment to the Charter, the HWBB will demonstrate its commitment to reduce this severe health inequality.

c. The JSNA currently does include top level data on homelessness. The findings of the audit report will be published on the Facts and Figures website, and as such contribute to the evidence base of the JSNA.

d. The audit highlighted the need for improving access to services, specifically mental health services, primary and secondary healthcare and preventative services for homeless people. Given the high level and high cost usage of acute and emergency health care services, there is an incentive both for the health and care system as well as for the best outcome for the individual.

National and local homelessness health policy

13. The Ministry of Housing, Communities and Local Government (MHCLG) Rough Sleeping Strategy, August 2018, identified the need for local recognition of the link between health and homelessness. Through acknowledgment of the findings of the Homelessness Health Audit, and approval of the recommendations, the HWBB will demonstrate such recognition in Herefordshire.

14. The Homelessness Act 2002 requires every council to carry out a review of homelessness in their district every five years and to publish a Homelessness Strategy based on the findings of the review. Rough sleeping is the most visible and damaging manifestation of homelessness. Herefordshire's first strategic objective in its Homelessness Prevention Strategy is to minimise rough sleeping and increase tenancy sustainment opportunities for rough sleepers and people with complex needs. As set out in the council's Homelessness Review document, homelessness places substantial costs on the NHS.

15. The Ministry of Housing, Communities and Local Government (MHCLG) Homelessness Code of Guidance for local authorities, February 2018 states that housing authorities should ensure that their homelessness strategy is co-ordinated with the Health and Wellbeing Strategy, and that their review of homelessness informs and is informed by the Joint Strategic Needs Assessment. The availability of data from the Homeless Link Health Needs Audit, and its inclusion in the JSNA, will support this.

Community impact

16. As stated in the JSNA 2018, Herefordshire Council's and Herefordshire Clinical Commissioning Group's focus is on prevention, early intervention and demand management in order to deliver better outcomes, whilst also managing the challenges of scarce public resources. This requires an understanding of the full range of socio-economic and lifestyle factors that affect the health and wellbeing of Herefordshire's people and communities, and an appreciation of the links between the wider determinants of health, the factors that contribute to multiple deprivation, and vulnerability. Nationally, rough sleepers and single homeless people have some of the poorest outcomes, and some of the costliest health needs in the population. However, prior to the completion of the audit very little reliable Herefordshire recent and specific information has been available.

17. Homeless people are recognised as a priority in the Herefordshire Health and Wellbeing Strategy: Priority 6, Special Consideration, includes reducing health inequalities and homeless people. Furthermore, the strategy recognises the importance of working together across the system to improve health and wellbeing.

18. As part of the government's national rough sleeping strategy, the MHCLG has announced its requirement that all councils update their homeless prevention strategies and rebadge them as homeless and rough sleeping strategies by winter 2019. Councils will be required to publish their strategies online, submit them to the MHCLG and to report progress on delivering the associated annual action plans. The data from the homeless health needs audit will support the achievement of this new duty.

19. Ten percent of audit participants reported previously being in local authority care and thus the data indicate that previously looked after children are over-represented in the homeless population. The recommendations set out, including high level leadership and identifying need, will positively impact on reducing the likelihood of homelessness for looked after children in the future.

Further information on the subject of this report is available from
Sandie Rogers, Tel: 01432 383531, email: Sandie.Rogers@herefordshire.gov.uk and Rebecca Howell-Jones, email: Becky.Howell-Jones@herefordshire.gov.uk

Equality duty

20. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows: A public authority must, in the exercise of its functions, have due regard to the need to –

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

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

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

21. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. Our providers will be made aware of their contractual requirements in regards to equality legislation.

22. This decision will benefit those with a protected characteristic through the provision of a service to support their continued integration. For example a Syrian refugee who has a physical disability would have the protected characteristics of race and disability, they would be supported to access appropriate benefits or employment, understand how to manage their tenancy and what their rights as tenants are.

23. Homelessness is both a symptom and a cause of significant health inequalities across individuals with all protected characteristic. By better understanding and addressing these needs commissioners are better placed to reduce inequalities.

24. Single homeless people experience significant health inequalities being more likely than the general population to experience multiple physical and mental health problems. However, for various reasons they may miss out on the health care they need. Where health problems go untreated until they become critical, this can result in expensive, and often avoidable, treatment.

Resource implications

25. The recommendations have no direct financial implications. HWBB partners should work together, allocating resources as appropriate, to reduce health inequalities in the homeless population.

Legal implications

26. There are no specific legal implications in the report. The Homelessness Reduction Act 2017 came into force on 3 April 2018. It places new legal duties on councils so that everyone who is homeless or at risk of homelessness will have access to meaningful help, irrespective of whether they are judged to be in priority need as long as they are eligible for assistance. Homelessness Act 2002 requires councils to review homelessness and its causes in their area and to develop a strategy for tackling homelessness.

Further information on the subject of this report is available from
Sandie Rogers, Tel: 01432 383531, email: Sandie.Rogers@herefordshire.gov.uk and Rebecca Howell-Jones, email: Becky.Howell-Jones@herefordshire.gov.uk

27. The Health and Social Care Act 2012 amends the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for health and wellbeing boards in relation to joint Strategic Needs Assessments.

Risk management

28. There is a reputational risk if it fails to consider the results of the Homeless Health Needs Audit.

29. There is a risk if partners do not work together to implement effective multiagency interventions to tackle the inequalities highlighted in this report.

Consultees

None

Appendices

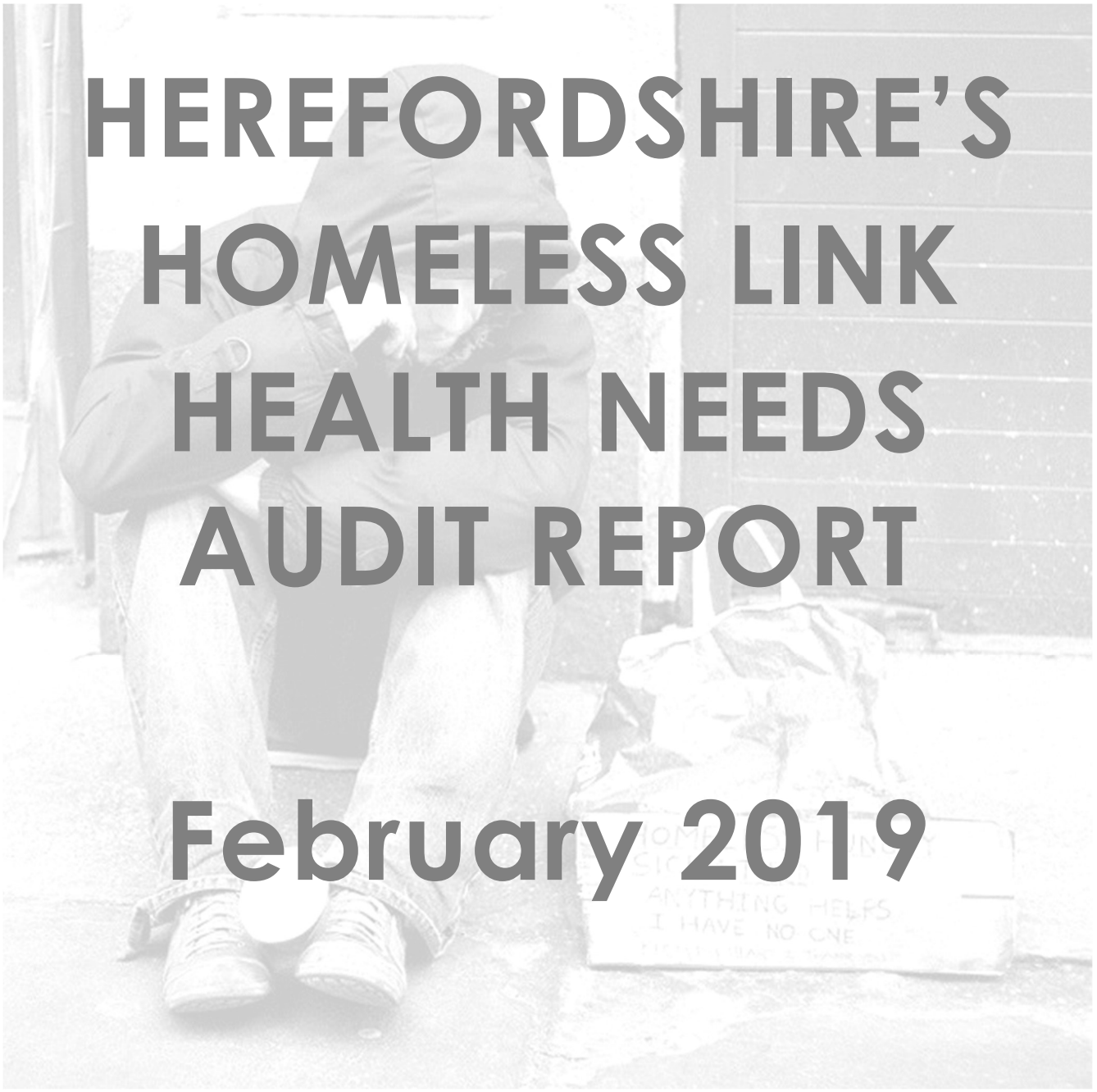
Appendix 1: Homeless Health Needs Audit Report

Appendix 2: Homeless Health Needs Audit toolkit printable questionnaire

Background papers

None identified.

Further information on the subject of this report is available from
Sandie Rogers, Tel: 01432 383531, email: Sandie.Rogers@herefordshire.gov.uk and Rebecca Howell-Jones, email: Becky.Howell-Jones@herefordshire.gov.uk



HEREFORDSHIRE'S HOMELESS LINK HEALTH NEEDS AUDIT REPORT

February 2019

1. Executive summary

Overall the data show that participants' physical and mental health, on all dimensions, is extremely poor compared to that of the population as a whole.

On average, homeless men die 30 years earlier and homeless women 37 years earlier than the general population in England.[1] People sleeping rough or in insecure or unstable accommodation have significantly higher levels of mental and physical ill health, substance abuse problems and higher rates of mortality than the general population.

The Homeless Link's Homeless Health Needs Audit[2] is an audit tool that has been developed nationally and aims to i) increase the evidence available about the health needs of people who are homeless and the wider determinants of their health, ii) bring statutory and voluntary services together to develop responses to local priorities and address gaps in services, iii) give people experiencing homelessness a stronger voice in local commissioning processes, and iv) help commissioners understand the effectiveness of their services.

The Homeless Health Needs Audit was undertaken in Herefordshire between December 2016 and February 2018. In Herefordshire the audit was used to capture the health needs data of people who were/are sleeping rough, sofa surfing, otherwise chaotically housed or living in specialist supported accommodation. Audits were undertaken through face-to-face interview by Home Group, Supported Housing for Young People Project (SHYPP) and Herefordshire Council's Outreach Service (HCOS).

One hundred and two audits were completed. The majority of respondents were male (82%), white British (92%) and the average age was 34.5 years. Participants were sleeping in a hostel or supported accommodation (n=43; 42%), in emergency accommodation (n=23, 23%), rough on the streets or in a park (n=15, 15%) or on

[1] Homelessness Kills, University of Sheffield and CRISIS: An analysis of the mortality of homeless people in early twenty-first century England, 2012

[2] Homeless Health Needs Audit toolkit. 2015. https://www.gov.uk/government/publications/homeless-health-needs-audit-toolkit

someone's sofa/floor (n=14, 14%). Six percent of respondents did not have recourse to public funds.

Backgrounds in institutions, including prison, local authority care and mental health admissions were common. The majority of respondents identified the cause of their most recent homelessness to be related to the loss of their individual personal support networks.

Health needs:

- **Physical health**: The most common physical health problems identified were joint/bone/muscle problems (26%), dental problems (19%), eyesight/eye problems (16%) and asthma (16%).
- **Mental health**: Participants experience high levels of stress, anxiety and other signs of poor mental health. Overall 76% of respondents reported a mental health problem/behaviour condition. Dual diagnosis (severe mental health issue and substance misuse) was reported by 18% (18 people, 78% of whom were told in the last 12 months); 14% reported psychosis (of whom 71% were told in the last 12 months). Just under half of those with a mental health problem felt that they were not receiving treatment that they would benefit from, this included respondents with severe mental health conditions and common mental health conditions.
- **Drugs and alcohol:** 43% of respondents did not use drugs, 15% used cannabis only and 42% used Class A, prescription or other non-cannabis drugs. 25 people identified themselves as having a drug problem or being in recovery, of which 32% felt they would benefit from more treatment. Approximately half of respondents drank frequently (from almost every day to once or twice a week). Those that drank, drank on average 10.7 units on a typical day.
- **Access to services:** 78% of respondents were registered with a GP and 29% with a dentist. Use of acute care services was common, and frequent. Mental health problems and self-harm/attempted suicide contributed to approximately 40% of A&E, ambulance and hospital admissions. Violence and accidents were the main reasons for approximately 30% of use of these acute services.
- **Staying healthy:** Basic nutrition in this population was identified as a problem with only 19% of respondents reporting an average of 3+ meals per day.

Uptake of preventative health interventions was low in this population, for example <10% of respondents had the flu vaccine last year.

Conclusion: The health inequalities faced by people who are homeless are considerable and the loss of decades of life, compared to average life expectancy, is stark. Whilst prevention of homelessness and insecure accommodation, and the risk factors that lead to it are paramount in reducing such inequalities, so is meeting the needs of population who are homeless. This audit has identified considerable need for physical and particularly mental health support. It has shown high use of acute, emergency and secondary care, often driven by mental health problems.

Recommendations:

- The Health and Wellbeing Board sign up to the 'Charter for Homeless Health' and implement its commitments, including identifying need, providing leadership and commissioning for inclusion;
- The Health and Wellbeing Board members review within their organisations access to services, including mental health services, primary and secondary health care and preventative services for homeless people with the aim to improve health and reduce first-line use of A&E and ambulance services;
- The Health and Wellbeing Board seeks assurance from lead agencies (including Herefordshire Council, Herefordshire Clinical Commissioning Group, Wye Valley NHS Trust and 2gether NHS Trust) on the actions they are taking to address this inequality and considers these in a future session together with local consideration/adoption of the national memorandum of understanding on health and housing "Improving health and care through the home: A National Memorandum of Understanding";
- The Homeless Health Needs Audit be undertaken again in 3 years' time (2022; completing the audit cycle) and reported to the HWBB.

2. Acknowledgements

We would like to acknowledge the efforts of the individuals who carried out the face-to-face health audits with homeless individuals in Herefordshire:

- Wendy Dyer – Home Group and Home Group Support Workers
- Khadine Whitefoot – Home Group and Home Group Support Workers
- Alicia Lawrence – SHYPP and SHYPP Support Workers
- Annie Doherty – Herefordshire Council Outreach Service

3. Contents

4. Introduction

4.1. Aims and Objectives

Homeless Link's Homeless Health Needs Audit[3] was first developed in partnership with the Department of Health. It was updated in 2015, with funding from Public Health England.

The audit aims to:

- Increase the evidence available about the health needs of people who are homeless and the wider determinants of their health.
- Bring statutory and voluntary services together to develop responses to local priorities and address gaps in services.
- Give people experiencing homelessness a stronger voice in local commissioning processes.
- Help commissioners understand the effectiveness of their services.

4.2. Background

4.2.1. Causes of homelessness:

Homelessness is usually the result of the cumulative interaction of structural, social and economic factors with individual personal and social support characteristics.

- Structural issues relate to the effects of the wider economy and the availability of a housing market, which is both affordable and accessible to single homeless people.
- Individual risk factors include poverty, traumatic relationship events such as family violence, abuse or breakdown; a background in local authority care;

[3] Homeless Health Needs Audit toolkit. 2015. https://www.gov.uk/government/publications/homeless-health-needs-audit-toolkit

experience of prison or the armed forces; mental ill-health and problematic drug and/or alcohol misuse.

In some cases, individual characteristics and circumstances may be a symptom of homelessness as well as an underlying cause. Drug and alcohol addiction, and crime and offending behaviour, are examples of where causal and symptomatic effects can sometimes be difficult to separate.

4.2.2. Health of the homeless population

Nationally, rough sleepers and people in insecure or unstable accommodation have significantly higher levels of mental and physical ill health, substance abuse problems and higher rates of mortality than the general population. The **average age of death is 47 years for men** compared to 77 years for the general population and **43 years for women** compared to 80 years for the general population.[4]

The 'Homelessness Kills' report[4], published in 2012, investigated the mortality of homeless people in England for the period 2001-2009. The report identified:

- At the ages of 16-24y, homeless people are at least **twice as likely** to die as their housed contemporaries; for 25-34 year olds the ratio increases to **four to five times**, and at ages 35-44y, to **five to six times**.
- Drug and alcohol misuse are particularly common causes of death amongst the homeless population, accounting for just over a third of all deaths.
- Homeless people have **seven to nine times** the chance of dying from alcohol-related diseases and **20 times** the chance of dying from drugs.
- Homeless people have **three times** the chance of dying from chronic lower respiratory diseases than their housed contemporaries, with an average age of death from chronic lower respiratory diseases of 56 years compared to 76 years in housed contemporaries.

[4] Homelessness Kills, University of Sheffield and CRISIS: An analysis of the mortality of homeless people in early twenty-first century England, 2012. https://www.crisis.org.uk/media/236799/crisis_homelessness_kills_es2012.pdf

- Homeless people are **twice as likely** to die as the general population from heart attacks and chronic heart disease, at an average age of 59 years, 16 years lower than the average age of 75 years of the general population.
- Homeless people have **seven times** the chance of dying from falls than the general population, with an average age of death of 45 compared to 77.
- Rough sleepers are over **nine times** more likely to die by suicide than the general population.[5]
- Research published by the Salvation Army found that 53% of homeless women, and 34% of homeless men **had attempted suicide** at least once.[6]

In addition, single homeless people can encounter barriers to accessing healthcare services and their experience of homelessness can mean that they neglect to do so. As a consequence, they are much more likely to use emergency ambulance and A&E services than the population as a whole.

Here we present the results of Herefordshire's Homeless Link Health Audit, undertaken to gain a better understanding the health of the homeless population in Herefordshire.

5. Methods of Herefordshire Audits

One hundred and two health needs audits were completed between December 2016 and February 2018. Audits were undertaken through face-to-face interview by Home Group, SHYPP (Supported Housing for Young People Project) and Herefordshire Council's Outreach Service. Home Group and SHYPP provide supported accommodation for single homeless people. HCOS works with single people who are sleeping rough or who are chaotically homeless or 'sofa surfing.' These might be considered to be experiencing the most extreme form of homelessness at the time of the audit.

The Audit consists of 42 questions including background information, physical and mental health, drug and alcohol use, access to services and staying healthy. The audit tool is given in Appendix 1.

[5] Quoted in Rough Sleeping (England), House of Commons Library Briefing Paper, February 2018
[6] The Seeds of Exclusion 2009, The Salvation Army, University of Cardiff and University of Kent

In Herefordshire the audit was used to capture data on the health needs of people who were/are sleeping rough, sofa surfing, otherwise chaotically housed or living in specialist supported accommodation. Participants were primarily single people who, although homeless, do not meet the 'priority need' criteria for housing as set down in statute and subsequent homelessness case law.

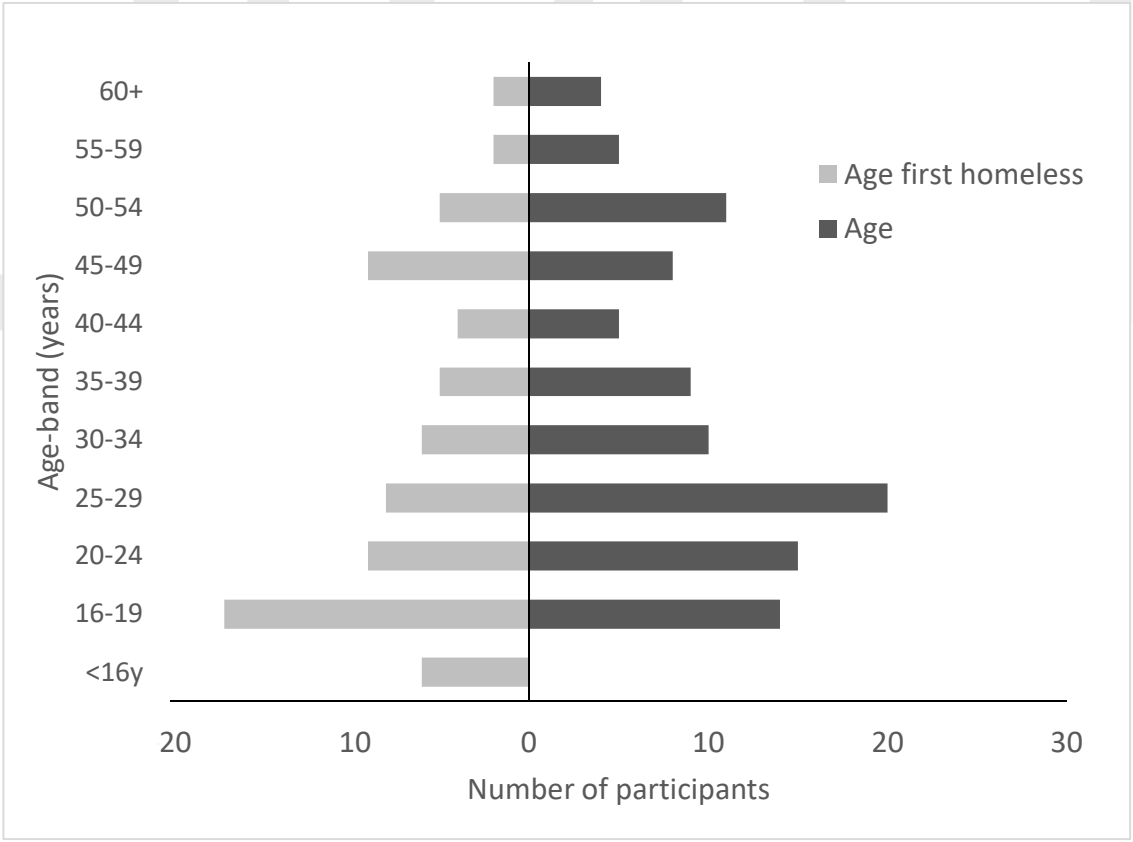
6. Results of Herefordshire Audits

6.1. Socio-demographics

6.1.1. Age, gender, sexuality and ethnicity

The average age of participants was **34.5 years (youngest 17 years, oldest 74 years)**. The average age at which respondents reported they had first become homeless[7] was 31 years (youngest 12 years, oldest 72 years). The age-distribution and age of first homelessness is shown in Figure 1 for all audit participants.

Figure 1. Age-distribution of Herefordshire Homeless Health Needs Audit participants, and age at which first homeless.



[7] Age at which respondent reported first staying at a hostel, foyer, refuge, night shelter or B&B hotel or any other type of homelessness service; stayed with friends or relatives because had no home of own ('sofa surfed'); slept rough; or applied to the council as homeless

Participants in the audit were overwhelmingly:

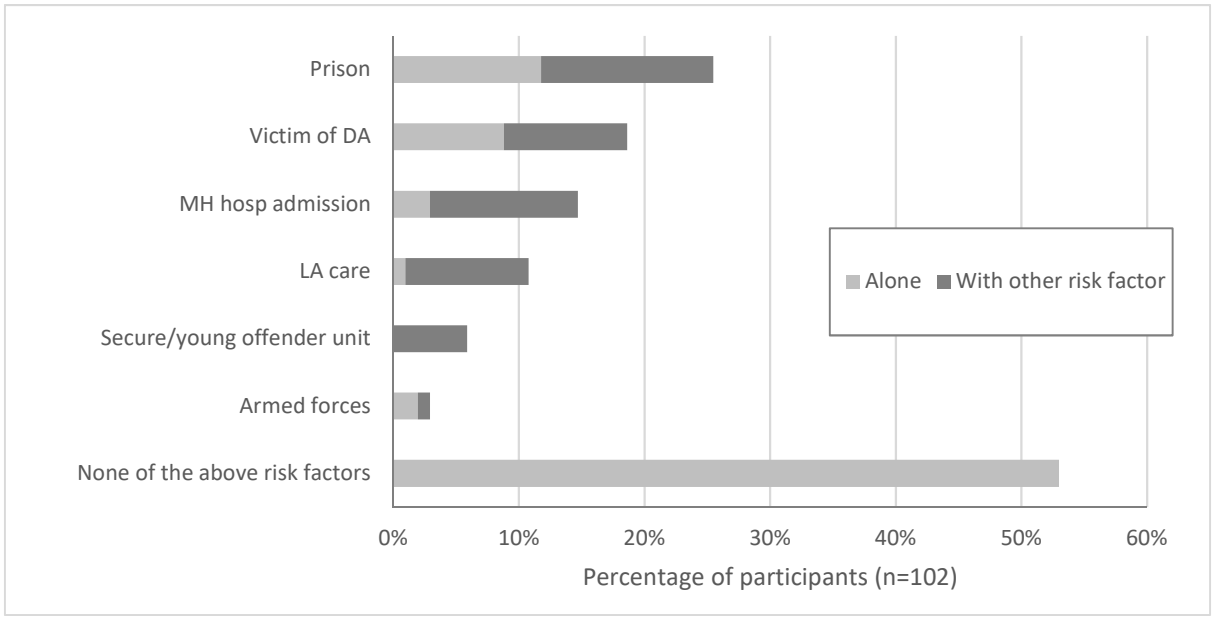
- Male (82 male and 18 female. 2 people did not answer).
- Heterosexual (7 out of 101 respondents described themselves as gay, lesbian or bisexual)
- UK nationals (96 participants) and,
- White British (94 participants).

Six participants (6% of those who answered the question) stated that they **did not have access to public funds** (welfare benefits); 93 participants had recourse to public funds; one did not know and two respondents did not answer.

6.1.2. Personal history

Almost half of participants (47%, 48 people) reported past experience of time spent in prison, secure unit/young offender institute, local authority care, armed forces, mental health hospital admission, or victim of domestic abuse. Figure 2 shows the breakdown of these background risk factors: 25% of respondents had spent time in prison (n=26), 19% been the victim of domestic abuse (n=19), 15% had been admitted to hospital because of a mental health issue and 11 (11%) had spent time in local authority care. Twenty participants had at least two of these background risks.

Figure 2. Percentage of participants who reported background risk factors for homelessness.



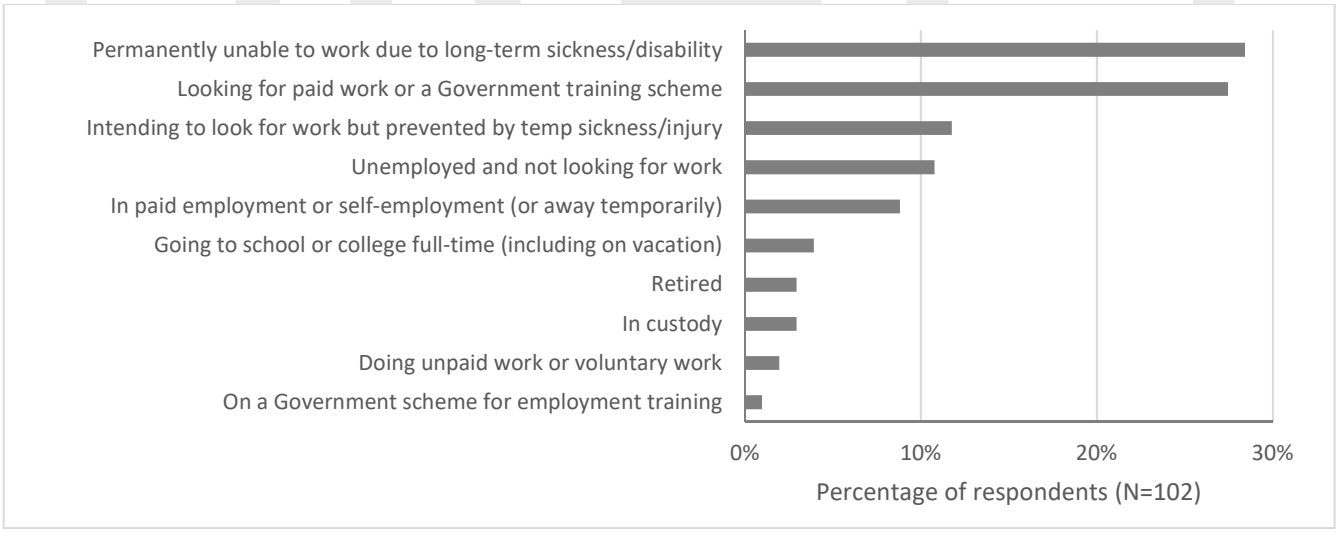
To some extent, the prevalence of local authority care and prison backgrounds in the homeless population in Herefordshire appear lower than national data, but caution should be exercised in interpreting these differences due to small numbers.

- **11%** of Herefordshire participants had a background in local authority care. In comparison, research commissioned by CRISIS,[8] which surveyed 437 single homeless people found that 25% of these had been in care at some point in their lives.
- **25%** of Herefordshire participants had spent time in prison compared to the **41%** of the homeless population in the broader 'Nations Apart' study.[9]

6.1.3. Employment

Forty percent of participants (41 people) were not working or looking for work due to their health, due either to long-term sickness/disability or temporary sickness/injury (Figure 3). Fifteen percent of participants were either studying or working, on a paid or volunteer basis.

Figure 3. Current employment status



[8] The Hidden Truth about Homelessness, Centre of Regional Economic and Social Research at Sheffield Hallam University, July 2015. https://www.crisis.org.uk/media/236815/the_hidden_truth_about_homelessness.pdf

[9] MacKie PK and Thomas I 2014. Nations apart? Experiences of single homelessness across Great Britain. London: Crisis http://orca.cf.ac.uk/70789/1/NationsApart.pdf

6.2. Homelessness experience

Participants were most commonly currently sleeping in a hostel or supported accommodation (n=43; 42%), in emergency accommodation (n=23, 23%), rough on the streets or in a park (n=15, 15%) or on someone's sofa/floor (n=14, 14%). The main reasons (primary or secondary) given for becoming homeless (most recent time) are shown in Figure 4. Many respondents gave reasons related to their individual personal support networks: parents/carers or other relatives/friends being unable or unwilling to accommodate or breakdown of a relationship (non-violent). Mental or physical health problems were reported as a reason by 13% of respondents, drug and alcohol problems by 12% and domestic abuse or violence for nearly 10%.

Figure 4. Reason given for most recent episode of homelessness (primary and secondary reasons) (% of respondents, N=102).

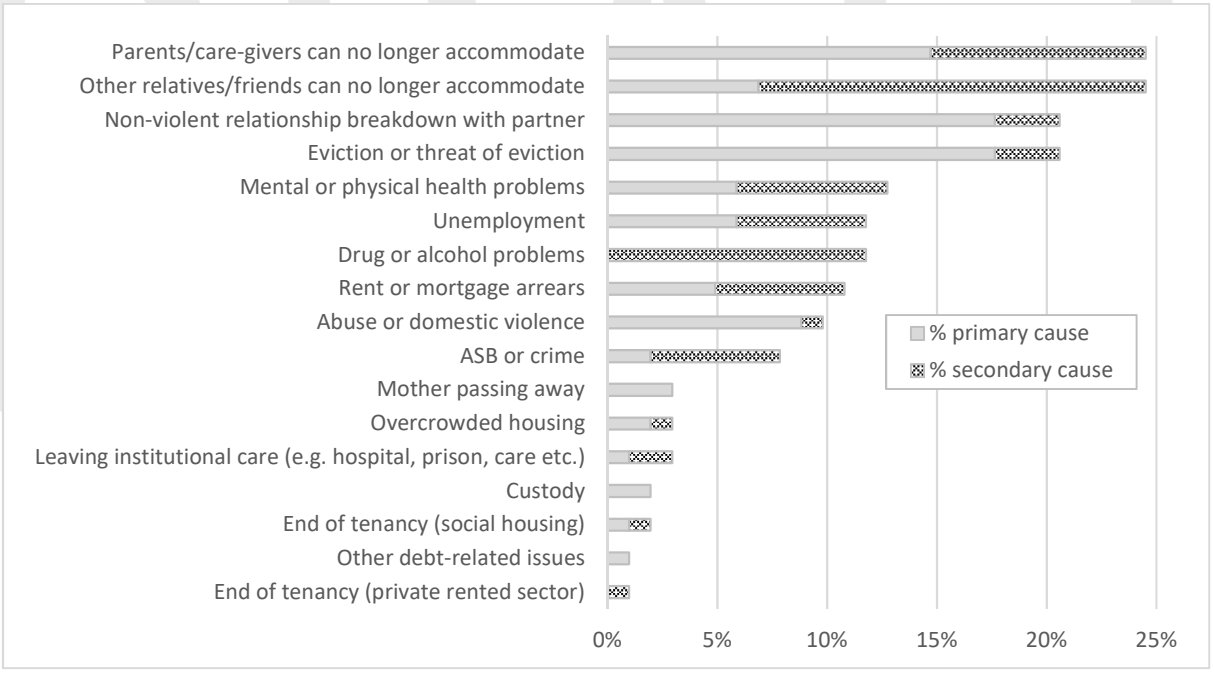
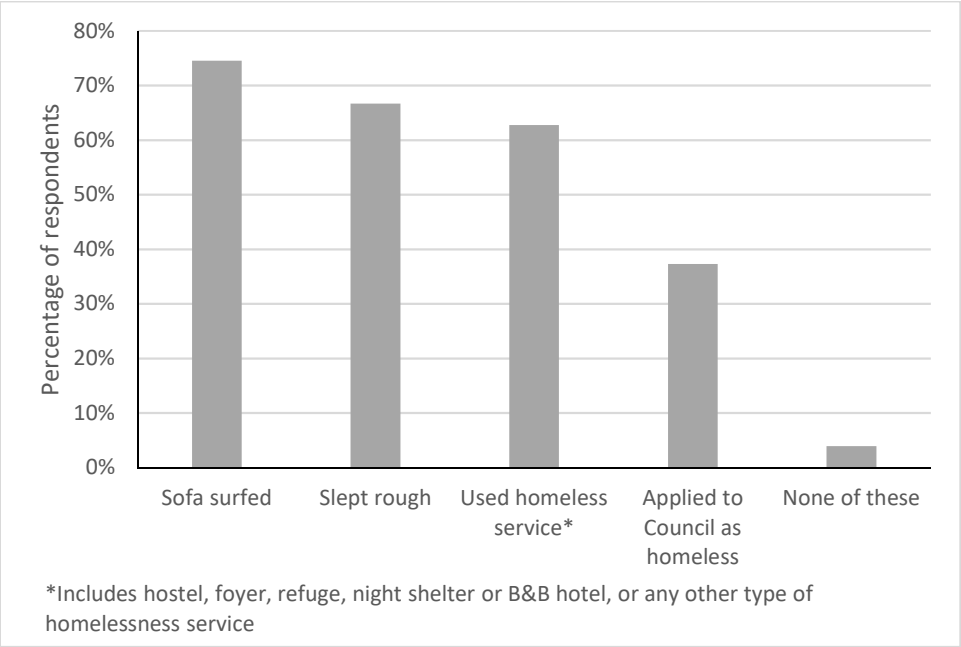


Figure 5 shows participants' previous homelessness history. The majority had previously experienced the most extreme forms of homelessness: rough sleeping (68 people, 67%). Three quarters had sofa surfed (76 people, 75%) and 37% (38 people) had made a homeless application to the council at some point. Three-quarters of respondents had experienced more than one type of homelessness previously.

Figure 5. Previous experience of homelessness (n=102)



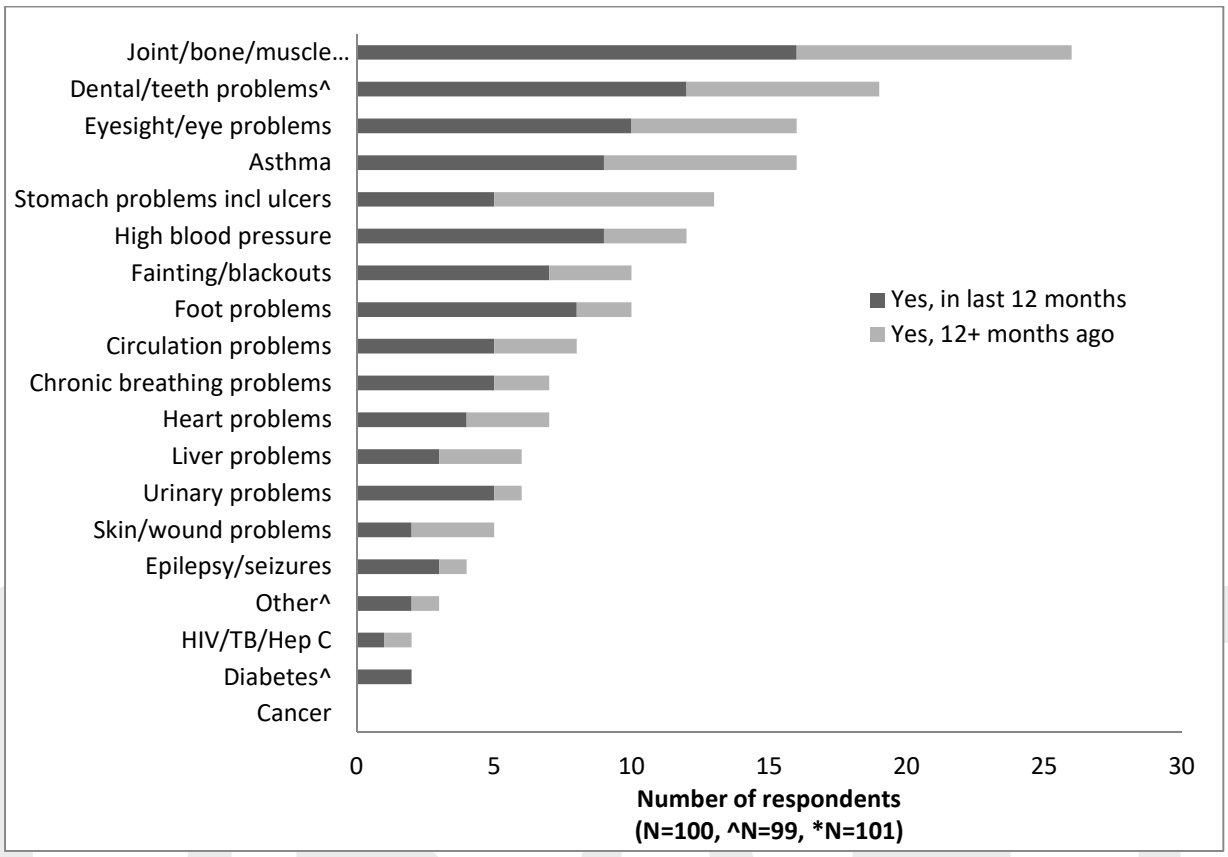
Forty-eight of those participating in the audit reported being supported by HHOS, 33 by Home Group and 19 by SHYPP (numbers include one respondent who reported receiving support from both Home Group and SHYPP). Three participants reported that they were not receiving support from any of these agencies. There was a difference in average age of participants supported by organisations which reflects their primary client groups: SHYPP 19.5 years, Home Group 35.4 years and HHOS 39.8 years.

6.3. Physical Health

6.3.1. Physical health problems and conditions

Participants were asked 'Has a doctor or health professional ever told you that you have any of the following, during the last 12 months or more than 12 months ago?', followed by a list of conditions. Figure 6 gives the breakdown of these conditions and shows the most common physical health problems to be joint/bone/muscle problems, dental problems, eyesight/eye problems and asthma. Whilst 44 respondents did not identify any physical health problems, 19 reported one single health problem and 38 respondents reported two or more.

Figure 6. Physical health problems or conditions



Comparison with general population show the prevalence of many health problems to be higher in the homeless population. For example, 14% of the general population report joint/bone/muscle problems compared with 26% in this audit. The Herefordshire results, although reasonably consistent, suggest some physical heath aspects which may be poorer than identified nationally for the homeless population, for example dental problems (Homeless Link report which analysed health needs data from 2,500 people). This does however, need to be treated with some caution due to the smaller number of participants in the Herefordshire audit.

Figure 7. Comparison of prevalence of physical health problems in the Herefordshire homeless population with national data and general population

Joint & muscle problems

Herefordshire Audit = 26%
(101 responses = 26 people)

Homeless Link Audit = 22%

General population = 14%

Dental problems

Herefordshire Audit = 19%
(100 responses = 19 people)

Homeless Link Audit = 15%

General population = unknown

Eye problems

Herefordshire Audit = 16%
(100 responses = 16 people)

Homeless Link Audit = 14%

General population = 1%

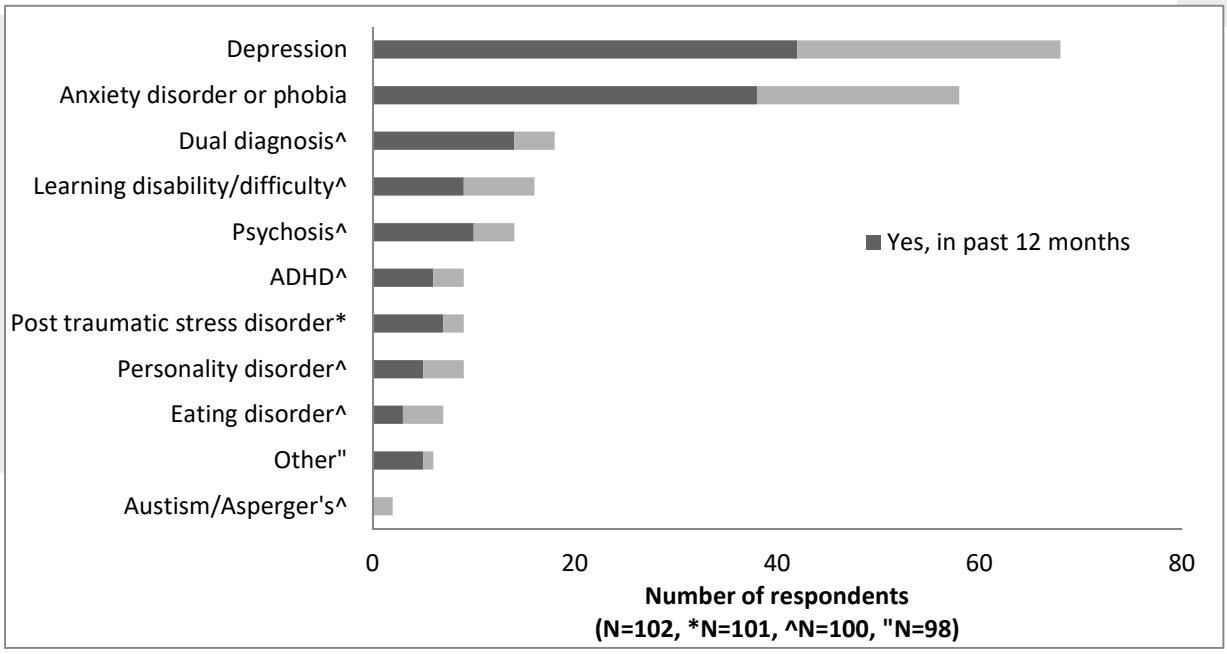
6.4. Mental Health:

6.4.1. Mental health problems and conditions

Participants were asked 'Has a doctor or health professional ever told you that you have any of the following mental health or behavioural conditions?', followed by a list of conditions.

Figure 8 shows the reported diagnoses. Two-thirds of respondents reported ever having had depression and 57% ever having anxiety. Only 24% reported no mental health issues. Dual diagnosis (severe mental health issue and substance misuse) was reported by 18% (18 people, 78% of whom were told in the last 12 months) and 14% reported psychosis (of whom 71% were told in the last 12 months).

Figure 8. Mental health problems or conditions



Whilst comparisons are difficult and should be treated with caution, Table 1 presents mental health prevalence amongst the Herefordshire homeless population, Homeless Link's Health Needs Audit data and general population data. It can be seen that mental health issues are considerably more prevalent in the homeless population, both common mental health disorders such as depression and anxiety and severe mental health illness (e.g. psychosis).

Table 1. Prevalence of mental health and behaviour conditions amongst Herefordshire Homeless population compared to other groups

	Percentage of population		
Mental health condition/behaviour	**Herefordshire Homeless Health Needs**	**Homeless Health National Data**	**General population**
Depression in the last 12 months	41%	36%[10]	19% (those aged 16y+)[11]
Anxiety disorder or phobia in last 12 months	37%	41% (Anxiety)[12]	6.6% England[13]
Psychosis, schizophrenia & bipolar disorder in last 12 months	10% in last year 14% ever	6% schizophrenia 6% bipolar disorder[10] 11% psychosis[14]	1% over a lifetime[15]
Dual diagnosis	14% in last year	12%[16]	6-15% in substance misuse settings; 20-37% in secondary mental health services[17] [18]

6.5. Drugs and alcohol use

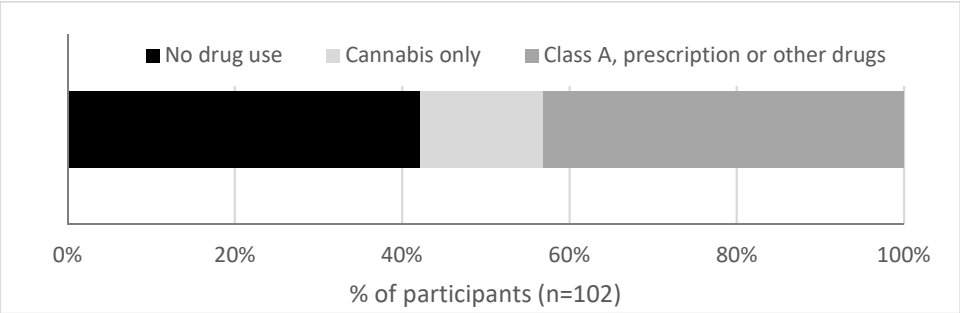
6.5.1. Drug use

43 (43%, N=102) respondents reported no drug use and 15 respondents (15%, N=102) reported use of cannabis only. Overall (i.e. alone or with other drugs), 34 respondents reported using cannabis (34%). Reported drug use by respondents is given in

Figure **9**.

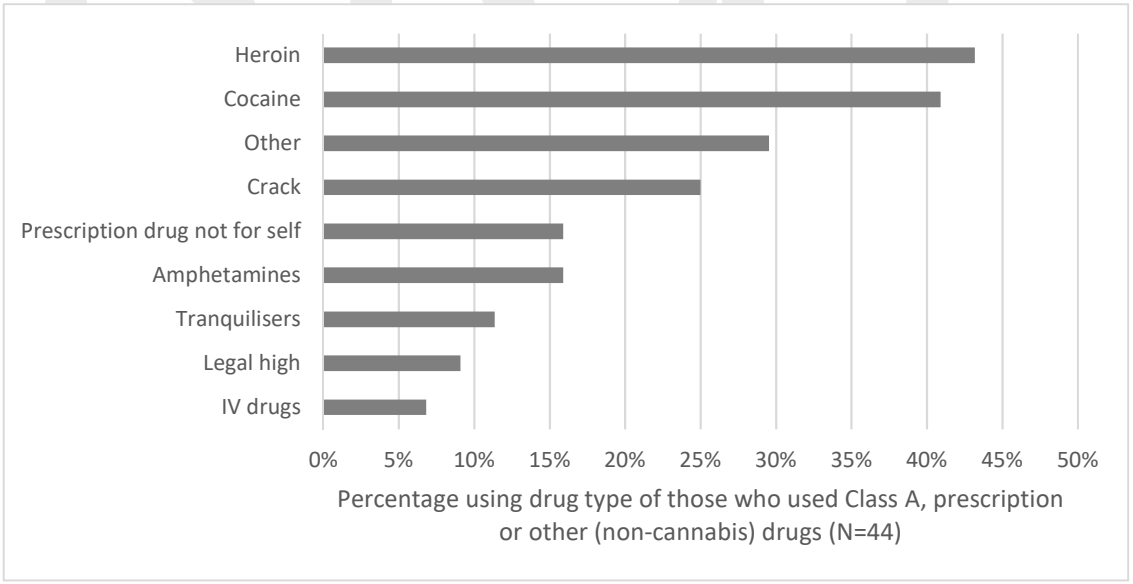
Figure 9. Reported drug use by respondents (%)

[10] Unhealthy State of Homelessness, Homeless Link, 2014
[11] ONS Measuring National Well-being: Domains and Measures 2016
[12] Mental Health and Wellbeing Guide, Homeless Link, 2011
[13] Mental Health Foundation, the one week prevalence of generalised anxiety in England
[14] Schizophrenia in homeless persons: as systematic review of the literature, Folsom, D., Jeste, D. 2002
[15] Psychosis & schizophrenia in adults, NICE Guidelines, 2013
[16] Turning Point, Dual Dilemma, July 2016
[17] Quoted in Severe mental illness and substance misuse (dual diagnosis), NICE, 2016
[18] It should be recognised that methodological challenges, including differing definitions of dual diagnosis and other issues means that national data should be treated with caution.



Drug use in the 44 respondents (44%, N=102) who reported using Class A, prescription drugs or other (non-cannabis) drugs in the past 12 months are given in Figure 10. 60% of participants who reported using these drugs, reported use of one type, 20% reported use of 2-3 different types and 18% reported use of 4 or more different drug types.

Figure 10. Drug use by those reporting Class A, prescription or other (non-cannabis) drug use (%)



Whilst comparison should again be treated with caution:

- **36 people** (36%, N=99) in the Herefordshire Audit said that they used drugs or alcohol to help them cope with their mental health (self-medicating). In the Homeless Link Audit national data almost 50% reported such use.
- The Homeless Link combined health needs audit[19] found that **64%** of participants used Cannabis. This is higher than the Herefordshire results at

[19] The Unhealthy State of Homelessness: Audit Results, Homeless Link as reference 11 above.

34% of participants, although, overall, it is the most commonly used drug by single homeless people taking part in Herefordshire the audit.

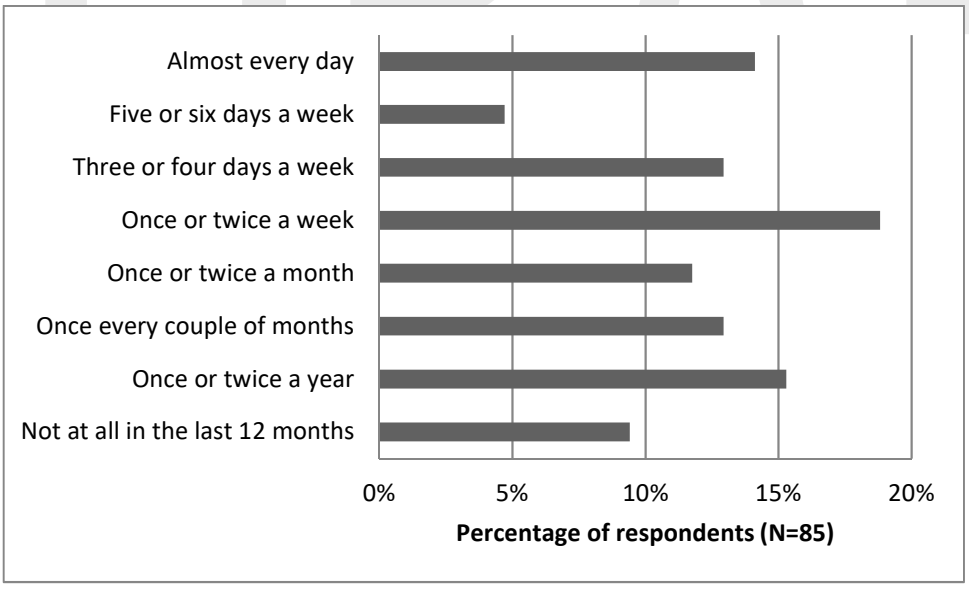
- **19%** of Herefordshire participants reported using heroin, again lower than the **27%** in the combined Homeless Link audit.

6.5.2. Alcohol Use

29%, of the 99 participants who answered the question, 'do you have or are you recovering from an alcohol problem, stated either that they did have (19 people) or that they were in recovery from an alcohol problem (10) people. This is broadly consistent with the 27% finding from the combined Homeless Link Audit results.

Participants were asked about how often they had an alcoholic drink in the past 12 months. Figure 11 shows the detailed frequency of alcohol consumption reported by respondents (17 people did not answer question).

Figure 11. Frequency of alcohol consumption



The data suggest that the frequency of alcohol consumption amongst participants is fairly uniformly split between those people who drink frequently, from almost every day to once or twice a week (43 people, 51%) and those who only drink once or twice a month to not at all in the last 12 months, (42 people, 49%).

However, participants reported high consumption on a typical day when they are drinking: average of 10.7 units per day. Excluding those that reported zero units,

the average was 14.8 units per day. The UK Chief Medical Officer's guidance on safe levels of drinking advises not to drink more than 14 units a week on a regular basis.

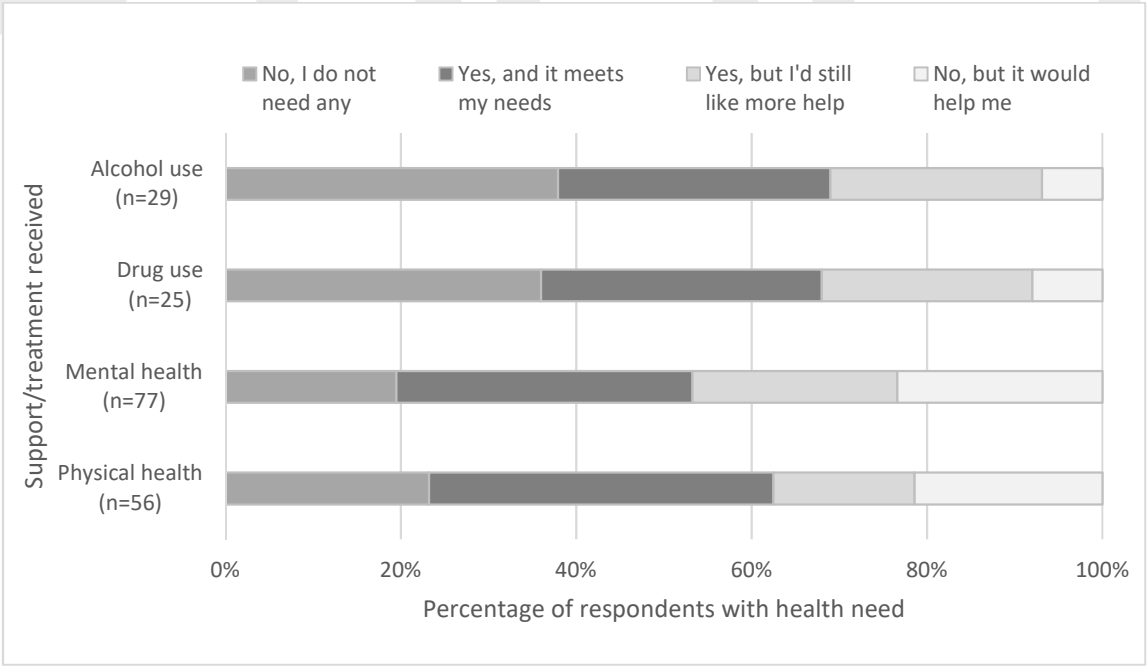
A third (33%) of those reporting their typical drinking day units, drank more than 10 units of alcohol a day. This is similar to the results of the Homeless Link audit data, which found that 35% of participants drink more than 10 units of alcohol per day.

6.6. Access to Services

6.6.1. Treatment and support for physical and mental health problems and drug and alcohol use

Figure 12 shows the support and treatment received by respondents for physical health, mental health, drug and alcohol problems. The greatest unmet felt need (i.e. those that were receiving treatment but reported they would benefit from more and those that were not in treatment but reported that it would help them) was for mental health problems with nearly half of respondents (47%) being in this category, compared to approximately one-third for physical health (38%), drug (32%) and alcohol (31%) problems.

Figure 12. Respondents' report on receipt and sufficiency of treatment/support for physical health, mental health, drug and alcohol problem.



- ***Treatment and support for mental and physical health problems***

Nearly half of respondents reported that they would like, or would like more, treatment/support for their mental health issues. The reported gap in treatment/support was identified in those with serious mental health issues as well as those with common mental health problems: of the 10 people reporting being diagnosed with psychosis (including schizophrenia or bipolar disorder) in the last 12 months, all reported receiving care although five (50%) would like more. Of the four diagnosed with psychosis more than 12 months ago, two were receiving treatment/support that they felt met their need, one was in treatment but would like more and one was not receiving treatment/support but felt they would benefit from it.

As shown in Table 2, overall the results would suggest that fewer people are receiving the mental health support that they feel they need than was the case in the results from the combined Homeless Link Audits.

Table 2. Comparison of respondents' views of sufficiency of care compared to national data

Herefordshire Audits		Homeless Link Audits
Receiving support that meets needs	33.3%	44.3%
Receiving some support but would like more	23.0%	28%
Not receiving support but it would help	23.0%	17.5%
Not receiving support and don't need it	19.2%	10.0%

27 (27%) of the 102 respondents were receiving professional talking therapy, support from a specialist mental health worker and/or a service that deals with dual diagnosis. Whilst the majority of participants had support from only one of these (8 in talking therapy, 8 with specialist mental health worker and 5 in service for dual diagnosis), 6 participants had support from more than one of these services. 25 of the 102 respondents (25%) reported that they received medication for their mental health. Of these 25, 10 received no other support/treatment.

Twenty respondents (20%) stated that there was a time in the last 12 months when they reported that they did not get the assessment or treatment they felt they needed for a mental health problem. This is higher than the comparative figure of 11% for physical health. The most common reason was wanting to wait to see if the problem got better on its own (n=6). Perhaps more concerning however, three reported being unable to get an appointment, two were refused

treatment/examination and two had a change in GP resulting in either cancellation of a referral to mental health services or loss of counselling service. For physical health, this was most commonly due to fear of medical institutions/treatments (n=4) or not being able to get an appointment (n=3). No respondents reported that they had been banned from services, travel was inhibitory or they were refused treatment/examination for a physical health problem.

- ***Treatment and support for drug and alcohol problems***

25 people reported that they had a drug problem, 19 people (18.6%, N=102) said that they had a drug problem and six that they were in recovery from a drug problem. Overall 14 of these reported receiving treatment.

Eleven of these 14 respondents reported taking Methadone, Subutex or another substitute drug, which was prescribed for them. In addition, two respondents who stated they did not need any treatment/support) reported taking substitute drugs, one that were prescribed for them and one prescribed for someone else.

Of the 29 people who reported that they have an alcohol problem or are recovering from an alcohol problem, one third stated that they did not need any help:

6.6.2. Primary Care Services

Data from the Herefordshire audit showed that:

- **78%** (80 people) of participants were registered with a GP[20]. This is lower than the combined data for the 'Unhealthy State of Homelessness' audits which found that 90% of people were registered with a GP. No respondents reported being refused GP registration in the past 12 months.
- **Only 29%** (28 people, N=97) were registered with a dentist in their local area.[21] Two people said that they had been refused registration during the last 12 months (due to waiting list and no NHS patients).

[20] Includes GP or homeless health service

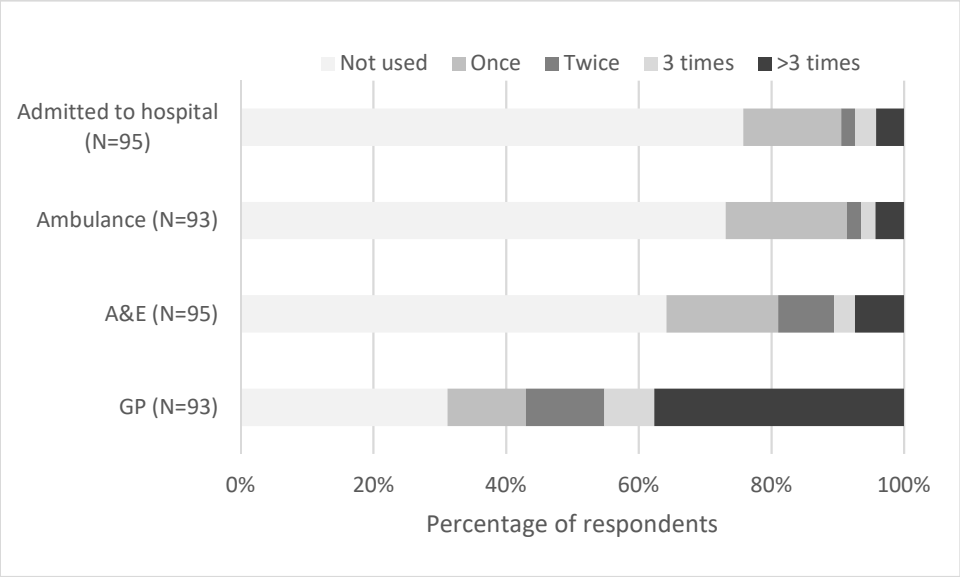
[21] An equivalent national statistic could not be identified, but 'Access to Dental Service' data NHS Outcomes Framework 2016/17 states that 94.6 who tried to get a NHS dental appointment over the previous two years did so.

Those who were being supported by HCOS, and therefore likely to be experiencing some of the most extreme forms of homelessness were significantly less likely to be registered with a GP than those supported by SHYPP and Homegroup (35.4% HCOS supported individuals not registered with GP compared to 9.3% of SHYPP or Homegroup supported individuals). This likely reflects the different homelessness experience of these groups.

6.6.3. Acute care services

Frequency of use of healthcare services in the past year are shown in Figure 13. Of the participants who answered the question, 69% had visited a GP during the last 12 months and 38% had visited more than 3 times. 36% had used A&E in the last year, and a quarter of participants (24%) were admitted to hospital. In total, the 95 respondents made a minimum 69 visits to A&E and had 43 admissions to hospital in the previous year.

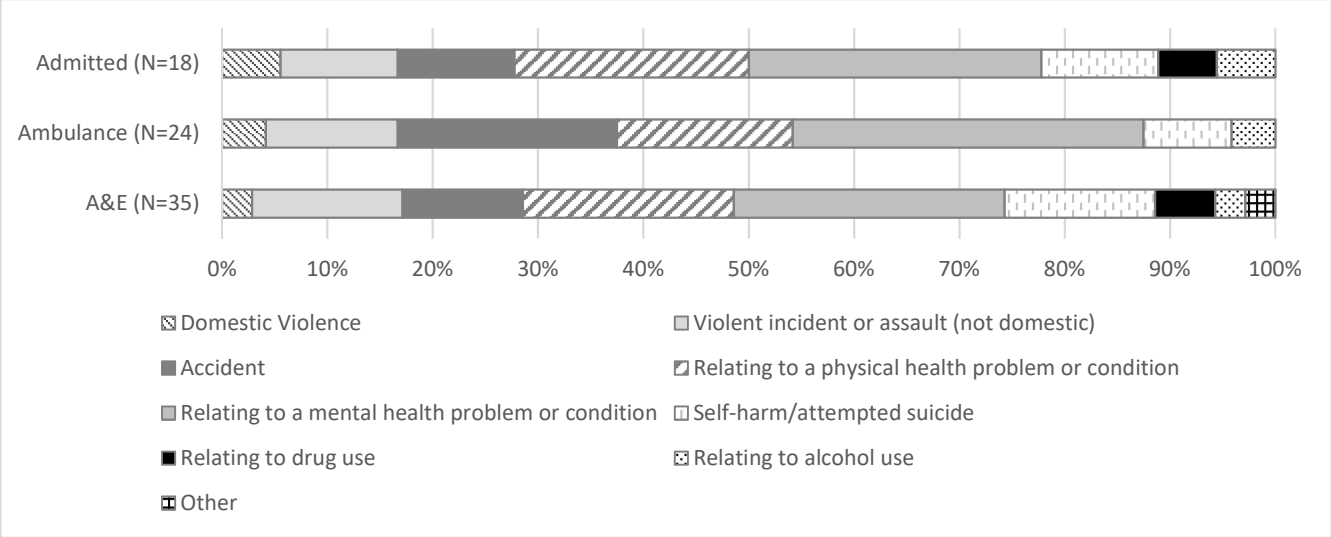
Figure 13. Use of acute health services in last year



Respondents were asked for the main reason for their use of each of the services A&E, ambulance and hospital use in the past year (i.e. only one reason could be given for each service even if there had been multiple use of the service).As can be seen in Figure 14, mental health problems and self-harm/attempted suicide

contribute to approximately 40% of the use of each of these services. Violence and accidents were the main reason for approximately 30% of use.

Figure 14. Main reason for use of acute health services



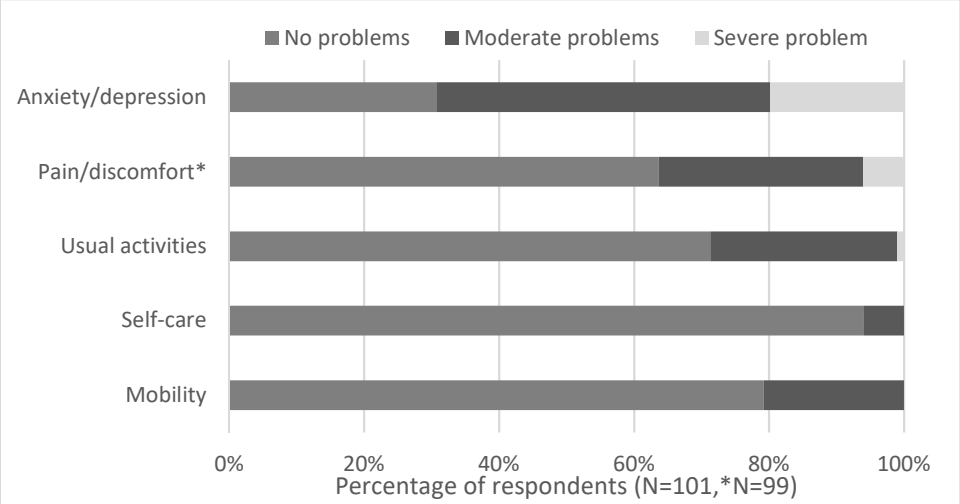
Of the 23 respondent who had been admitted to hospital, 16 were discharged into accommodation suitable to meet their needs, three could not remember where they were discharged to, one did not answer admission, however, three were discharged back onto the street (13%).

6.7. Wellbeing

6.7.1. Self-reported wellbeing

Whilst the majority of respondents reported no problems with mobility and self-care, ~70% of respondents reported moderate or severe problems with anxiety or depression and nearly 40% reported problems with pain and discomfort (Figure 15). 68% reported a long-standing illness or disability (LSI).

Figure 15. Description of own health state



Participants were asked to rate their health state on a scale from 0 to 100, where 100 is the best state they could imagine and 0 the worst. The mean score was 58, with a minimum of 4 and maximum of 100.

The majority of respondents (n=49) felt their health to be about the same as it was 12 months ago, with equal numbers reporting better and worse health (26 and 27 respectively, out of 102 respondents).

Self-reported long standing illness, disability or infirmity: 68% (67 people) report a long-standing illness or disability (LSI) of 99 respondents to this question.

6.7.2. Life Style

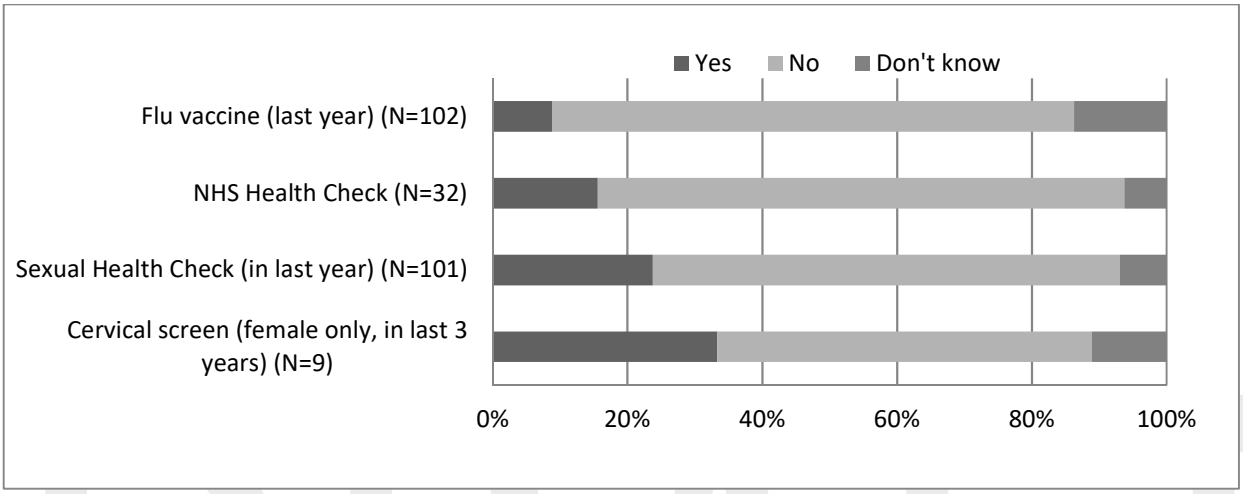
Smoking: 82%, of participants (84 people) smoke tobacco, which is more than five times higher than the national population at 16%.[22]

- 23% of participants said that they would like to give up altogether.
- 33% did not know whether or not they want to give up altogether.
- 74% had not been offered help by a health professional to give up smoking.
- 19% had been offered help to give up but did not take it.

[22] Office for National Statistics, 2016

Prevention: There was low uptake of preventative health services, including health checks and vaccinations (Figure 16). For example, fewer than 10% of respondents received flu vaccine last year.

Figure 16. Uptake of preventative health interventions



Nutrition: 44% of respondents reported eating an average of one meal a day, 37% reported eating two meals a day. Only 19% of respondents reported eating, on average, 3 or more meals a day. One respondent reported an average of no meals a day (N=101).

27% respondents reported consuming less than one fruit or vegetable a day, 33% reported 2-3 portions a day and only 9% four or more portions a day (N=101).

Exercise: 21 respondents (21%, N=101) reported exercising for 30 minutes five or more times per week, thereby meeting the recommended exercise levels. However, the vast majority never exercised (56%).

7. Conclusion

The results presented here highlight the poor physical and mental health, and substance misuse, of the homeless population in Herefordshire. These factors can be both the cause and consequence of homelessness.[23]

Self-reported health in this population is considerably worse than that of the general population: here 68% reported a long-standing illness or disability (LSI)

[23] Royal College of Physicians (1994). Homelessness and ill health.

which compares to 36% of the general population nationally[24] and is only marginally lower than the 69% of general population aged over 75 years who report having a LSI.

The Homeless Link 'Unhealthy State of Homelessness'[25] report found that almost all long-term physical health problems are more prevalent in the homeless population that in the general public. The data for Herefordshire would support this.

Mental health problems were extremely prevalent in this population.

Drug and alcohol abuse, especially when combined with a mental illness, are linked to homelessness as causal risk factors and triggers, but also as the consequence of being homeless.[26]

[24] Adult Health In Great Britain, Office for National Statistics
[25] The Unhealthy State of Homelessness, Health Audit Results 2014, Homeless Link.
[26] Evidence Review of the Costs of Homelessness, DCLG, August 2012

There is a growing awareness that individuals with dual diagnosis experience some of the worst health, wellbeing and social outcomes, and are among the most vulnerable in society.'[27]

Accessing the right health care early can prevent problems deteriorating to a point where they become critical and, therefore, significantly more costly both to the individual and to health care services.

Homeless people if not supported, treated effectively and given appropriate access to healthcare services are one of the most costly populations to the NHS. They consume eight times more NHS resources than that of the housed population, with 'homelessness' being an independent risk factor for experiencing emergency department and inpatient admissions high usage status.[28]

According to a Department of Health study, which provides estimates based on 40,500 rough sleepers or those living in a hostel, homeless people are 3.2 times more likely than the general population to be an impatient admission, at an average cost 1.5 times higher.[29]

Research has shown that that people who experience homelessness for three months or longer cost on average:

- £4,298 per person to NHS services.
- £2,099 per person for mental health services.
- £11,991 per person in contact with the criminal justice system.[30]

Hospital admissions and accident and emergency attendances are likely to represent only a small fraction of the total costs to health services. The Evidence Review of the Costs of Homelessness suggest that, due to the high prevalence of drug and alcohol dependency and mental health problems amongst this population, the more significant costs to health are likely to come from drug and alcohol treatment and mental health services.[31]

[27] Severe mental illness and substance misuse, prepared for NICE, December 2015
[28] Health of Homelessness, John S Bradley ,NHS Principal Public Health Practitioner Wales, the bmj, February 2018
[29] Department of Health (2010) Healthcare for single homeless people.
[30] Better than a Cure? Nicholas Pleace and Dennis Culhane, University of York, 2016.
[31] Department for Communities and Local Government (2012). Evidence review of the costs of homelessness. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

Being homeless can cause or intensify social isolation, and create barriers to education, training and paid work.

There is also a substantial body of evidence that being homeless can make it extremely difficult to have a healthy lifestyle. It has a major detrimental impact on personal wellbeing and can cause significant long-term health problems or exacerbate those which are pre-existing. The longer a person is living on the streets, is sofa-surfing or living without a safe and stable home, the more these problems multiply and the harder they are to overcome.

8. Recommendations

- The Health and Wellbeing Board sign up to the 'Charter for Homeless Health' and implement its commitments, including identifying need, providing leadership and commissioning for inclusion;
- The Health and Wellbeing Board members review within their organisations access to services, including mental health services, primary and secondary health care and preventative services for homeless people with the aim to improve health and reduce first-line use of A&E and ambulance services;
- The Health and Wellbeing Board seeks assurance from lead agencies (including Herefordshire Council, Herefordshire Clinical Commissioning Group, Wye Valley NHS Trust and 2gether NHS Trust) on the actions they are taking to address this inequality and considers these in a future session together with local consideration/adoption of the national memorandum of understanding on health and housing "Improving health and care through the home: A National Memorandum of Understanding";
- The Homeless Health Needs Audit be undertaken again in 3 years' time (2022; completing the audit cycle) and reported to the HWBB.

9. Appendix 1.

Homeless Health Needs Audit Survey Questions

HOMELESS HEALTH NEEDS AUDIT

PRINTABLE VERSION OF THE SURVEY

Welcome to the Health Needs Audit. This is the paper version of the audit questions. If you are using the paper version, please input the responses afterwards onto the online tool.

This survey asks clients questions about their health needs and access of health services in your local area. Interviewer: Please refer to **Information for Interviewers (R5)** to help you carry out the survey. Make sure the client has read **Information for Clients (R6)** and understands how this information will be used.

INTRODUCTION

Before you get started, we want to make sure you have read about this survey.

☐ I (the client) understand how this information will be used and am happy to go ahead

1 ACCESS OF HEALTH SERVICES

1 **ARE YOU REGISTERED WITH THESE SERVICES IN YOUR LOCAL AREA?**

	yes, permanent	yes, temporary	no
A homeless health care or NFA health service	○	○	○
GP	○	○	○
Dentist	○	○	○

2 **WHICH OF THESE SERVICES HAVE YOU USED IN THE PAST 6 MONTHS?**

	Not used	1-2 times	3-5 times	over 5 times
GP/doctor	○	○	○	○
Dentist	○	○	○	○
Optician	○	○	○	○
Nurse	○	○	○	○
Walk-in clinic	○	○	○	○
Outpatient appointment	○	○	○	○
Homeless health / NFA service	○	○	○	○
Visited A&E	○	○	○	○ number of times……
Used an ambulance	○	○	○	○ number of times……
Admitted into hospital	○	○	○	○ number of times……

2a) **If you have used ANY of A&E, hospital OR ambulance in the past 6 months please answer these questions:**

What was the reason why you last used:
Please select the reason which best fits the primary cause of using the service, or use the other box if the reason is not listed.

	A&E	Ambulance	Admitted into hospital
Violent incident or assault	○	○	○
Accident	○	○	○
Breathing problems/chest pains	○	○	○
Seizure/fitting	○	○	○
Stomach pain	○	○	○
Relating to mental health	○	○	○
Self harm	○	○	○
Relating to drug use	○	○	○
Relating to alcohol use	○	○	○
○ Other for A&E, ……			
○ Other, for ambulance……..			
○ Other, for hospital ……..			

.

2b) **If you were ADMITTED INTO HOSPITAL, please answer these questions about your most recent admission:**

How many nights did you stay in for? …….. (Please estimate if you need to)

Did staff in the hospital make sure you had somewhere suitable to go when you were discharged?

○ Yes ○ No

3 **HAVE YOU BEEN REFUSED REGISTRATION TO A GP OR DENTIST IN THE PAST 12 MONTHS?**

○ Yes ○ No

IF YES, why was this?.....

4 **HAS YOUR HOUSING OR HOMELESSNESS PROJECT GIVEN YOU INFORMATION ABOUT LOCAL HEALTH SERVICES YOU CAN USE?**

○ Yes ○ No ○ Don't know

IF YES, did you find it useful?

○ Yes ○ No ○ Don't know

5 **OVERALL, WHO HELPS YOU MOST WHEN IT COMES TO YOUR HEALTH?** Please choose **all** that apply:

☐ GP ☐ friend/peer ☐ drug worker
☐ staff member at housing/homelessness project ☐ family ☐ mental health worker
☐ Homeless health care team ☐ alcohol worker ☐ nobody
☐ A&E staff ☐ Other:……

2 YOUR PHYSICAL HEALTH

6 **DO YOU SMOKE?**
○ Yes ○ No If 'no' go to Q7.

Do you want to stop smoking?

○ Yes ○ No

Have you been offered advice or help to stop smoking?

○ Yes, and took this up ○ Yes, but did not take this up ○ No

7	**ON AVERAGE, DO YOU EAT AT LEAST 2 MEALS A DAY?** If this is difficult, please think about the meals you ate yesterday. ○ Yes ○ No
8	**HOW MANY PIECES OF FRUIT AND VEG DO YOU USUALLY EAT PER DAY?** If this is difficult to answer, please think about what you ate yesterday. ○ none ○ 1-2 ○ 3-4 ○ 5+
9	**DO YOU EXERCISE AT LEAST TWICE A WEEK?** (play sport, swim, or cycle for at least 30 minutes each time?) ○ Yes ○ No **IF NO, would you like to?** ○ Yes ○ No ○ Don't know
10	**DO YOU EXPERIENCE ANY OF THE FOLLOWING HEALTH PROBLEMS?** Please choose **all** that apply:

	Yes, less 12 mnths	Yes, 12 mnths +	No
chest pain/breathing problems	○	○	○
joint aches/problems with bones and muscles	○	○	○
difficulty seeing/eye problems	○	○	○
skin/wound infection or problems	○	○	○
problems with feet	○	○	○
fainting/blackouts	○	○	○
urinary problems/infections	○	○	○
circulation problems/ blood clots	○	○	○
liver problems	○	○	○
stomach problems	○	○	○
dental/teeth problems	○	○	○
diabetes	○	○	○
epilepsy	○	○	○
Other: ……	○	○	○

10b	**IF YES TO ANY PHYSICAL HEALTH NEED:** **Are you receiving support/treatment to help you with your physical health problem?** ○ Yes, and it meets my needs ○ Yes, but I'd still like more help ○ No, but it would help me ○ No, I do not need any

3 YOUR MENTAL HEALTH

11	**DO YOU EXPERIENCE ANY OF THE FOLLOWING MENTAL HEALTH DIFFICULTIES?**

	Yes, less 12 mnths	Yes, 12 mnths +	No
Often feel stressed	○	○	○
Often feel anxious	○	○	○
Panic attacks	○	○	○
Feel depressed	○	○	○
Difficulty sleeping	○	○	○
Suicidal thoughts	○	○	○
Self harm	○	○	○
Hear voices	○	○	○
I find it hard to control my anger	○	○	○
I can be aggressive or violent towards others	○	○	○

.

12	**DO YOU HAVE A MENTAL HEALTH NEED OR CONDITION WHICH HAS BEEN DIAGNOSED BY A DOCTOR OR OTHER HEALTH PROFESSIONAL?** ○ YES ○ DON'T KNOW ○ NO (please go to Q13)

IF YES, what was this, and how long have you experienced it for? Please select all that apply

	Yes, less 12 mnths	Yes, 12 mnths +	No
Depression	○	○	○
Schizophrenia	○	○	○
Bipolar disorder	○	○	○
Personality disorder	○	○	○
Post traumatic stress disorder	○	○	○
Dual diagnosis with a drug or alcohol problem	○	○	○
Other mental health condition (please state)…….	○	○	○

13 **DO YOU GET SUPPORT WITH YOUR MENTAL HEALTH, eg from a worker, medic or support service?**

○ Yes, and it meets my needs GO TO 13a
○ Yes, but I'd still like more help GO TO 13b
○ No, but it would help me GO TO 13b
○ No, I do not need any GO TO 14

13a **What type of support helps you?** Tick all that apply

☐ Talking therapies (eg counselling, psychological therapies)
☐ A specialist mental health worker – eg Community Mental Health team
☐ Service to address my dual diagnosis
☐ Activities to do like arts, volunteering or sport
☐ Practical support to help me with my day to day life
☐ Other ……

13b **What sort of support would help you?** Tick all that apply

☐ Talking therapies (eg counselling, psychological therapies)
☐ A specialist mental health worker – eg Community Mental Health team
☐ Services to address my dual diagnosis
☐ Activities to do like arts, volunteering or sport
☐ Practical support to help me with my day to day life
☐ Other ……

14 **DO YOU USE DRUGS OR ALCOHOL TO HELP YOU COPE WITH YOUR MENTAL HEALTH – this can be called 'self-medicating'?**

○ Yes ○ No

4 DRUGS AND ALCOHOL

15 **DO YOU TAKE ANY DRUGS OR ARE YOU RECOVERING FROM A DRUG PROBLEM?** *(by drugs this does not include medication prescribed to you for a specific medical condition)*

○ YES, use drugs ○ No ***GO TO Q18***

If YES, IN THE LAST MONTH, HAVE YOU USED ANY OF THE FOLLOWING? Please choose **all** that apply:

☐ heroin
☐ crack/cocaine
☐ cannabis /weed
☐ amphetamines/ speed
☐ benzodiazepines/ benzos
☐ prescription drugs
☐ Other drugs, please say……
☐ None

	Do you take methadone? ○ YES ○ NO **IF YES: is this prescribed to you**? ○ YES ○ NO
16	**DO YOU CURRENTLY INJECT DRUGS?** ○ YES ○ No (Go to Q17) **IF YES: Do you share injecting equipment with others?** ○ yes, usually ○ yes, sometimes ○ no **Do you know about:** A needle exchange scheme you can use: ○ yes ○ no Advice or training on safer injecting: ○ yes ○ no .
17	**DO YOU GET SUPPORT TO HELP YOU ADDRESS YOUR DRUG USE?** ○ Yes, and it meets my needs GO TO 17a ○ Yes, but I'd still like more help GO TO 17b ○ No, but it would help me GO TO 17b ○ No, I do not need any GO TO 18
17a	**How does this support help you?** Tick all that apply ○ Helps me to better control my drug use ○ Helps me to reduce my drug use ○ Helps me to use drugs more safely ○ Helps me to stop using drugs ○ other……
17b	**What sort of help would you like?** Tick all that apply ○ Help to better control my drug use ○ Help to reduce my drug use ○ Help to use drugs more safely ○ Help to stop using drugs ○ other……
18	**HOW OFTEN DO YOU HAVE AN ALCOHOLIC DRINK?** ○ never *go to Q 19* ○ monthly or less ○ 2-4 times per month ○ 2-3 times per week ○ 4 -6 times per week ○ every day **How many units do you drink on a typical day when you are drinking?** Please refer to flashcard to work this out ○ 1-2 ○ 3-4 ○ 5-6 ○ 7-9 ○ 10+

19 **DO YOU HAVE OR ARE YOU RECOVERING FROM AN ALCOHOL PROBLEM?**

○ YES ○ NO (go to Q 20)

Do you get support to help with this?

○ Yes, and it meets my needs GO TO 19a
○ Yes, but I'd still like more help GO TO 19b
○ No, but it would help me GO TO 19b
○ No, I do not need it GO TO 20

19a **How does this support help you?** Tick all that apply

☐ helps me to better control my alcohol intake
☐ helps me to reduce my alcohol intake
☐ helps me to manage the impact drinking has on my health
☐ helps me to stop drinking
☐ other……

19b **What sort of support would help you?** Tick all that apply

☐ help to better control my alcohol intake
☐ help to reduce my alcohol intake
☐ help to manage the impact drinking has on my health
☐ help to stop drinking
☐ other……

5 VACCINATIONS AND SCREENING

20 **HAVE YOU BEEN VACCINATED FOR THE FOLLOWING?**

Please choose the appropriate response for each item:

	Yes	No	Don't know
Hep A	○	○	○
Hep B	○	○	○
Flu (past 12 mnths)	○	○	○

21 **HAVE YOU BEEN TESTED FOR THE FOLLOWING HEALTH PROBLEMS?**

	Not tested	Tested +ve	Tested -ve	Prefer not to say
Hep C	○	○	○	○
TB	○	○	○	○
HIV	○	○	○	○

If you tested positive for ANY of these, did you go on to receive any treatment?

	Yes	No, not offered any	No, offered but didn't take it up	N/A	Prefer not to say
Hep C	○	○	○	○	○
TB	○	○	○	○	○
HIV	○	○	○	○	○

IF TESTED FOR TB:

What type of TB screening was this? ○ skin test ○ x ray ○ Don't know

22 **HAVE YOU HAD A SEXUAL HEALTH CHECK IN THE PAST 12 MONTHS?**

○ Yes ○ No ○ Don't know

23	**DO YOU KNOW WHERE TO ACCESS ADVICE ABOUT SEXUAL HEALTH?** ○ Yes ○ No (go to Q25) **IF YES, Where would you go?** ○ GP or nurse ○ Homeless/housing staff ○ GUU/sexual health clinic ○ Other……..
24	**FEMALE CLIENTS ONLY: Have you had access to specialist women's health services?**

	Yes	No	Uncertain
cervical smear in past 3 years	○	○	○
breast examination in past 3 years	○	○	○

6 A FEW QUESTIONS ABOUT YOU

25	**HOW WOULD DESCRIBE WHERE YOU ARE CURRENTLY SLEEPING?** (if this frequently changes, please say where you slept last night) ○ sleeping rough on streets/parks ○ hostel ○ 2nd stage or supported accommodation ○ squatting ○ sleeping on somebody's sofa/floor ○ nightshelter ○ Other ……..
26	**AT THE MOMENT, ARE YOU:**

	Yes	No
In training or education	○	○
volunteering	○	○
In employment	○	○
Accessing guidance around work or training	○	○

	Do you think your health stops you being able to undertake any training, volunteering or employment that you want to? ○ Yes ○ No ○ Don't know
27	**PLEASE TICK IF YOU ARE WORKING WITH ANY OFFENDING SERVICES:** ○ currently with probation ○ current community order ○ Youth Offending service/YOT ○ Other ……..
28	**DO YOU HAVE ANY OF THESE BACKGROUNDS? (this helps us to understand how your past experience may have affected your health or services you've been able to access)** ○ Left prison within last 12 months ○ Left prison more than 12 months ago ○ Left Care Services (for young people) within past 5 years ○ None of these backgrounds
29	**DO YOU CONSIDER YOURSELF TO HAVE A DISABILITY?** ○ Yes ○ No (Go to Q 30)

	How would you describe this disability? Choose any that apply ☐ mobility ☐ sensory impairment (eg hearing or sight problems) ☐ learning disability ☐ developmental disability ☐ mental health ☐ long term condition ☐ Other:.....
30	**WHAT IS YOUR MIGRATION STATUS?** *Please refer to Definitions guidance if necessary* ○ UK resident ○ Indefinite leave to remain ○ A2 national ○ asylum seeker ○ other EU national ○ Unknown ○ Other ……
31	**WHAT AGE RANGE DO YOU FALL INTO?** ○16-17 ○36-45 ○66-75 ○18-25 ○46-55 ○over 75 ○26-35 ○56-65
32	**GENDER: are you** ○ **male** ○ **female** ○ **did not disclose** **Do you identity yourself as transgender?** ○Yes ○ No ○ Don't know ○ Prefer not to say
33	**WHAT IS YOUR SEXUAL ORIENTATION?** ○ Heterosexual ○ Gay man ○ Gay woman/lesbian ○ Bi-sexual ○ Prefer not to say
34	**HOW WOULD YOU DESCRIBE YOUR ETHNICITY?**

White				Asian/Asian British				Black/Black British			Mixed				Other ethnic background		
White British	White Irish	White European	White other	Indian	Bangladeshi	Pakistani	Other Asian	African	Caribbean	Other black	White and Black Caribbean	White and Black African	White and Asian	Other mixed	Chinese	Romany/traveler	Other ethnic background
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	Please state: ……

35	**IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT YOUR HEALTH & THE SUPPORT YOU RECEIVE?** **What works well?** **What could be improved?** **Any other comments:**
36	**INTERVIEWER: please write down the service where this survey was completed – eg day centre name** ……

THANK YOU FOR COMPLETING THIS SURVEY

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**5 March 2019**
Title of report:	**Herefordshire and Worcestershire Dementia Strategy 2019-2024**
Report by:	**Managing Director of NHS Herefordshire Clinical Commissioning Group**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose and summary

To review Herefordshire and Worcestershire dementia strategy and endorse the high level actions set out for 2019-2024.

Over the last five years the delivery of dementia care in Herefordshire and Worcestershire has evolved into a multi-agency approach with each county having separate strategies.

As strong as our foundations are, we know that we have more to do to ensure we provide timely diagnosis and that people with dementia and their carers get the right support whatever their individual circumstances.

We must continue to strive towards becoming more dementia friendly as a wider community. Our ambition is to ensure that people at whatever stage of their condition are given the best opportunity to live well, remain active, feel valued and connected within their family and community.

The 2019-2024 strategy sets out a shared vision for a collaborative approach across both counties It will build upon the successes of our local dementia partnerships delivered by a wide range of local stakeholders who are key to supporting people living with dementia, their family, friends and communities.

Further information on the subject of this report is available from:
Jacinta Meighan-Davies, Clinical Programme Manager Herefordshire, email: jacinta.meighan-davies@herefordshireccg.nhs.uk;
Carol Rowley, Transformation Delivery Programme Manager Worcestershire, email: carol.rowley5@nhs.net

The strategy reflects:

- Feedback and priorities identified via an engagement survey and workshop events.
- Key findings and recommendations identified during NHSE Intensive Support Team assessments and reviews of dementia pathways during 2017/18.

Recommendation(s)

That the health and wellbeing board:

(a) consider how improvements in joint working could be encouraged by the draft STP Dementia Strategy; and

(b) agree that partner organisation will take the draft strategy through their governance systems for consideration and approval.

Alternative options

1. There are no alternative options, this is an STP pledge to work together to improve the health and wellbeing of people affected by dementia and is a shared priority health outcome area for both counties. The STP are committed to working together to achieve the strategy aims and encourage you to join us in meeting this challenge by understanding our strategy and working with us to deliver it over the next five years.

Key considerations

2. The strategy is underpinned by the NHS England Well Pathway for Dementia Model and endorses continuation of the collaborative approach that exists in our counties to build dementia friendly communities. By both, continuing to work on improving dementia care from diagnosis to end of life, while at the same time developing more dementia aware and supportive communities, we aim to improve the lives of people with dementia and their carers.

3. A fundamental challenge is to address local stigma and negative image of dementia which is creating fear and a sense of hopelessness within our aging population

4. A new element of the strategy is a focus on preventing well. Opportunities will be created to raise public awareness of the link between vascular health and dementia risk and how adopting a healthy lifestyle can also have a positive impact on the brain helping to prevent some types of dementia.

5. The strategy reflects key messages we have heard from people affected by dementia:

6. 92 responses via our engagement survey which included people living with dementia and their carer's; members of the public; volunteers; professionals, and organisations involved in research, education and the care and support for people affected by dementia.

7. Detailed feedback captured during a series of workshops (attended by over 80 people) and presentations with partners.

Key messages

- Focus on prevention – greater emphasis on primary prevention of dementia

- Continue to build dementia-friendly communities in collaboration with key partners in localities and neighbourhoods
- Identify passionate multi-agency leaders and champions who will work together to support delivery of this strategy within locality and neighbourhood teams
- Support the expansion of the Meeting Centre Model which nurtures community partnership to support user-led dementia friendly community facilities
- Endorse and support the Dementia Action Alliance movement to address stigma and fear
- Greater support for Carers to enable them to fulfil their role
- Build on identification and diagnosis – including underrepresented groups
- Greater recognition of palliative care needs and improved dementia end of life in the community

Key challenges

- Stigma and fear about dementia
- Increasing demand due to aging population
- Complexity owing to co-morbidities
- Capacity pressures in home care and care home market
- Financial constraints across health and social care
- Third sector financial constraints
- Engagement with wider community and underrepresented communities
- Pressure for affordable respite care

8. The scale of the challenge is significant with an estimated 12,456 people currently living with dementia in Herefordshire and Worcestershire including more than 592 people with young onset dementia. We must respond to the growing number of people who are developing dementia later in life whilst still needing to work and many of whom often have another significant chronic condition.

9. The strategy includes actions to:

- Improve the support offered to family and friends (informal carers) of people with dementia, to assist them in their caring role and support their own health and wellbeing.
- Improve dementia care provided in care homes.
- Improve care and support for people with more advanced dementia living at home.

10. We need to continue to work with partners to reach all of our communities. We also need to embed earlier advanced care planning processes to ensure people's choices and wishes are respected throughout the stages of their condition.

11. More care needs to be delivered within our communities, however we also need to ensure that palliative care and end of life care services for people with dementia are flexible and responsive to individual need.

12. Building on the progress made around provision of support after diagnosis and throughout the course of the illness we need to ensure that support is truly person-centred and flexible to take account of personal needs and circumstances.

13. We are committed to working together to achieve the strategy aims and encourage you to join us in meeting this challenge by understanding our strategy and working with us to deliver it over the next five years.

Reporting and governance

14. The strategy will run 2019-2024 with a delegated action plan within each county, reviewed quarterly by the STP and individual county aligned Dementia Programme Partnership Boards.

15. An annual dementia dashboard and highlights report will be produced for STP partnership board and the Health and Wellbeing Boards.

16. Leadership for the strategy implementation will be supported within each county by a council Lead and Clinical Lead who together will champion work being taken forward.

Community impact

17. Dementia is a priority public health area identified by Herefordshire and Worcestershire Health and Wellbeing Boards. The joint dementia strategy sets out a clear vision and commitment to take action on the key areas to be addressed to embed the Well Model across communities in both counties.

Equality duty

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

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

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

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

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

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

Equality and Diversity Implications

20. An Equality Relevance Screening has been completed in respect of these recommendations. The screening did not identify any potential Equality considerations requiring further consideration during implementation.

21. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate

that we are paying ‘due regard’ in our decision making in the design of policies and in the delivery of services. Where services are commissioned, our providers are made aware of their contractual requirements in regards to equality legislation.

22. The dementia strategy supports all communities across the two counties helping to reduce inequalities and reach and support the most vulnerable within our society. It is not envisaged that the recommendations in this report will negatively disadvantage the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity race, religion or belief, sex and sexual orientation.

23. Through supporting the joint dementia strategy the health and wellbeing board will be demonstrating its commitment to the equality agenda.

Resource implications

24. There are no specific resource implications to the recommendations.

Legal implications

25. There are no specific legal implications to the recommendations.

Risk management

26. The risks associated with the delivery are unknown at this stage, as the resource implications have not been identified and agreed with partners. This will need to be agreed prior to the launch of the strategy.

Consultees

27. This strategy has built upon local engagement work led by the Dementia Partnership, then topped up by partnership events and a public survey. In terms of organisations, in addition to those that attend the local Dementia Partnership such as the council/ CCG / Herefordshire Carers, for example the events had attendance from care homes, e.g. Stretton Nursing Home, domiciliary care agencies, e.g. Radfield / Sure, VCS, e.g. Age UK H&W, Onside, Healthwatch and NHS bodies, e.g. 2g, WVT.

28. The above approach was based on the fact that Herefordshire had a dementia strategy and therefore this refresh was able to take that engagement plus Older People’s Needs Assessment and then target the engagement on the priorities that have emerged in the Strategy.

Appendices

Appendix 1: Herefordshire and Worcestershire Living Well with Dementia Strategy 2019-2024

Appendix 2: Herefordshire and Worcestershire Living Well with Dementia Consultation

Appendix 3: Dementia strategy event and survey feedback and next steps

Background papers

None identified.

Further information on the subject of this report is available from:
Jacinta Meighan-Davies, Clinical Programme Manager Herefordshire, email: jacinta.meighan-davies@herefordshireccg.nhs.uk;
Carol Rowley, Transformation Delivery Programme Manager Worcestershire, email: carol.rowley5@nhs.net

Herefordshire and Worcestershire's Living Well with Dementia Strategy

2019-2024

Produced by:

NHS Herefordshire Clinical Commisisoning Group | NHS Redditch and Bromsgrove Clinical Commissioning Group | NHS South Worcestershire Clinical Commissioning Group | NHS Wyre Forest Clinical Commissioning Group |

1. Introduction

Early diagnosis and access to support for those living with dementia and their carers remains a priority for Herefordshire and Worcestershire. Our Strategy sets out the Herefordshire and Worcestershire ambition to support people to live well with dementia.

It reflects the national strategic direction outlined in The Prime Minister's Challenge on Dementia which details ambitious reforms to be achieved by 2020.

The Strategy is informed by what people have told us about their experiences either as a person living with dementia or as a carer and is written for those people; specifically those with memory concerns, those with a dementia diagnosis, their families and carers, communities and organisations supporting them.

1. Introduction

Hereford and Worcestershire's Living Well with Dementia Strategy 2019-2024 has been developed in partnership with local health, social care and the voluntary and community sector. An important focus of our strategy is to move towards delivery of personalised and integrated care.

We have used the NHS England Well Pathway for Dementia to give us a framework that puts the individual and their carer at the centre of service development and implementation across health and social care. As a partnership, we are committed to minimising the impact of dementia whilst transforming dementia care and support within the communities of Herefordshire and Worcestershire, not only for the person with dementia but also for the individuals who support and care for someone with dementia.

We want the well-being and quality of life for every person with dementia to be uppermost in the minds of our health and social care professionals.
https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

2. What is dementia?

‘Dementia describes a set of symptoms that include loss of concentration and memory problems, mood and behaviour changes and problems with communicating and reasoning. These symptoms occur when the brain is damaged by certain diseases, such as Alzheimer’s disease, a series of small strokes or other neurological conditions such as Parkinson’s disease’ **‘Prime Minister’s Challenge on Dementia 2020’**

Prime Minister’s Challenge on Dementia 2020

Dementia is most common in people over the age of 65 but there are also a smaller cohort of people who develop ‘young onset’ or ‘working age’ dementia from as young as 35.

For most people the cause is unknown but there are some known causes or risk factors such as:

- Diseases and infections that affect the brain e.g. Alzheimer’s disease or meningitis
- Pressure on the brain e.g. brain tumour
- Lack of blood and oxygen supply to the brain e.g. stroke and head injuries
- Cardiovascular insufficiencies.

There is clear evidence that the earlier into the disease that dementia is diagnosed the better the outcomes for those with the illness and their informal carers, it will help with decision making and preparing the individual and their family for choices they will need to make in the future.

Links to further information about the different types of dementia are provided at the end.

3. Vision, guiding principles and aim is dementia?

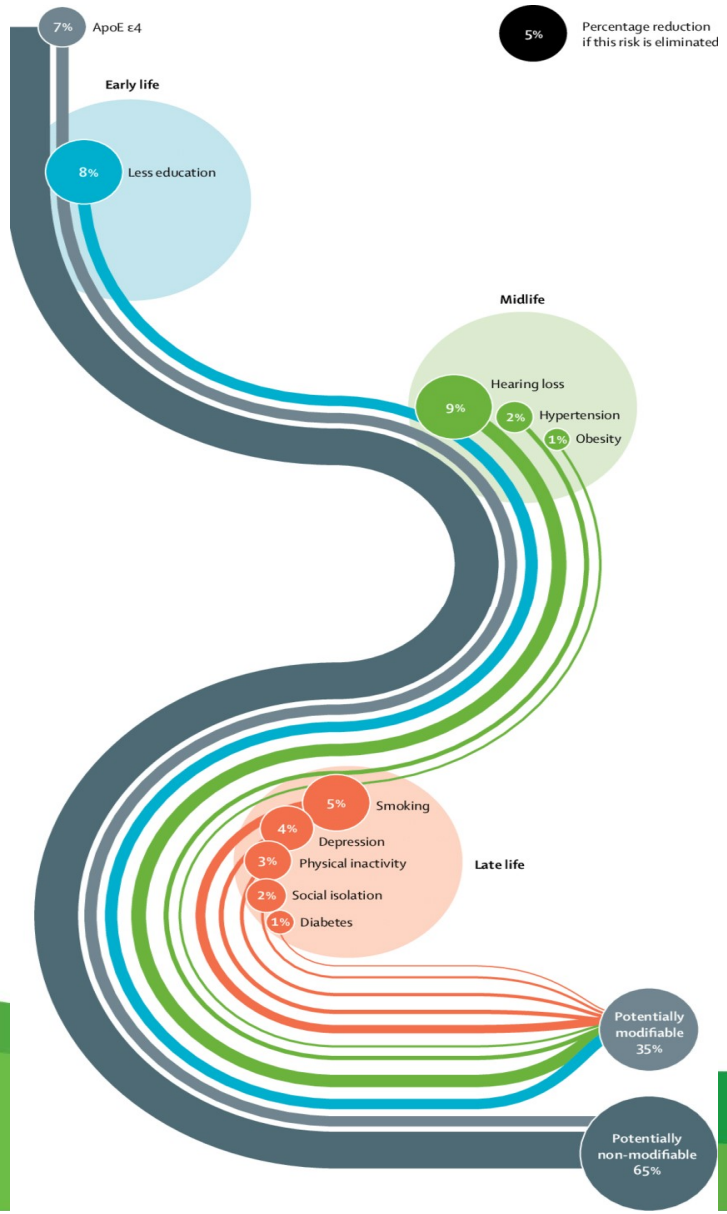
This strategy has been guided by principles developed by NHS England in their transformation framework. This 'Well Pathway for Dementia' is based on NICE guidelines, the Organisation for Economic Co-operation and Development framework for Dementia and the Dementia I-statements from The National Dementia Declaration.

Our vision is that in Herefordshire and Worcestershire people with dementia can live well through the following guiding principles:

- Preventing Well
- Diagnosing Well
- Supporting Well
- Living Well
- Dying Well

Our new strategy focuses on people and patients so that every person with dementia, their carers and families have access to and receive compassionate care and support not only before diagnosis but after diagnosis and through to end of life.

3.1 Preventing Well - Risk Factors to Dementia



4. National context and background

There are a number of national drivers that shape and influence the way the UK should address dementia as a condition

Prime Minister's Challenge on Dementia 2020

In February 2015, the Department of Health published a document detailing why dementia remains a priority and outlined the challenges the UK continues to face in relation to dementia.

The priorities identified within this are:

1) To improve health and care
2) To promote awareness and understanding
3) Research

Legislation

- Care Act 2014
- Equality Act 2010

Context

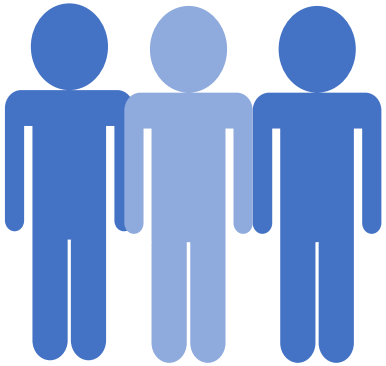
- Living Well with Dementia 2009
- Dementia 2015
- NHS & Adult Social Care Outcomes Frameworks
- Fix Dementia Care 2016

National picture

There are currently 850,000 people living with dementia in the UK. 42,325 of these have early onset dementia.

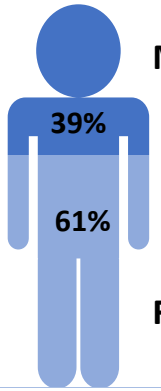
The number of people with dementia is forecast to increase to 1,142,677 by 2025 – an increase of 40%.

It is estimated that 1 in 3 people in the UK will care for someone with dementia in their lifetime



In the UK 61% of people with dementia are female and 39% are male. There are a higher proportion of women with dementia as women tend to live longer, however, this does reverse when considering the data for people with early-onset dementia.

Gender

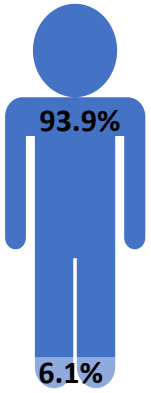


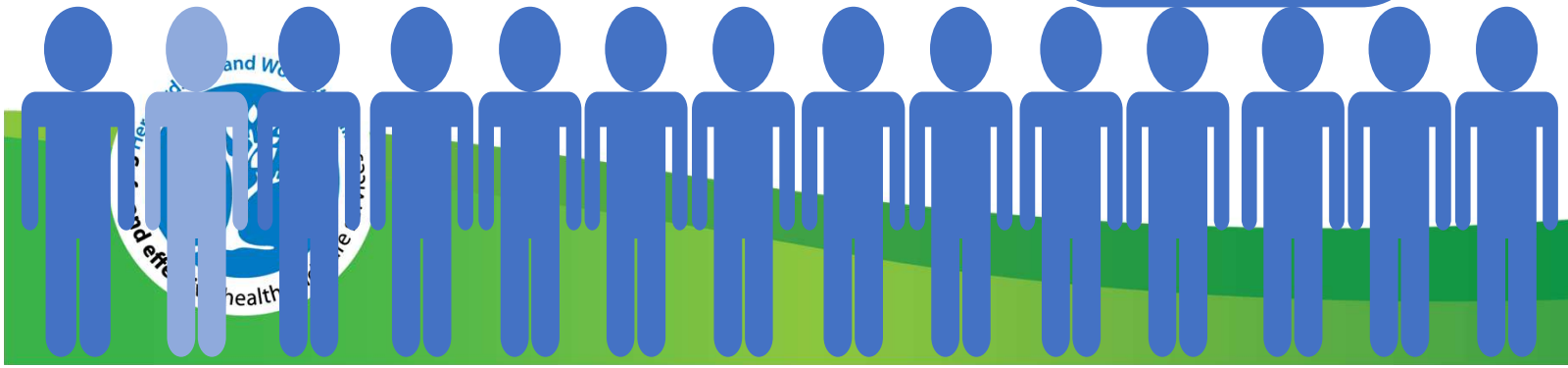
1 in every 14 of the population over 65 years has dementia

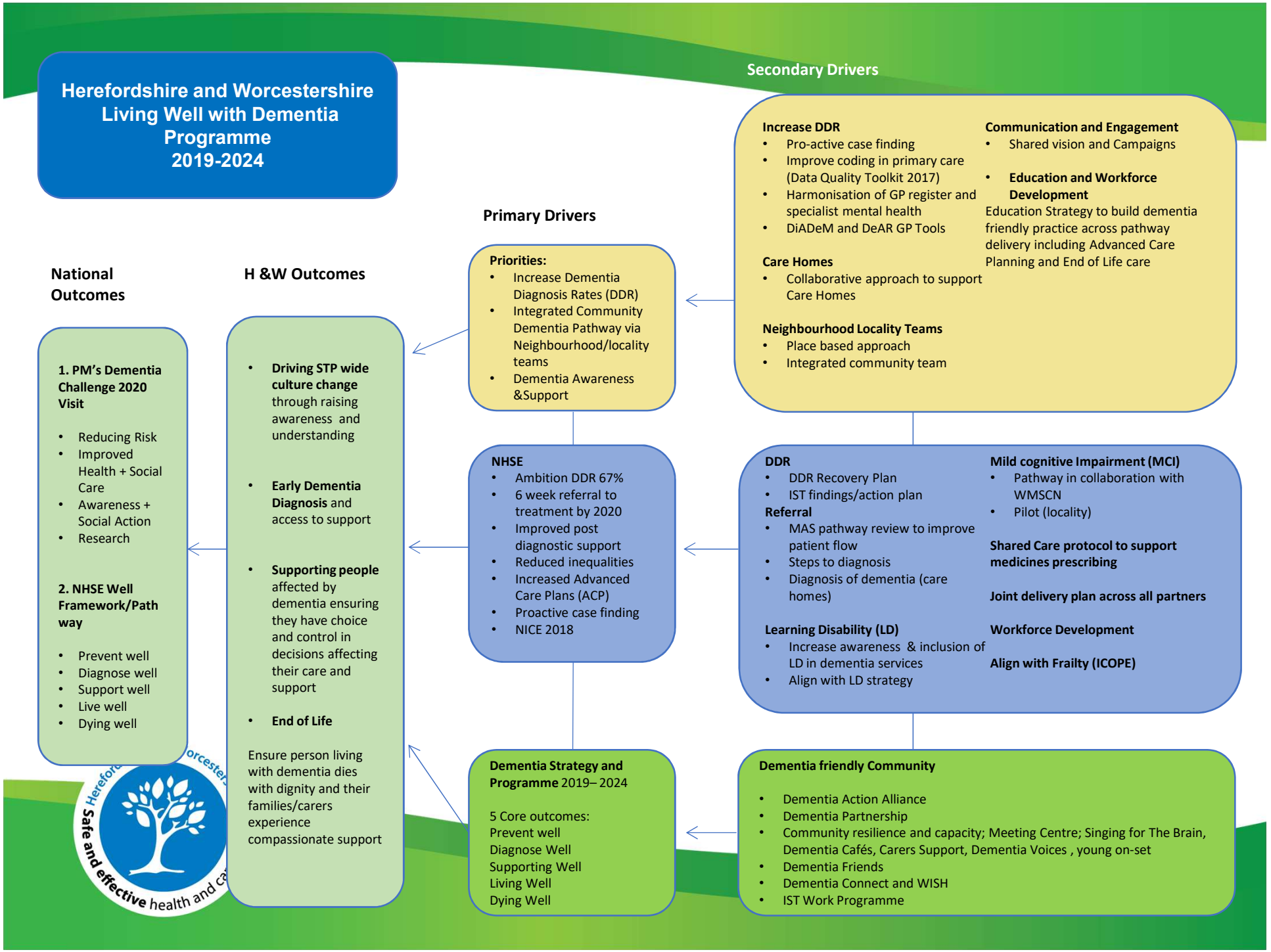
1 in 3 people who die over the age of 65 years have dementia. Dementia now accounts for 11.6% of all recorded deaths in the UK.

It is estimated that there are 11,392 people from black and minority ethnic (BME) communities who have dementia in the UK. 6.1% of all those are early onset, compared with only 2.2% for the UK population as a whole, reflecting the younger age profile of BME communities.

Dementia and Ethnicity






Herefordshire and Worcestershire Living Well with Dementia Programme 2019-2024
Secondary Drivers
Increase DDR
• Pro-active case finding
• Improve coding in primary care (Data Quality Toolkit 2017)
• Harmonisation of GP register and specialist mental health
• DiADeM and DeAR GP Tools
Care Homes
• Collaborative approach to support Care Homes
Neighbourhood Locality Teams
• Place based approach
• Integrated community team
Communication and Engagement
• Shared vision and Campaigns
• Education and Workforce Development
Education Strategy to build dementia friendly practice across pathway delivery including Advanced Care Planning and End of Life care
Primary Drivers
Priorities:
• Increase Dementia Diagnosis Rates (DDR)
• Integrated Community Dementia Pathway via Neighbourhood/locality teams
• Dementia Awareness &Support
National Outcomes
1. PM's Dementia Challenge 2020 Visit
• Reducing Risk
• Improved Health + Social Care
• Awareness + Social Action
• Research
2. NHSE Well Framework/Path way
• Prevent well
• Diagnose well
• Support well
• Live well
• Dying well
H &W Outcomes
• Driving STP wide culture change through raising awareness and understanding
• Early Dementia Diagnosis and access to support
• Supporting people affected by dementia ensuring they have choice and control in decisions affecting their care and support
• End of Life
Ensure person living with dementia dies with dignity and their families/carers experience compassionate support
NHSE
• Ambition DDR 67%
• 6 week referral to treatment by 2020
• Improved post diagnostic support
• Reduced inequalities
• Increased Advanced Care Plans (ACP)
• Proactive case finding
• NICE 2018
DDR
• DDR Recovery Plan
• IST findings/action plan
Referral
• MAS pathway review to improve patient flow
• Steps to diagnosis
• Diagnosis of dementia (care homes)
Learning Disability (LD)
• Increase awareness & inclusion of LD in dementia services
• Align with LD strategy
Mild cognitive Impairment (MCI)
• Pathway in collaboration with WMSCN
• Pilot (locality)
Shared Care protocol to support medicines prescribing
Joint delivery plan across all partners
Workforce Development
Align with Frailty (ICOPE)
Dementia Strategy and Programme 2019– 2024
5 Core outcomes:
Prevent well
Diagnose Well
Supporting Well
Living Well
Dying Well
Dementia friendly Community
• Dementia Action Alliance
• Dementia Partnership
• Community resilience and capacity; Meeting Centre; Singing for The Brain, Dementia Cafés, Carers Support, Dementia Voices , young on-set
• Dementia Friends
• Dementia Connect and WISH
• IST Work Programme
Safe and effective health and

5. Local context and background

The Sustainability and Transformation Partnership (STP) in H&W is a partnership committed to improving health and social care to enable us to plan and be responsive to the needs of the whole population. This includes a dementia work stream to deliver the Well Pathway for Dementia

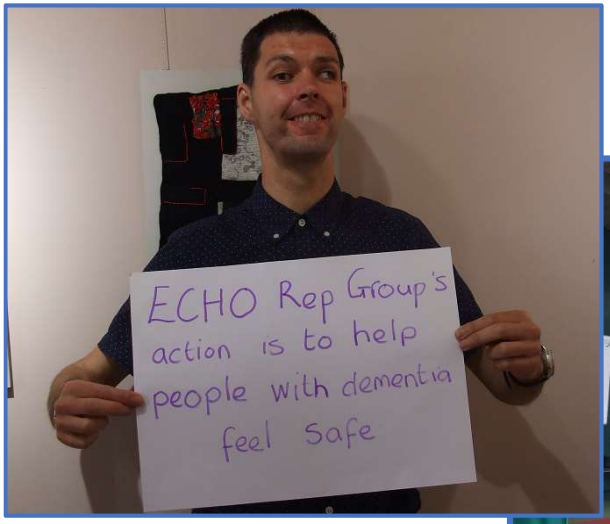
Local Dementia Delivery Plans reflect the key findings and recommendations of a dementia review undertaken by NHSE Intensive Support Team 2017
A further review was undertaken Oct 2018

5. Local context and background

Each county has a Dementia Partnership Programme Board overseeing the development of a refreshed strategy and high-level delivery plan. The multi- agency partnership works to ensure that interdependencies are identified including but not limited to:

- Integrated locality Neighbourhood teams
- Carers Support
- Primary care
- Community and voluntary organisations
- Secondary Care
- Urgent and emergency care
- Planned care
- Mental health
- Prevention
- Medicines Management
- Learning disabilities
- End of life
- Continuing health care and personal budgets
- Information and support- WISH, ART

5. Local context and background



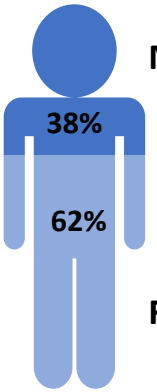
"Having contact with the Dementia Adviser Service has helped me to continue to be part of my community by enabling me to participate in the Focus on Dementia Network" (a local service user).

Local Picture

There are currently 12,456 people living with dementia across Herefordshire and Worcestershire (this number is set to increase to 18.669 by 2035).
592 of these people have early onset dementia.

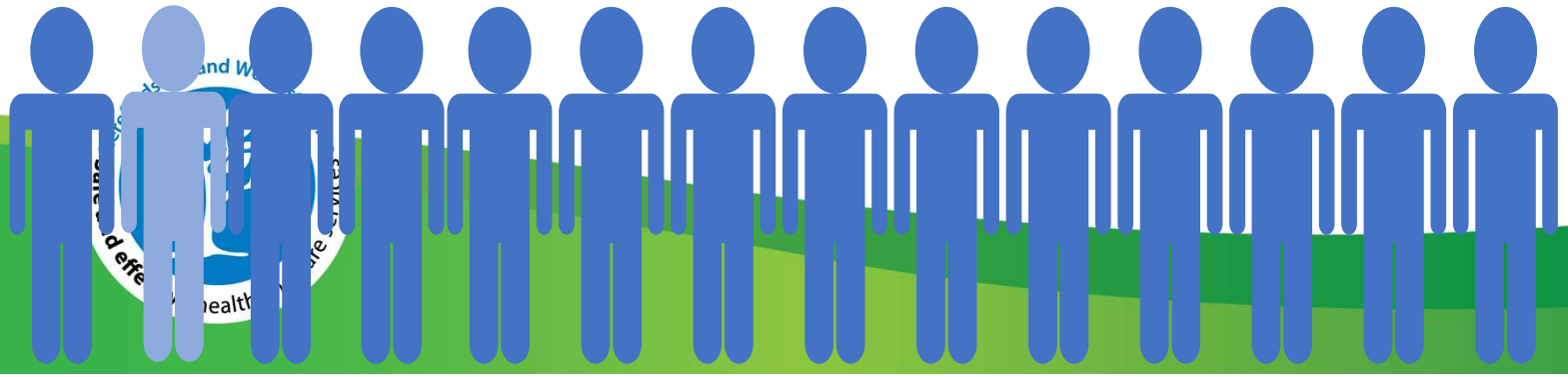
Across H&W 62% of people with dementia are female and 38% are male. This reflects the national trend.

Gender



It is estimated that there are 84985 carers across H&W. For further information relating to carers, see the draft H&W Carers Strategy.

1 in every 15 of the population of H&W over 65 years has dementia, reflective of the national trend



Local Picture

The dementia diagnosis indicator compares the number of people thought to have dementia with the number of people diagnosed with dementia. The target set by NHS England is for at least two thirds of people with dementia to be diagnosed (67%). The national prevalence of dementia is 1.3% of the entire UK population equating to approximately 850,000 individuals.

Local NHS Diagnosis Rates

Herefordshire	South Worcs CCG	Redditch & Bromsgrove CCG	Wyre Forest CCG
57.05%	56.7%	64.4%	59.6%

(Percentages represent the proportion of people living with dementia that have a formal diagnosis as of November 2018)

Herefordshire

- Total Population 187,878
- 3116 individuals thought to be living with dementia
- 2966 of these are 65 years or over
- 150 individuals living with Young Onset Dementia
- The total population of people aged 65 years or over is 46,102 which equates to 6.43%* of this cohort of the population living with dementia

Worcestershire

- Total Population 607,971
- 8,748 individuals thought to be living with dementia
- 8306 of these are 65 years or over
- 442 individuals living with Young Onset Dementia
- The total population of people aged 65 years or over is 127,811 which equates to 6.5%* of this cohort of the population living with dementia

Local Picture - What people tell us

Local Picture

"Having support from a DA has reduced my anxiety and made me feel that I am not so dreadfully alone"

"memory clinic referral went smoothly along with appointment was an overview of what to expect .. experience was good, ongoing support excellent we have a remarkable CDN"

Person attending a Memory Morning Drop In
"It was a friendly setting where I was able to talk freely about my concerns without family members talking for me."

"Thank you so much for all the help you have given over the years. We would have been lost without you."

"As always your support and advice is very much appreciated. You are such a help for people like us as individuals, and for the community as a whole"

"People really like the meeting centre as it runs for a good amount of time. For one gentleman, it gave his wife (carer) a break and he wishes there was more things like it where he could go on other days of the week."

Person with LD and dementia
"I do like the signs and I want to put my photo on my bedroom door."

Family carer of person with LD
"There is a definite change where my learning disabled daughter lives. I observe the person who has learning disability and dementia now listening to music through headphones, and the environment is dementia friendly. The rugs and patterns are all gone; the carers have really embraced the learning. The impact on other people who have a learning disability who live there is that they are more relaxed. They have stopped telling her to be quiet."

Herefordshire and Worcestershire Safe and effective health and care services

Local Picture

The things we still need to improve on

Dementia Adviser Service user - *"We find the amount of paperwork we receive from other services to be overwhelming – please continue to talk to us rather than give us paperwork ."*

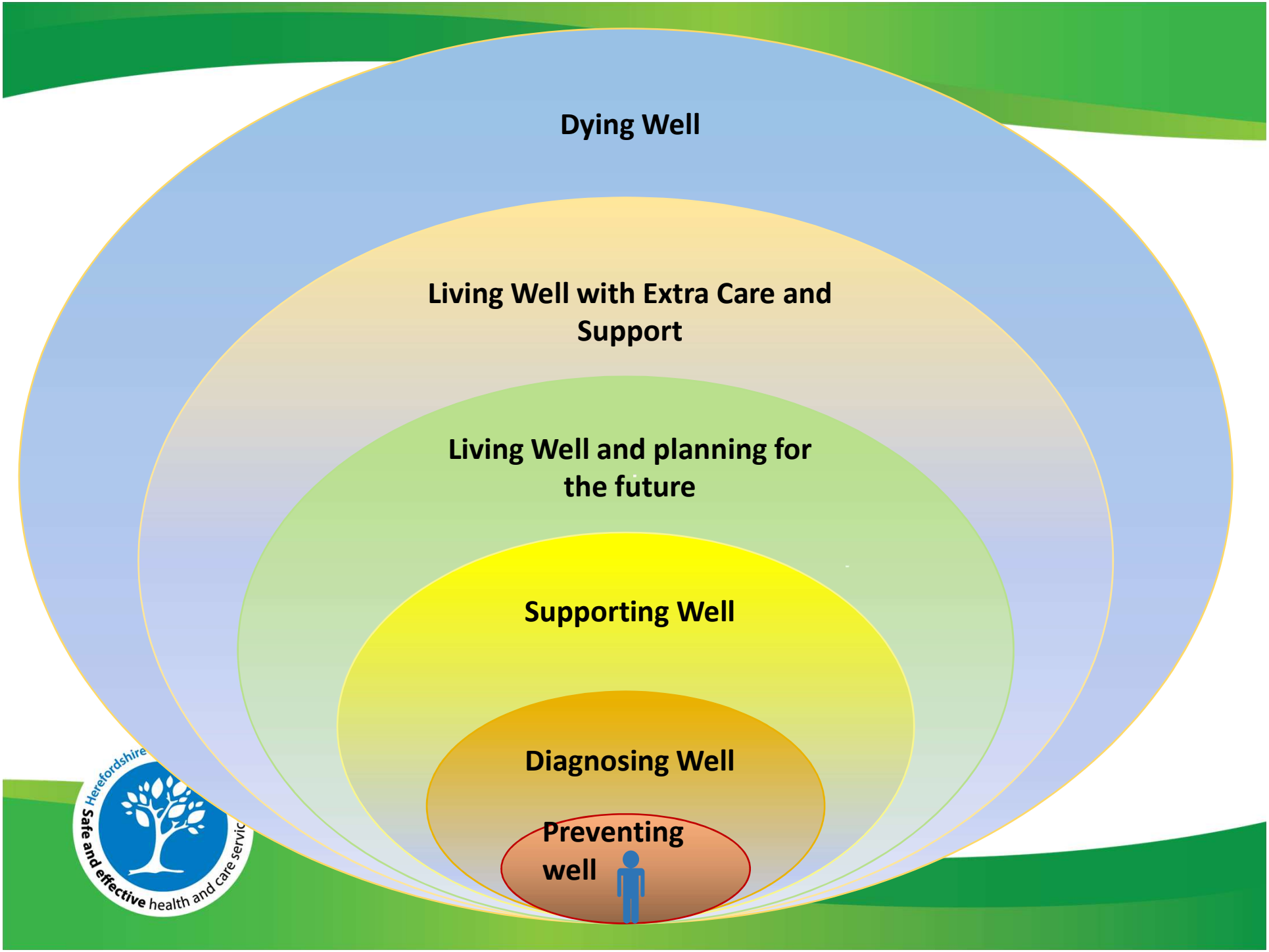
Lots of groups in the area but not much coordination between them, for example, everything seems to happen at the same time/day.

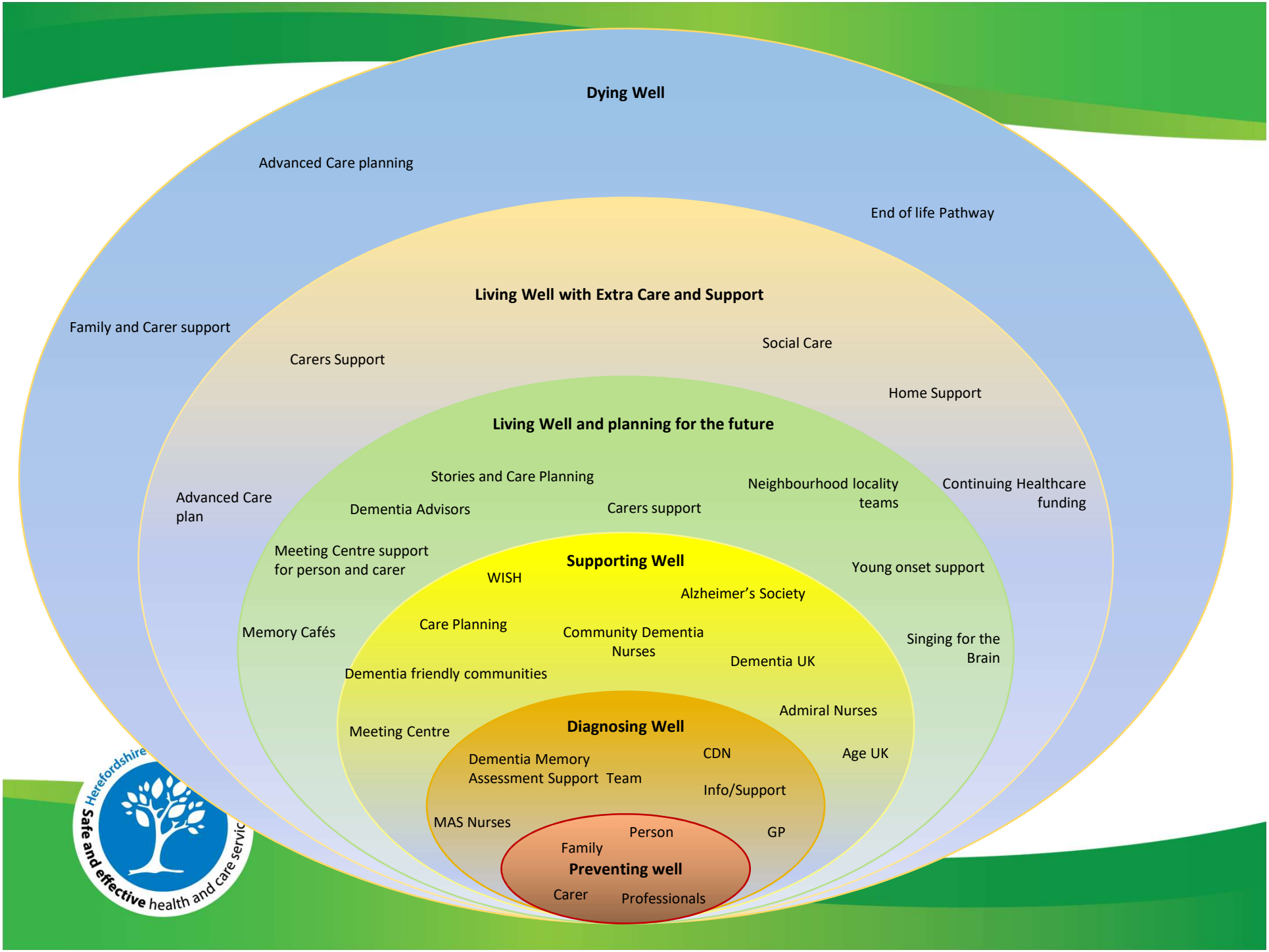
Carer - *"professionals need to understand dementia can make people intolerant of waiting; noisy places but few have taken this on board"*

"Dementia Friendly ongoing support is not really understood at surgeries …"

"Hard to find affordable, short-term, ad hoc respite – mother is settled at home and it would be better if someone could come to the home even if it was just for a few hours." - Family member

A daughter of a lady with dementia who lives away has found it extremely difficult to find support services over the internet. She hasn't been in the area to come across things on noticeboards etc so has needed to just rely on the internet.


Dying Well
Living Well with Extra Care and Support
Living Well and planning for the future
Supporting Well
Diagnosing Well
Preventing well


Dying Well
Advanced Care planning
End of life Pathway
Living Well with Extra Care and Support
Family and Carer support
Social Care
Carers Support
Home Support
Living Well and planning for the future
Stories and Care Planning
Neighbourhood locality teams
Continuing Healthcare funding
Advanced Care plan
Dementia Advisors
Carers support
Meeting Centre support for person and carer
Supporting Well
Young onset support
WISH
Alzheimer's Society
Memory Cafés
Care Planning
Community Dementia Nurses
Singing for the Brain
Dementia UK
Dementia friendly communities
Admiral Nurses
Meeting Centre
Diagnosing Well
Dementia Memory Assessment Support Team
CDN
Age UK
Info/Support
MAS Nurses
Person
GP
Family
Preventing well
Carer
Professionals

7. Achievements of the previous Worcestershire Strategy 2009-2016

GP's have been supported to understand and promote key preventative messages as well as developing health checks and a dementia focused GP toolkit.

The memory pathway is well embedded across the area with good connections from primary care, an award winning memory clinic, post diagnostic support services through the voluntary and community sector and adult social care.

There has been a modernisation of the older adult mental health services to ensure that key objectives are met and to ensure that specialist services can complement the more generic development of health and social care services across the county. A new community and hospital based Dementia Pathway has been developed with a single point of access for people with dementia, carers and professionals

Worcestershire has a fully integrated personalised approach to dementia support, including an Admiral Nurses who have specialist dementia nursing expertise

Models of Peer Support have been developed to increase access to services.

Engagement with people living with dementia and their carers has been undertaken across the area to understand their experiences of the health and social care system to inform future work

Awareness raising has been undertaken by the Voluntary and Community Sector in the form of pop up road shows, GP training.

7. Achievements of the previous Worcestershire Strategy 2009-2016

Carers are supported through specific services, including advice, information, training and respite

Worcestershire has many Dementia Action Alliances and a number of dementia friendly practices.

The Johns Campaign has been adopted by all hospital trusts in all hospital settings

The Dementia CQUIN for assessment has been embedded in all hospital settings

A bespoke group has been set up specifically for people with Young Onset Dementia for PWD carers their family and professionals to meet

A Dementia training programme for Care Homes, Domiciliary Care and the wider community has been completed.

8. Achievements of the previous Herefordshire Strategy

Herefordshire Dementia Integrated Care Pathway promotes a person centred approach and is well embedded across the county with effective team working across GP practices, Memory Assessment Service and community dementia support offering post diagnostic support in collaboration with voluntary and community sector and adult social care.

Herefordshire continues to strive towards the 67% national target in relation to diagnosis rates with appropriate referrals being made to memory assessment services, underpinned by a shared care agreement

A review of our strategic approach helping to facilitate effective participation and involvement across programme board; partnership and alliances to maximise impact and productivity

There has been extensive work to improve clinical coding (DQT), data reconciliation across stakeholders within the pathway helping to improve communication and information sharing and ensure people have access to and receive timely diagnosis, information and support.

Expert voice of people living with dementia raising awareness of Living Well with dementia contributing to society and changing perceptions.

Auditing public services and spaces suggesting improvements which have been implemented Old Market, Cathedral.
Working on GP audit tools; participating in service improvement audits; staff development days & Co-facilitating dementia friends sessions

Carers are supported through specific services, including advice, information, training and respite care. Carers attend cafes and Singing for the Brain along with the person who has dementia. Dementia Advisors support the partnership of carer and cared for.

Significant Awareness raising has been undertaken via Dementia Partnership and Dementia Alliances and Dementia Friendly communities who work diligently to help build a dementia friendly Herefordshire. Herefordshire Dementia Action Alliance achieved Dementia Friendly Status in January 2017.

8. Achievements of the previous Herefordshire Strategy

Meeting Centre at Leominster and Ross on Wye offering a membership model where carers and people with dementia are enabled to be actively involved and included in their community

Partnership working has enabled the roll out and buy in to Dementia Friends at strategic level with people living with dementia actively involved in the delivery. There are over 5,000 dementia friends across the county helping to promote awareness and support communities and businesses to take actions towards a dementia friendly Herefordshire. A number of GP practices are already working to become dementia friendly practices

A partnership commitment to building awareness has led to a county wide communication network approach which continues to promote events; news; opportunities and strengthening links between WISH and Alzheimers Society Dementia Information and Support web pages

Listening to people living with dementia and their carers to understand their experiences of the health and social care system to inform future work. Engagement with rural communities and older people via Healtwatch continues to help inform our delivery plan

A bespoke support group has been set up specifically for people with Young Onset Dementia for people with dementia; carers; family and professionals to meet

Reaching into Under-participating groups: Learning disability and dementia a project led by Alzheimers Society has helped build awareness and understanding across stakeholders and actions to improve experience of people living with LD and dementia and their ability to live well for longer

Memory Mornings – reaching into rural communities where people worried about their memory can talk access support in a non-clinical setting.

Building resources and continuous shaping of support for people affected by dementia. Admiral nurses are a new resource for Autumn 2018. A Deme[illegible]gramme for Care Homes, Domiciliary Care and the wider community has been completed along with clinical updates for var[illegible]ups of staff.

[illegible] care planning

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

To monitor achievements an annual dementia dashboard and highlights report will be produced for the Health and Wellbeing Board

The most important outcome of Herefordshire and Worcestershire Dementia Strategy is to ensure more people with dementia are able to live safely and with as good a quality of life as possible at home or in a homely setting for as long as they and their family wish.

To achieve this we have a key over-arching action to ensure there is good information, advice and support for people living with dementia and for their carers and families so that people are more confident that they can live well and independently with dementia and have access to appropriate support and services when required

Prevention	Diagnosing	Supporting	Living	Dying	High Level Actions	Lead	Outcomes	Timeframe
x	x	x	x	x	Strengthen leadership and accountability for delivery of the strategy		Dementia partnership programme board includes clinical and executive level leadership and accountability	
	x	x	x	x	Undertake forward planning to ensure diagnosis and post-diagnostic support is designed to meet growth in dementia prevalence in over 65s and aligns with relevant strategies (Housing Frailty and EoL Strategy)	LA/CCG and Partnership	There is a regular programme of joint strategic needs assessment between LA and CCG commissioners which is communicated to all partners to inform local dementia service planning	
x	x				Strengthen dementia risk reduction messages in NHS Health Checks and within public health & wellbeing opportunities /initiatives; schools and workplace	Public Health /LA/CCCG	Increased prevention opportunities offered to people at risk of developing dementia Raised dementia awareness leading to timely diagnosis Public Health take a lead role in the Dementia Partnership Programme Board	
x	x	x			Improve referral pathway and partnership working between MAS and healthy lifestyles services to expand risk reduction opportunities offered to people diagnosed with dementia	Public Health/Memory Service/ Community Dementia	Increased uptake of lifestyle services by people with dementia (especially vascular dementia) and people diagnosed with MCI Healthy Lifestyle services links and participation in drop-ins and post diagnosis support groups	
x	x	x	x	x	Dementia and inequalities: Addressing equalities around accessing a dementia diagnosis and services is a key strand of our pathway work and fundamental to early diagnosis and support Work with partners to continue to ensure clearly signposted, robust culturally competent and locally informed services and post-diagnostic support pathways Promote opportunities to participate in research to people living with dementia and their carers throughout the entire dementia pathway	LA/Public Health/CCG & Dementia Partnership Dementia Programme Board	An engagement and empowerment approach adopted by all partners to reach and include BME, rural and unrepresented communities (LD, Farming and travellers) Increased awareness and understanding of signs and symptoms of dementia among all of our counties population groups Contracts with providers include a commitment to facilitate access to research opportunities People with dementia and their carers participate in national and local research opportunities Research Opportunities are discussed at Partnership meetings	

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Prevention	Diagnosing	Supporting	Living	Dying	High Level Actions	Lead	Outcomes	Timeframe
	x	x			*Find, treat and support*: further reduce the diagnosis gap by • Delivering a timely diagnosis in line with national ambition and patient wishes • Promoting memory pathway and use of supportive diagnostic tools • Ensuring care home residents with dementia are included on dementia registers and by working with professionals looking after patients with vascular related conditions to identify memory problems earlier	Dementia Partnership CCG/2g Admiral Nurses & CCG Quality Care Home Team	Dementia Diagnosis rates in H. and W. are in the top 20% performing CCG in England An established proactive case-finding culture across services and a referral pathway between MAS and Long-term condition services (diabetes, heart failure, Parkinson's disease, MCI, stroke service, Learning Disability and expert patient programmes) is developed and implemented for seamless transition to dementia pathway. DeAR GP tool supports care home staff and enhances communication between care homes and GP practices DiaDem Tool supports community diagnosis Number of people with LD and LTCs diagnosed with dementia is comparable with national standards	
			x	**x**	Strengthen links with carers support, frailty and End of Life work streams	Dementia partnership programme board	Advanced Care Planning is embedded in all elements of the pathway and all partners are clear on their role and responsibility The provision of responsive services is comparable with those for people with terminal physical health conditions with hospice standard care Carers receive EoL and bereavement support	
					Address local stigma and negative image of dementia which is creating fear and a sense of hopelessness within our aging population		Communities are empowered to champion the benefits of early diagnosis Neighbourhood/Locality support is available for people who are reluctant to be assessed and receive diagnosis All partnership members are dementia friends Communication and engagement strategy established to achieve consistent language used to describe dementia Local Media are partners in Dementia communication and engagement delivery Patients and carers participate in promoting positive messages about living with dementia Herefordshire and Worcestershire are dementia friendly counties with local supportive communities	
x	x	x	x	x	GP practice are supported to become a recognised dementia friendly practice	CCG	Dementia Friendly GP practices established with a dementia champion identified at each surgery % sign up by ? % working towards Dementia friendly status	

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Prevention	Diagnosing	Supporting	Living	Dying	High Level Actions	Lead	Outcomes	Timeframe
	x	x	x	x	Workforce Development to ensure a focus on high levels of expertise throughout the dementia pathway Increased training and support for informal carers to support them in their carer's role and to facilitate improved health and wellbeing for carers	STP One Herefordshire Education/Workforce Development Dementia Partnership Carers Support	Improved and increased education, training and opportunities for skills development for all (including informal carers) who are involved in the care and support for people affected by dementia. Training opportunities are available and aligned to the different stages of dementia progression Carers programme offering specific support for people caring for someone with dementia Assessment, management and support for people living with dementia and their carers is delivered in accordance with NICE Guidelines (NG97)	
x	x	x	x	x	Maintain effective engagement processes with people living with dementia and their carers	Dementia Partnership Programme Board	There is an established model which partners follow to support patient and carer involvement and participation in pathway design and service improvement processes Patient and carer feedback is utilised to inform service improvement and enhance patient/carer experience Partners collaborate creating shared opportunities facilitating patient and carer involvement and participation	
		x	**x**		Expansion of memory drop-ins across the counties delivered collaboratively by dementia professionals and volunteers developed in partnership with people with dementia	Dementia Partnership and Specialist community dementia team (CDN/DA) Alzheimer's Society Admiral Nurses	Quality local peer support offered across both counties reaching into and tailored to rural and BME communities, meets the needs of people with dementia and their carers and where volunteers feel supported in undertaking their role. A network of facilitators to exchange good practice and share challenges are a mobile resource across localities and neighbourhoods Opportunities for dementia be-friending exists across our counties	

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Prevention	Diagnosing	Supporting	Living	Dying	High Level Actions	Lead	Outcomes	Timeframe
x	x	x	x	x	Continue to build and extend dementia friendly communities through the contribution of community and partnership working	LA Education Dementia Partnership CCGs & Dementia Partnership All Providers Dementia Action Alliance	An established protocol to support organisations to become dementia friendly There is greater awareness and involvement by the community in local drop-ins A Dementia Friendly Housing Charter and guidance toolkit in place with all housing partners signed up Dementia friendly local environments (Hairdressers) to support people to remain connected to their local community Schools/Colleges are participating in dementia friends training and intergenerational Activities to promote dementia awareness and understanding A network of dementia friendly community pharmacists, podiatrist, dentists, opticians supporting people with dementia linking in with drop-ins to help with sign-posting and earlier recognition for diagnosis and support An increase in the number of organisations, businesses, Council departments and community groups signed up to the local Dementia Action Alliance working together to achieve dementia friendly status	
X	**x**	**x**	**x**	**x**	Develop pro-active dementia support model within Locality and neighbourhood teams	Locality /neighbourhood teams (GP clinical leads; clinical/care leads across partner organisations)	Locality and neighbourhood teams have received dementia friends training and have access to tools and approaches to be pro-active in providing care and support to people affected by dementia Increased use of contingency & ACP planning in care plans ReSPECT Tool implemented to guide ACP process across professionals and teams Shared care pathway Increased update and use of assistive technology	

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Prevention	Diagnosing	Supporting	Living	Dying	High Level Actions	Lead	Outcomes	Timeframe
		x	**x**	**x**	Review and promote dementia information and support to ensure it includes prevention, diagnosis, living well, supporting well, and planning for end of life with appropriate signposting to local community support opportunities /groups Develop Information and advice resources to be made available for people attending peer support groups (e.g. drops-ins; Meeting Centres)	CCG, Memory Assessment and community dementia teams with Dementia Partnership	There is an established consistent approach to ensure everybody affected by dementia has timely access to information advice and support A road map signposts people to local dementia information, care and support MAS and Hospital and provider services use standardised information packs for people who are newly diagnosed and carers packs for their family/friends Standardised welcome/Information packs are also issued community support including cafes, drop ins and meeting centres	
		x		x	Continue to create responsive community services which promote re-ablement and effectively manage crises for people affected with dementia either at home or in a care home	Locality Teams In-reach team; CCG quality nursing team; Admiral palliative care team	Neighbourhood and Locality teams have access to • Hospital avoidance service (out-reach support) • Specialist advice and support when managing a crisis Good Quality flexible home care services available to help dementia patients maintain independence and reduce social isolation A network of support for care homes facilitates advanced dementia care planning including palliative care and End of Life care	
x	x	x	x	x	Work collaboratively to achieve a co-ordinated pathway across partners		Patients and carers are partners in care planning Partners collaborate to achieve a seamless pathway which promotes and respects patient and carer choice and control	
					Improve provision of residential care for people living with advanced or complex dementia	LA/CCG	People living with advanced or complex dementia have access to a range of local care options	
					Ensure carer support is tailored to their needs		Carers participate in contingency and ACP planning (ReSPECT) Respite care is available when needed to support carers in their carer role Carers have access to information, advice and support to assist them in their caring role, enabling them to look after their own health and wellbeing	

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Prevention	Diagnosing	Supporting	Living	Dying	High Level Actions	Lead	Outcomes	Timeframe
x	x	x	x	x	Continue to improve standard of data recording and completeness across dementia diagnosis and care pathways	Health and social care partners	There is evidence of • Robust data recording and reporting across partner organisations • A rolling programme of data harmonisation and peer reviews in place across all pathways	
x	x	x	x		Review local Pathways to include Mild Cognitive Impairment	CCG and providers/Memory Assessment Services Community Dementia Service	A recognised and fully supported pathway in place to Identify, code and review MCI patients	
	x	x	x	x	Continue to focus on improving the in-patient experience and hospital discharge pathways		Hospital wards and departments are dementia friendly environments Dementia Champions are identified and work collaboratively to increase dementia awareness Patient experience questionnaires confirm patient choice and control is respected	
	x	x	x		Develop the post diagnostic pathway to include the provision of and access to appropriate IAPT services for people living with dementia , those with a non-dementia diagnosis (MCI) and their carers	CCG/Specialist MH provider	IAPT opportunities are routinely offered, where appropriate to people living with dementia and those with MCI and their carers IAPT workforce and services are trained and skilled to provide interventions which support people with dementia and MCI and their carers	

10. Useful websites

Context

NHS England Well Pathway for Dementia: england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

Further information about the different types of dementia: nhs.uk/conditions/dementia-guide/Pages/dementia-choices.aspx and alzheimers.org.uk/info/20007/types_of_dementia

Prime Ministers Challenge on Dementia: gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

Living Well with Dementia: gov.uk/government/uploads/system/uploads/attachment_data/file/168221/dh_094052.pdf

Dementia 2015 – Aiming Higher to Transform Lives (report by the Alzheimer's Society): alzheimers.org.uk/info/20093/reports/253/dementia_2015

NHS Outcomes Framework & Adult Social Care Outcomes Framework

https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions

Fix Dementia Care 2016: https://www.alzheimers.org.uk/our-campaigns/fix-dementia-care

NHS Digital Patients Registered at GP Practice (as of 1st November 2018): https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/november-2018

Application of prevalence rates from Dementia UK 2014 Update: https://www.alzheimers.org.uk/about-us/policy-and-influencing/dementia-uk-report

A guide to the support people should get from local services in England if they or someone they know have been diagnosed with dementia
https://www.gov.uk/government/publications/after-a-diagnosis-of-dementia-what-to-expect-from-health-and-care-services

Legislation

Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Equality Act 2010: https://www.gov.uk/guidance/equality-act-2010-guidance

Local Policy

Herefordshire Council Health and Wellbeing Strategy 2015-2019:
https://www.herefordshire.gov.uk/download/downloads/id/3677/health_and_wellbeing_strategy.pdf

Worcestershire County Council Health and Wellbeing Strategy 2016-2021 http://worcestershire.moderngov.co.uk/documents/s8318/Health%20and%20Well-being%20Strategy.pdf

Herefordshire Carers Strategy: https://www.herefordshire.gov.uk/directory_record/3416/carers_strategy

Worcestershire Carers Strategy:
http://worcestershire.moderngov.co.uk/documents/s5437/6b%20Carers%20Strategy%20Draft%20Final%20DRAFT%2030%204%202015.pdf

Local Policy

Herefordshire Housing Strategy:

https://www.herefordshire.gov.uk/download/downloads/id/8436/interim_housing_strategy_2016-2020.pdf

https://www.herefordshire.gov.uk/directory_record/4808/homelessness_review_and_prevention_strategy

Herefordshire Learning Disability Strategy: http://councillors.herefordshire.gov.uk/ieDecisionDetails.aspx?ID=5164

Herefordshire JSNA: https://factsandfigures.herefordshire.gov.uk/understanding-herefordshire

Worcestershire JSNA: http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment

Hereford and Worcestershire's Living Well with Dementia Strategy 2019-2024

Overview

We are developing a draft strategy showing the actions we intend to undertake, which reflects the national strategic direction and is to be informed by what people tell us about their experiences, as a person living with dementia, as a carer or an organisation that supports them.

Why we are consulting

We aim to provide a health and social care system that works together so that every person with dementia, their carers and families have access to and receive compassionate care and support not only before diagnosis but after diagnosis and through to end of life.

We also aim to improve access to diagnosis and support services for patients and service users in all our communities including those in a rural setting and from Black, Asian, minority ethnic and under-represented groups.

The strategy is for everyone affected by dementia – people with a diagnosis of dementia, their families and carers, and people and organisations who work to support them.

When the consultation closes in December we will update the strategy taking into account views that have been expressed. We will develop a joint action plan, based around our offer for people affected by dementia and their carers.

The new Strategy will be launched in March 2019 and will commence on 1st April 2019.

Our strategy

We achieved many successes under our previous strategies, which focused on collaboration with partners and joint commissioning of services. This new strategy is more focused on people and patients.

Aims of the strategy

- To minimise the impact of dementia whilst transforming care and support, not only for the person with dementia but also for carers.
- To move towards personalised and integrated care.
- To put the individual and their carer at the centre of service planning and design
- To improve access to diagnosis and support services for patients and service users in our communities including from Black, Asian, minority and rural and unrepresented groups.

The next few pages ask for your views on our proposed actions. These are arranged under five guiding principles:

- Preventing well
- Diagnosing well
- Supporting well
- Living well
- Dying well

Preventing well - your views

We plan to:

- Help our communities to be more aware and seek earlier diagnosis and support
- Help our GP practices to be more aware of and give support to people with dementia by using a standard professional guide
- Promote health checks in primary care
- Increase involvement of Public Health in the board's work.
- Work together to establish dementia friendly environments and reduce stigma
- Help communities and individuals be more aware of the lifestyle risk factors for dementia (smoking, physical inactivity, increased alcohol consumption, unhealthy diets, and being overweight), and how they can reduce their risk

1. Do you think these actions will raise awareness of risk factors associated with dementia?

Please select only one item

◯ Yes ◯ No ◯ don’t know

2. If no, please give reasons why:

3. Is there anything else we could do to raise awareness of risk factors associated with developing dementia and reduce stigma?

Diagnosing well - your views

We plan to:

- promote information on what people should do if they are worried about their memory or have a diagnosis of dementia
- improve up process of diagnosis
- review memory assessment and referral processes including patient and carer involvement
- introduce diagnosis toolkit to care homes

- promote post diagnostic information and support for people who have a diagnosis of dementia.

4. Do you think these actions will ensure that people receive a timely diagnosis?

Please select only one item

◯ Yes ◯ No ◯ don't know

5. If no, please give reasons why:

6. Is there anything else we could do to diagnose dementia well?

7. Is there anything else we could do to improve diagnosis and raise dementia awareness across all our communities including rural, Black, Asian, minority ethnic and unrepresented groups?

Supporting well - your views

We plan to:

- monitor the dementia support services we buy to ensure they provide high quality support, provide equal access for all and give good value
- raise awareness of dementia with housing providers
- develop high levels of expertise among those who provide care and support for
- people living with dementia
- improve the experience of inpatient care and the hospital discharge process by ensuring staff involved are dementia aware.
- Improve the experience of all patients and carers to ensure staff across all environments are dementia friendly.
- Improve practice of care planning across shared teams by using ‘about me’
- Ensure people with dementia, as well as their carer’s, have choice and control in decisions affecting their care and support

8. Do you think these actions will give people with dementia (and their carers) access to safe, high quality health and social care?

Please select only one item

◯ Yes ◯ No ◯ don’t know

9. If no, please give reasons why:

10. Is there anything else we could do to support people with dementia?

Living well - your views

We plan to:

- make sure we talk with people with dementia and their carers to make our services relevant to their needs
- support the Dementia Action Alliance to develop more dementia friendly communities
- review the dementia information available to ensure it covers a range of topics including accommodation options
- promote dementia support services
- agree a common set of care and support standards across Hereford and Worcestershire.
- support work to improve residential services for people with complex dementia
- develop training and support for care homes and other providers to manage crises
- Ensure carer support is tailored to their needs and preferences, and provided in a format suitable for them

11. Do you think these actions will enable people living with dementia to live well and safely within their communities?

Please select only one item

◯ Yes ◯ No ◯ Don't know

12. If no, please give reasons why:

13. Is there anything else we could do to support people with dementia to live well?

Dying well - your views

We plan to:

- Educate and strengthen links with working groups (such as EOL, palliative care teams), particularly around care for people with dementia who are approaching the end of their lives.
- Encourage and facilitate involvement of person living with dementia and their carer's in early discussions about advance care planning to ensure that persons express wishes are recorded and inform their care pathway across shared teams.

14. Do you think this action will ensure people with dementia can die with dignity in the place of their choosing and that their families and carers experience compassionate support?

Please select only one item

◯ Yes ◯ No ◯ Don't know

15. If no, please give reasons why:

16. Is there anything else we could do to ensure people living with dementia can die with dignity?

Additional information

If you choose to give us your email address in question 19, it will be kept in accordance with terms of the Data Protection Act and will only be used to contact you about dementia services. Your details will not be passed on to any other individual, organisation or group. Redditch and Bromsgrove CCG is the data controller for the purposes of the Data Protection Act.

17. Are you commenting on the dementia strategy in...? (Tick all that Apply)
(Required)

Please select all that apply

- ◯ Hereford
- ◯ SWCCG
- ◯ RBCCG
- ◯ WFCCG

18. Tell us about yourself (please tick all that apply)
(Required)

Please select all that apply

- ◯ I have a diagnosis of dementia
- ◯ I am a family member / carer of a person with dementia
- ◯ I am an interested member of the public
- ◯ I work for a council
- ◯ I work for a dementia service provider
- ◯ I work for a CCG
- ◯ I am a representative of a voluntary sector organisation or charity
- ◯ I work as a GP / pharmacist or other healthcare professional
- ◯ I am a stakeholder (like an elected member, representative of statutory body)
- ◯ other (please specify)

19. If you would like to be involved in future work to develop plans and improve services, please provide your email address:

Email

20. What is your postcode? (Home or work as appropriate)

Please note: we collect postcode data to gain a better understanding of which parts of the city / county respond to our consultations. We cannot identify individual properties or addresses from this information.

Equality monitoring

The information you provide in this final section of the questionnaire will be kept in accordance with terms of the Data Protection Act and will only be used for the purpose of monitoring. Your details will not be passed on to any other individual, organisation or group. Redditch and Bromsgrove CCG is the data controller for the information on this form for the purposes of the Data Protection Act.

21. Ethnic background:

Please select only one item

◯ Asian or Asian British: Bangladeshi ◯ Asian or Asian British: Indian

◯ Asian or Asian British: Pakistani

◯ Asian or Asian British: Any other Asian background

◯ Black or Black British: African ◯ Black or Black British: Caribbean

◯ Black or Black British: Somali

◯ Black or Black British: Any other Black background ◯ Chinese

◯ Chinese: Any other Chinese background

◯ Dual/Multiple Heritage: White & Asian

◯ Dual/Multiple Heritage: White & Black African

◯ Dual/Multiple Heritage: White & Black Caribbean

◯ Dual/Multiple Heritage: Any other heritage background ◯ White: British

◯ White: European ◯ White: Irish ◯ White: Any other White background

◯ Other ethnic group: Gypsy/Romany/Irish Traveller

◯ Other ethnic group: Any other ethnic group ◯ Prefer not to say

If you said your ethnic group was one of the 'Other' categories, please tell us what this is:

22. Age:

Please select only one item

◯ Under 18 ◯ 18 - 25 ◯ 26 - 35 ◯ 36 - 45 ◯ 46 - 55 ◯ 56 - 65

◯ 66-76 ◯ over 76 ◯ Prefer not to say

23. Disability

The Equality Act 2010 defines a person as disabled if they have a physical or mental impairment which has a substantial and long-term effect on their ability to carry out normal day-to-day activities and has lasted or is likely to last for at least 12 months. People with HIV, cancer, multiple sclerosis (MS) and severe disfigurement are also covered by the Equality Act.

Do you consider yourself to be a disabled person?

Please select only one item

◯ Yes ◯ No ◯ Prefer not to say

If you have answered **YES** to the previous above, please state the type of impairment that applies to you. People may experience more than one type of impairment, in which case you may need to tick more than one box. If none of the categories apply, please tick 'Other' and state the type of impairment.

Please select all that apply

◯ A long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease, or epilepsy

◯ A mental health difficulty, such as depression, schizophrenia or anxiety disorder

◯ A physical impairment or mobility issues, such as difficulty using your arms or using a Wheelchair or crutches

◯ A social / communication impairment such as a speech and language impairment or Asperger's syndrome / other autistic spectrum disorder

◯ A specific learning difficulty or disability such as Down's syndrome, dyslexia, dyspraxia or ADHD

◯ Blind or have a visual impairment uncorrected by glasses

◯ Deaf or have a hearing impairment

◯ An impairment, health condition or learning difference that is not listed above (specify if you wish)

◯ Prefer not to say

24. How would you define your religion or belief?

Please select only one item

◯ Atheist ◯ Bahai ◯ Buddhist ◯ Christian ◯ Hindu ◯ Jain

◯ Jewish ◯ Muslim ◯ Sikh ◯ No religion ◯ Prefer not to say

◯ Any other religion or belief (please specify)

25. Sexual orientation. Do you consider yourself to be ...

Please select only one item

◯ Bisexual ◯ Gay / lesbian ◯ Heterosexual / straight ◯ Prefer not to say

◯ Other (please specify)

26. What is your gender identity?

Please select only one item

◯ Male ◯ Female ◯ Other (e.g. pangender, non-binary etc)

◯ Prefer not to say

If other, please specify

Is your gender identity the same as the gender you were assigned at birth?

Please select only one item

◯ Yes ◯ No

Please return completed questionnaires to:

Ms. Carol Rowley
Delivery Programme Manager
Redditch and Bromsgrove CCG
Barnsley Court
Barnsley Hall Road
Bromsgrove
Worcestershire
B61 0TX

Dementia Strategy Event and Survey Feedback and next steps

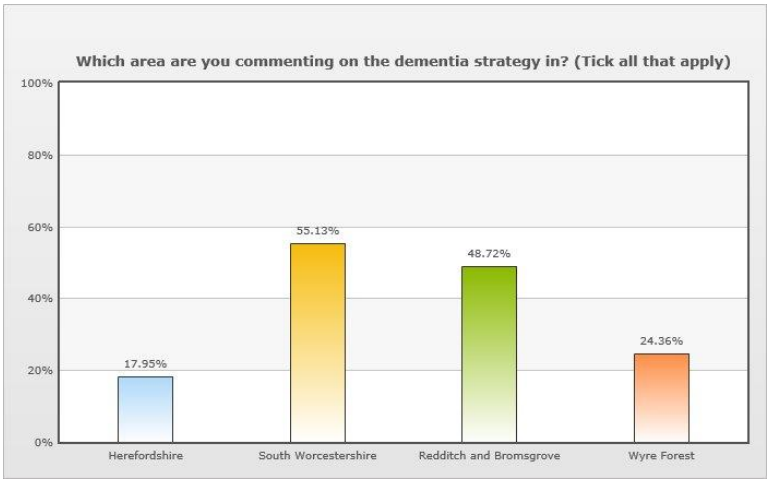
An event was held on 27th November 2018 across both Counties. It was well attended at both the morning and afternoon session, with good representation across the partnerships.

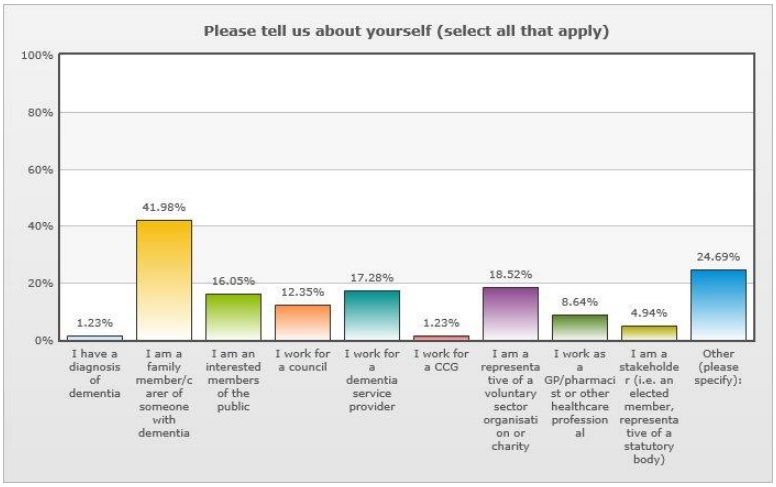
The draft strategy was presented at the event and a series of workshops then looked closely at the actions to ensure they represented stakeholder's views.

Actions were broken down into Entire Pathway, Diagnosing Well, Supporting Well, Living Well and Dying Well.

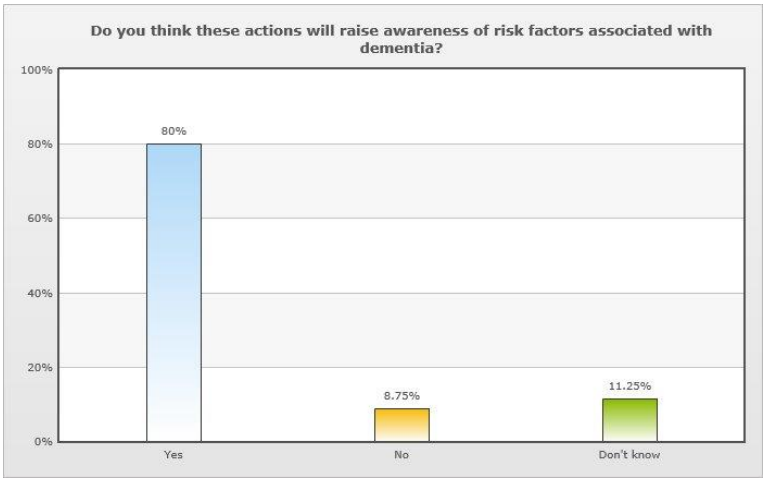
Themes which were identified at the events were; Workforce Development / Education, Community Support, Carer Support, Specialist Support, Advice and Guidance, Care Homes and Respite, Infrastructure, Primary Care, Dementia Pathway, Stigma.

A survey ran from early November until the end of December we had 88 responses to the survey.

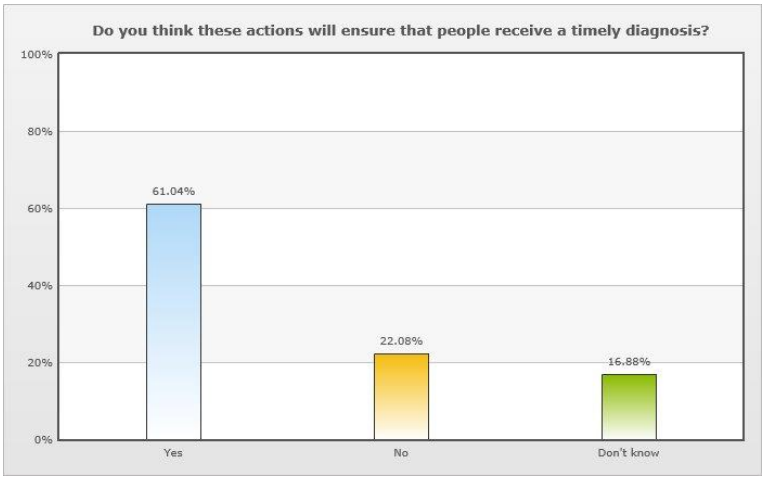




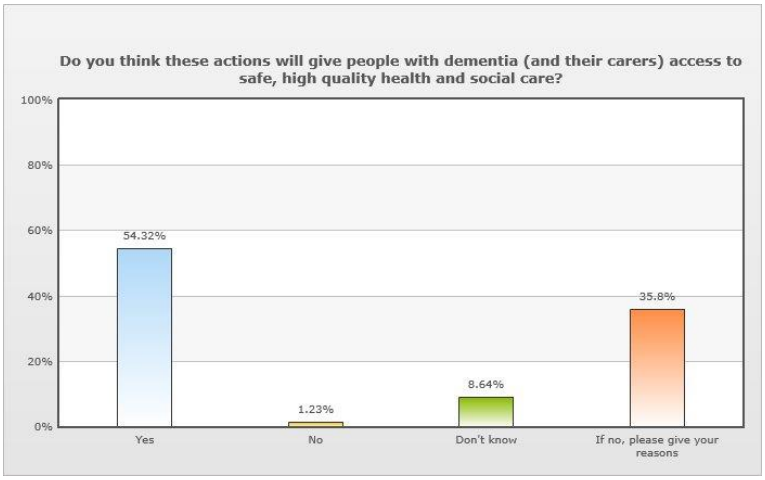
Preventing Well Responses



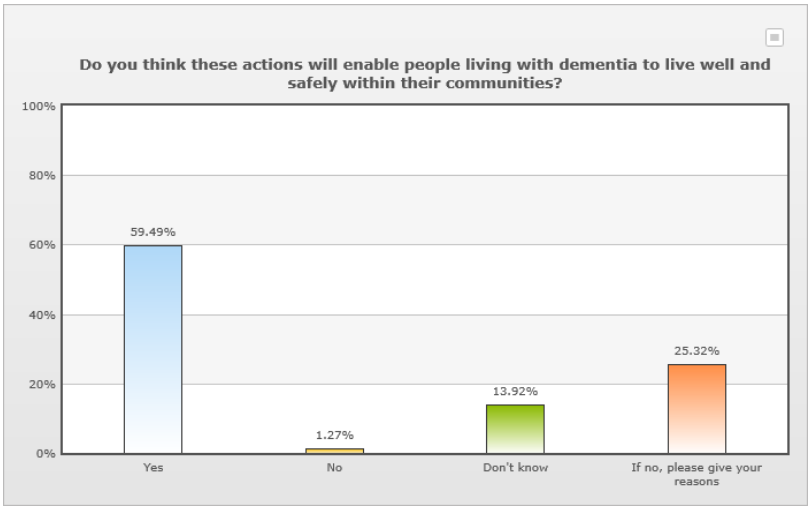
Diagnosing Well Responses



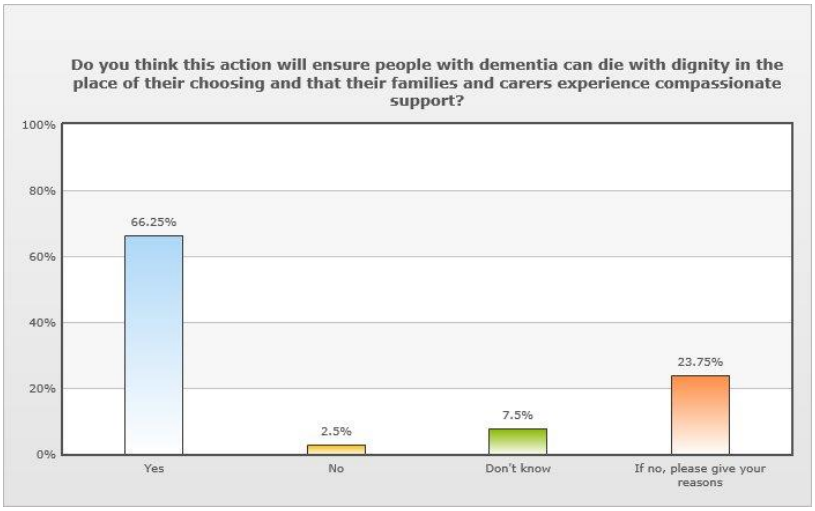
Supporting Well Responses



Living Well Responses



Dying Well Responses



We have been working through the detailed feedback from the surveys to ensure that everyone's views are represented.

The final draft of the strategy will be presented to the STP Board and Health and Wellbeing Boards across both counties in February 2019 and will then be launched at an event on 12 March 2019.

This event will be publicised and booking will take place electronically.