Herefordshire Council

Agenda

Health and wellbeing board

Date:	**Monday 8 July 2019**
Time:	**2.30 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, democratic services** 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
Vice-Chairperson **Dr Ian Tait**

Chris Baird
Ingrid Barker
Russell Hardy
Jo Melling
Ian Stead
Simon Trickett
Stephen Vickers
Karen Wright

Chris Baird	Director for children and families
Ingrid Barker	2gether NHS Foundation Trust
Russell Hardy	Wye Valley NHS Trust
Jo Melling	NHS England
Ian Stead	Healthwatch Herefordshire
Simon Trickett	NHS Herefordshire Clinicial Commissioning Group
Stephen Vickers	Director for adults and communities
Karen Wright	Director of Public Health

Agenda

		Pages
1.	**APOLOGIES FOR ABSENCE** To receive apologies for absence.	
2.	**NAMED SUBSTITUTES (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** To approve and sign the minutes of the meeting held on 5 March 2019.	7 - 14
5.	**QUESTIONS FROM MEMBERS OF THE PUBLIC** To receive any written questions from members of the public. For details of how to ask a question at a public meeting, please see: www.herefordshire.gov.uk/getinvolved The deadline for the receipt of a question from a member of the public is Tuesday 2 July at 5.00 pm. To submit a question, please email councillorservices@herefordshire.gov.uk	
6.	**QUESTIONS FROM COUNCILLORS** To receive any written questions from councillors. The deadline for the receipt of a question from a councillor is Tuesday 2 July at 5.00 pm, unless the question relates to an urgent matter. To submit a question, please email councillorservices@herefordshire.gov.uk	
7.	**BETTER CARE FUND QUARTER 4 REPORT 2018/19** To review the better care fund 2018/19 quarter four national performance and end of year feedback.	15 - 90
8.	**ONE HEREFORDSHIRE AND INTEGRATION BRIEFING** To provide an updated overview of the Sustainability and Transformation Programme (STP), One Herefordshire and Integration agenda for health and social care.	91 - 130
9.	**DATE OF NEXT MEETING** The next scheduled meeting is 14 October 2019.	

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Minutes of the meeting of Health and wellbeing board held at Committee Room 1, Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Tuesday 5 March 2019 at 3.00 pm

Present: **Councillor Paul Rone (Herefordshire Council) (Chairperson)**

J Alner	NHS Herefordshire Clinical Commissioning Group
C Baird	Director for children and families
C Price	Healthwatch Herefordshire
D Sutherland	2gether NHS Foundation Trust
Elissa Swinglehurst	Herefordshire Council
S Vickers	Director for adults and communities
K Wright	Director of public health

In attendance: **Councillor Polly Andrews, Dr M Hearne, Professor J Melton and C Merker**

Officers: **Ben Baugh, Kate Coughtrie, Annie Doherty, Rebecca Howell-Jones, Alistair Neill, Amy Pitt, Sandie Rogers and Charlotte Worthy**

Election of chairperson for this meeting

Due to the receipt of apologies for absence from the chairperson and the vice-chairperson, the first matter of business was to elect a chairperson for this meeting, in accordance with paragraph 4.1.10 of the council's constitution.

Councillor Paul Rone was elected as chairperson for this meeting.

168. APOLOGIES FOR ABSENCE

Apologies for absence had been received from Councillor Lester, Ingrid Barker, Jane Ives, Ian Stead, Dr Ian Tait and Simon Trickett.

169. NAMED SUBSTITUTES

The following substitutes were noted: Duncan Sutherland for Ingrid Barker; Christine Price for Ian Stead; and Jo-anne Alner for Simon Trickett.

170. DECLARATIONS OF INTEREST

No declarations of interest were made.

171. MINUTES

The minutes of the previous meeting were received.

Resolved:

That the minutes of the meeting held on 1 October 2018 be approved and be signed by the chairperson.

172. QUESTIONS FROM MEMBERS OF THE PUBLIC (Pages 9 - 12)

The questions received and responses given are attached as appendix 1 to these minutes.

173. QUESTIONS FROM COUNCILLORS

No written questions had been received from councillors for this meeting.

174. UPDATE ON THE DELIVERY OF DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2017 RECOMMENDATIONS

The director of public health provided an update on the implementation of the recommendations of the director of public health's annual report 2017, as agreed at the 1 October 2018 meeting (minute 167 refers). The key points included:

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

Public health had been working with planning, licensing and other areas of the council to ensure that health issues were considered in policy development and decision making.

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…

The oral health needs assessment was progressing well and should be published at the end of May 2019.

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…

The children and young people scrutiny committee was congratulated on its dental health and childhood obesity spotlight review which had brought together a range of organisations to explore these issues. Work on the healthy weight plan was progressing, including mapping. Some targeted weight management programmes were being offered through schools and an assessment of school meal provision was to be undertaken.

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…

Increased focus on working with communities, including the roll out of 'Let's Talk Community Hubs' and embedding 'Making Every Contact Count' across the system, were helping to build community resilience.

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.

This plan was being developed and should be completed by June 2019.

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.

The HLN had recruited 39 different organisation and 79 people had been trained to date, with further activity planned to support community networks and recruit more members.

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.

Alongside other initiatives, a parenting programme was being rolled to promote children's mental health, build confidence, and provide access to the right support.

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.

The benefits of the prevention agenda and strengths-based model of working to improve health and wellbeing and reduce demand on social care were noted. Developments included the multi-agency domestic abuse strategy, locality profiles, and improving the uptake of NHS health checks.

In response to a questions from the chief executive about the use of dental sealants and fluoride varnishes for children, the director of public health acknowledged the ongoing need to raise awareness of and access to this intervention; an undertaking was given to explore the longevity of new products and the potential for professionals other than dentists to apply such treatments.

There was a discussion around the issues arising from recommendation 7, the key points included:

i. Duncan Sutherland commented on the importance of identifying and treating mental health issues in childhood and ensuring connectivity between settings.

ii. The director of public health outlined the role of children's community nurses.

iii. The director for children and families said that some schools were doing some good work in this area, with pupils acting as champions and points of contact for others. The director of adults and communities added that schools were excellent at delivering results and, whilst it would be helpful it was part of the Ofsted agenda, there could be opportunities to work in a more collaborative way locally.

iv. Jo-anne Alner commented on the proposals for the development of children and young people's mental health care, as detailed in the NHS Long-Term Plan and in the government's response to the children and young people's mental health green paper consultation.

v. Professor Melton reported on initiatives to tackle stigma and raise awareness of emotional wellbeing, such as the 'Crucial Crew' event, and work to support transitions between age groups and services.

Resolved:

That the update be received and the role of the board in taking forward the priorities be noted.

[Note: The Homeless Link Health Needs Audit item was considered next, but the original agenda order is preserved in these minutes for ease of reference]

175. FUTURE ARRANGEMENTS AND PRIORITIES FOR THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

The consultant in public health summarised the proposed changes to the JSNA process and outputs as follows:

a. One of the statutory functions of the health and wellbeing board was to produce a JSNA of the health and wellbeing needs of Herefordshire and its residents.

b. The current approach included the production of a summary report which was refreshed every year and published on the 'Facts and Figures about Herefordshire' website.

c. It was proposed that the annual document be replaced with a summary report every three years and the JSNA be repositioned as a live resource, supported by quarterly intelligence bulletins.

d. As there had not been time to consider priorities during a board member workshop, it was suggested that the identification of priorities for analysis and understanding for 2019/20 and beyond be delegated to a workshop involving partner organisations.

The consultant in public health and the intelligence unit team leader responded to questions, the key points included:

1. Population health profiles would form part of the JSNA resource and work was being undertaken on smaller, locality profiles.

2. The 'Facts and Figures about Herefordshire' website would be rebranded 'Understanding Herefordshire: people and places' to reinforce its repositioning as the JSNA and evidence base hub.

3. The current annual report was resource intensive to produce and many strategic indicators did not change significantly year-on-year. The revised approach would enable greater focus on the analysis and understanding of the data, in a more real-time way.

4. Different boards took different approaches, but it was considered that the new arrangements would complement the focus on localities and assets.

5. It was anticipated that the changes would release some capacity in the team, potentially to support discrete pieces of work going forward.

6. Jo-anne Alner expressed her appreciation for the frailty integrated care pathway. It was confirmed that such documents would still be produced, with the director of public health adding that there would be opportunities for other organisations to upload documents to the website, subject to quality assurance. It was noted that the new JSNA Delivery Group would comprise those responsible for the production of evidence and intelligence across the whole system.

Resolved: That

(a) 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, be approved;

(b) **The key areas for analysis and intelligence for the 2019/20 JSNA be delegated to a workshop involving partner organisations and the outputs be circulated to board members; and**

(c) **The director of 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.**

176. BETTER CARE FUND QUARTER 2 AND 3 REPORT 2018/19

The head of partnerships and integration reported on the better care fund 2018/19 quarter two and three national performance report and drew attention to the following matters:

a. Due to the national submission deadlines, the quarterly reports had been submitted and the board was invited to note the completed data.

b. The report reflected national conditions and metrics, and the requirement to implement the High Impact Change Model for Managing Transfers of Care.

c. The board was advised that Delayed Transfers of Care had been peer reviewed recently and there were key programmes in place to support the system, including the implementation of a trusted assessor model, appointment of an integrated discharge lead, and an integrated discharge team function.

In response to a question, the director for children and families explained that the forecast in the ‘Section 75 Agreement Finance Summary 2018/19’ for ‘Total Pool 4 – Children’s Services’ related to children with complex needs and any underspend would be returned to the agencies that contributed to the pooled fund.

Resolved: That

(a) **the better care fund quarter two and three performance reports, as submitted to NHS England, be noted; and**

(b) **there were no further actions that the board wished to recommend to secure improvement in efficiency or performance at this time.**

177. HOMELESS LINK HEALTH NEEDS AUDIT

The consultant in public health presented the results of Herefordshire’s Homeless Link Health Needs Audit, with attention drawn to the following:

a. The audit was identified as an action in Herefordshire’s Homelessness Prevention Strategy 2016-20.

b. The health inequalities faced by people who were homeless were considerable, with greatly reduced average life expectancy compared with the general population; over 30 years lower for men and 40 years lower for women.

c. The audit was undertaken between December 2016 and February 2018, with 102 audits completed through face-to-face interviews by undertaken by Home Group, Supported Housing for Young People Project (SHYPP) and the council’s outreach service.

d. The key findings were summarised, including background information, physical and mental health conditions, drug and alcohol use, and access to services.

e. The rough sleeper outreach worker outlined two case studies which highlighted the complexities: the first demonstrated that access to mental health services were often vital for people who were homeless; and the second demonstrated that the provision of accommodation had to be complemented by a willingness to engage and support to address mental health and addiction issues.

f. The recommendations were outlined, and it was suggested that a workshop be held to examine care pathways. The audit would be published on the JSNA website, with the intention of repeating it again in three years.

Duncan Sutherland welcomed the audit and commented on the importance of breaking down silos and taking a pro-active approach. An overview was provided of an integrated initiative in Bristol that was achieving impressive results and it was recommended that consideration be given to the submission of a bid to the Homes England 'Move On Fund' to increase the availability of move-on accommodation.

The chief executive emphasised that expressions of commitment had to be backed up by actions to support vulnerable people. Noting that 25% of respondents had spent time in prison, it was suggested that the Ministry of Justice could be involved in the development of creative initiatives and solutions. It was acknowledged that the issues were profoundly challenging for any community, especially where people rejected help, and some practical shape was needed to take this work forward.

The director of public health said that the audit was a good piece work, it reinforced the need to focus on community resilience, the workshop should result in an action plan, and the board had an important role to play in holding lead agencies to account.

The cabinet member children and families suggested that opportunities for community work could be explored to help homeless people reengage with the wider community.

Jo-anne Alner supported a workshop to identify and overcome barriers to healthcare and other services, noted that a new mental health crisis line was being developed, and re-iterated a commitment to consider representation on the Herefordshire Homelessness Forum.

Dr Hearne said that the workshop should explore care pathways from the perspectives of homeless people and then make recommendations at network and strategic levels to deliver the changes needed.

Resolved: That the health and wellbeing board:

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

(b) requests board members to 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) seeks assurance from lead agencies (including Herefordshire Council, NHS Herefordshire Clinical Commissioning Group, Wye Valley NHS Trust and 2gether NHS Foundation 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) endorses the Homeless Health Needs Audit being undertaken again in three years' time (2022; completing the audit cycle) and being reported to the board.

178. HEREFORDSHIRE AND WORCESTERSHIRE DEMENTIA STRATEGY 2019-2024

The clinical programme manager of the CCG gave a presentation on the Herefordshire and Worcestershire 'Living Well with Dementia Strategy 2019-2024', the principal points are summarised below:

a. The purpose of the new strategy was to set out a shared vision for a collaborative approach across both counties, with each county having its own action plan.

b. Improving the health and wellbeing of people affected by dementia was a shared priority health outcome area for both counties and there were similarities, particularly between south Worcestershire and Herefordshire, in terms of challenges around dementia diagnosis and geography; the four CCGs were underperforming against the national target for dementia diagnosis.

c. The strategy had been informed by the Older People's Needs Assessment, local partnership events, a public survey, and feedback from service users, carers and a range of other stakeholders.

d. The vision was that 'in Herefordshire and Worcestershire people with dementia can live well through the following guiding principles: preventing well; diagnosing well; supporting well; living well; and dying well.

e. The key messages and challenges that had emerged during a series of workshops were outlined.

f. It was estimated that around 12,500 people were living with dementia in Herefordshire and Worcestershire, and this was expected to rise to around 20,000 people by 2025. Consequently, there was a need to pool resources and share learning in order to achieve the best possible outcomes.

g. A further engagement event was to take place during the following week to explore the high-level actions and to consider the immediate priorities.

h. A five-year plan was considered realistic and would provide time to drive the culture change required and achieve longer-term outcomes.

The director for adults and communities said that the work was positive overall but, whilst there had been engagement with a range of stakeholders, more could be done to engage with the local authorities in the two counties, especially given the finite management resources available to attend individual events. Concern was expressed about potential risks in terms of governance processes and ensuring that plans were relevant to the localities in which they were to be implemented. The director added that there was a lot of strategy development happening locally which needed to be aligned; for example, the economic development strategy could contribute directly towards shaping dementia friendly communities.

Jo-anne Alner emphasised that the Herefordshire and Worcestershire Sustainability and Transformation Partnership did not operate in isolation, commented on the various

engagement opportunities, and reiterated that each county would have its own action plan.

Resolved: That

(a) the draft Herefordshire and Worcestershire Dementia Strategy 2019-2024 be noted; and

(b) partner organisations be recommended to take the draft strategy through their governance systems for consideration and approval.

179. PROVISIONAL MEETING DATES FOR 2019/20

Provisional meeting dates for 2019/20 were noted, with the next scheduled meeting on Monday 8 July 2019.

The meeting ended at 4.50 pm **Chairperson**

Meeting:	Health and wellbeing board
Meeting date:	Monday 8 July 2019
Title of report:	Better care fund quarter 4 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 four national performance and end of year feedback, as per the requirements of the programme. In summary, the report identified the following points:

- At the end of 2018/19 Herefordshire was on track to meet the ambition rate for the national metric for non-elective admissions;
- Achievement of 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 continued to pose challenge to partners;
- Herefordshire showed significant improvement in delayed transfers of care although achieving the ambition rates was still continuing to pose a challenge.
- The overall delivery of the BCF in Herefordshire for 2018/19 has had a positive impact on integration.

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

Recommendation(s)

That:

(a) the better care fund (BCF) quarter four performance report at appendix one as submitted to NHS England, be reviewed and the board determine any further actions necessary to improve performance; and

(b) on occasions when board meetings do not coincide with national submission dates, the director for adults and communities has delegated authority, following consultation with the accountable officer of the Clinical Commissioning Group, to approve the submission and to present this to the next available board meeting to enable review of performance and make recommendations for improvement; and

(c) the director for adults and communities be authorised, following consultation with the chairperson of the Health and Wellbeing Board and with the agreement of the accountable officer at the Clinical Commissioning Group, to approve the 2019/20 BCF and Integration plan.

Alternative options

1. 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.

2. The board could reconvene and have an additional meeting, if there are any significant changes to the guidance and budgets.

Key considerations

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

4. End of year performance showed that Herefordshire was on track to meet the ambition for the national metric of reducing the rate of non-elective admissions. This has been a consistence performance during 2018/19.

5. Delayed transfers of care (DToC) continued to be higher than the ambition rates set across the health and social care system in Herefordshire; however, during the first three months (January, February, March) of the year, there was a significant improvement.

6. In February 2019 the council underwent a DToC peer review carried out by the Local Government Association (LGA). This has provided Herefordshire health and social care system with some clear recommendations for the next steps and highlighted some integrated working across the system. The review also provided an opportunity for all staff and partners directly affected to input into the process, improvements and current work being undertaken.

7. Demand within the care home market in Herefordshire continues to impact upon the ability to achieve the ambition rate of permanent admissions into residential care. The council has been experiencing a higher number of respite placements, which has in some instances

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

converted into long term placements. In addition, Herefordshire has a growing older age population requiring care home placements.

8. Demand continues to be high for the Home First service. Improvements have been made including training for new and some existing staff, a CQC inspection rated the service as good and additional staff recruited too. With a new structure, training and new staff the target for March was achieved.

9. Throughout quarter four progress has been made on the key areas of integration work areas, including the following:

Herefordshire's Integrated Urgent Care Model, which includes two key initiatives:

- Integrated Hospital Discharge - previously the local authority hospital discharge team and the Wye Valley Trust Complex discharge team work together to support hospital discharge. However, this program of work is to achieve an improved flow for discharged through implementing a single, **integrated discharge team (IDT) function**. This consists of a group of professionals, from both social care and health, who are co-located at the acute hospital and collaboratively work together to ensure the safe and timely discharge of patients

- An Integrated Discharge Lead has been recruited across the IDT and partners have put in place reporting mechanisms, a clear set of principles and agreement of work plan across the team.

- Integrated Community Capacity Function - Health and social care both currently provide a number of community services to support individuals to remain within their own home or to transfer home from hospital. Although the services work together, where necessary this work programme is scoping options where closer working could enhance the community offer in Hereford and improve outcomes for people who require these services. Hospital at Home (WVT) and Home First (HC) are the two teams that are being reviewed and considered within the scope of the project.

- Discharge to Assess (D2A) – The D2A beds is a pilot delivered by Shaw Healthcare in Ledbury and has been operational since 4 March 2019. The pilot service, which is due to run to 31 March 2020, consists of a 14 bed-based provision for adults, predominantly aged over 65 years, who could potentially return home after a period of additional rehabilitation and assessment of their future needs. The service provision focuses on patients who have completed an acute episode of care but are unable to return to their previous place of care and need on-going assessment of their long-term care needs.

- The lead commissioner is the council and the council along with the CCG, has redesigned and negotiated the model with the provider and additional funding for the scheme has been through BCF/iBCF.

- Trusted Assessor (TA) – The 'Trusted Approach' approach is an initiative driven to reduce the number of delayed discharges and improve the experience for patients. The underlying principle of the approach is to promote safe and timely discharges from NHS Trusts to adult social care services, which allows trusted assessors to undertake assessments on behalf of the care home market to reduce duplication and improve the flow of transfer from hospital.

- Improving quality in care homes – The quality within the care homes in Herefordshire had been reducing which was identified through the Care Quality Commission (CQC) inspections and the CCG/LA independent quality assurance visits.
- The pilot commenced in January 2019 and aimed to develop and establish a joint health and social care, care home quality team. Teams are aligned under one joint manager who would provide leadership and oversight of the team and coordinate the resources effectively.

- High Impact Change Model implementation - ongoing throughout 2019/20

10. Community EMIS, a digital clinical system supporting joined-up working across all care settings is being rolled out amongst health professionals, however this remains a challenge. A joint Digital Manager has been recruited through the BCF to support this integration of health and social care.

11. The policy framework for the BCF was published in May 2019, however the BCF guidance for 2019/20 has been delayed, current advice is that it will be published during June 2019. Partners continue to work together to proceed with planning delivery and agreeing budgets, where possible.

12. Early advice on the guidance is that 2019/20 will be a continuation of current plans and funding levels, which will be no more than £60m and the national conditions of:

    a) a jointly agreed plan;
    b) NHS contribution to adult social care is maintained;
    c) agreement to invest in NHS commissioning out of hospital services; and
    d) managing transfers of care

    will remain the same as well as the national performance measures of:

    a) non-elective admissions;
    b) admissions to residential care home;
    c) effectiveness of reablement; and
    d) delayed transfers of care (DToC)

13. The current integration and BCF plan can be found at appendix two which shows the expected levels of funding, spend and schemes which are currently being agreed between the council and CCG ahead of the guidance being issued.

Community impact

14. 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.

15. The changes described are aligned and integral to delivering the NHS Long Term Plan and by providing services at a locality level also supports the local authorities corporate objective to ‘enable residents to live safe, healthy and independent lives.’

16. The plans are intended to move our health and social care system to a new service model in which patients get more options, better support and properly joined up care at the right time in the optimal care setting will support communities to remain within their own homes and reduce the need for hospitalisation and long term care. This will support our objectives of building community resilience and tackling health inequalities.

17. The BCF plan is a critical component of One Herefordshire, and financially supports many of the integration services and redesign. One Herefordshire is our place based partnership; a five year "integration" plan is currently being developed and the vision is for Herefordshire to be a county of healthy individuals living within healthy communities.

18. It will support One Herefordshire partners in improving wider wellbeing and population outcomes, as well as addressing their statutory duties around health inequalities. Citizens have the right to expect their NHS to assess the health requirements of their community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.

Equality duty

19. 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.

20. 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.

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

22. The 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 homes and communities. There are no negative impacts for looked after children or with respect to the council's corporate parenting role.

23. 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. The STP is developing a more joined up approach to its equality duties, and has an STP equality work stream which is developing a robust and uniform approach to equality

impact assessment across Herefordshire and Worcestershire which the BCF will be included.

24. Where appropriate, an Equality Impact Assessment (EIA) is undertaken for separate schemes and services that are within the BCF. Where large changes are planned via the BCF an EIA will be completed.

Resource implications

25. Overall the schemes that comprise the section 75 agreement ended the financial year with a net overspend of £1,345k (2.4% over budget), chiefly due to overspends on pool 2 in-county care home placements; and pool 5 – community equipment loans..

26. The table below shows the summary outturn at month twelve (March 2019) for the schemes that make up the section 75 agreement.

Section 75 Agreement Finance Summary 2018/19 **Out-turn at Month 12 (March 19)**	**Plan**	**Spend**	**(Under) / Over Spend**	**% (Under) / Over Spend**
	£'000	**£'000**	**£'000**	
Spending on Social Care Services (PASC)	4,760	4,695	(65)	(1.4%)
Spending on Social Care Services (Care Act)	479	350	(129)	(26.9%)
Sub-Total- Spending on Social Care from Minimum Mandatory Fund	**5,240**	**5,046**	**(194)**	(3.7%)
NHS Commissioned Out of Hospital Care	6,947	6,935	(12)	(0.2%)
Sub Total- Mandatory Minimum BCF Contribution from CCG	**12,187**	**11,981**	**(206)**	**(1.7%)**
Disabled Facilities Grant (Capital)	2,072	2,072	0	0.0%
Total Pool 1- Mandatory Better Care Fund Contributions	**14,259**	**14,053**	**(206)**	**(1.4%)**
Herefordshire CCG Funded Packages	9,564	9,611	47	0.5%
Herefordshire Council Funded Packages	21,359	23,246	1,886	8.8%
Total Pool 2- Additional Better Care Fund Contribtutions	**30,923**	**32,856**	**1,933**	**6.3%**
Improving Integrated Commissioning Capacity	226	248	21	9.5%
Meeting Adult Social Care Needs	3,285	3,360	76	2.3%
Reducing Pressures on the NHS including Supporting Hospital Discharge	971	999	28	2.8%
Supporting Local Social Care Provider Market	200	115	(85)	(42.6%)
Total Pool 3- Improved Better Care Fund (IBCF)	**4,722**	**4,722**	**0**	**0.0%**
Childrens' Commissioning Unit	80	72	(8)	(9.4%)
Childrens' Short Breaks	440	408	(32)	(7.4%)
Childrens' Complex Needs Solutions	3,493	2,908	(585)	(16.8%)
Childrens' Safeguarding Board	214	214	0	0.0%
Total Pool 4- Childrens' Services	**4,227**	**3,602**	**(625)**	**(14.8%)**
Integrated Community Equipment Store	1,000	1,243	243	24.3%
Total Pool 5- Integrated Community Equipment Store	**1,000**	**1,243**	**243**	**24.3%**
Total Section 75 Agreement	**55,131**	**56,476**	**1,345**	**2.4%**

Legal implications

27. 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

28. 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.

29. The Better Care Partnership Group (BCPG), a joint steering group between the council and CCG, responsible for monitoring the delivery of the Herefordshire BCF Plan, will monitor a risk register and escalate to the directorate risk register where necessary. Higher risks, such as ability to deliver DToC, will also be escalated to the council's corporate register.

Risk / Opportunity	Mitigation
Schemes that have investment do not achieve the desired outcomes and impact planned	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.
Increasing demand due to the demography of expected older age population could outstrip the improvements made	A number of the schemes are both areas that support prevention and the urgent care parts of the system to spread the risk. In addition, the local authority is leading development with communities and implementing strengths based assessments to reduce demand where possible.
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.
The national policy framework has been received however, planning guidance is yet to be published and confirmation of the funding allocation for 2019/20,which provides a level of risk to some of the iBCF schemes	Partners continue to work together to proceed with planning delivery. Further discussions will take place when planning guidance is received.
BCF Funding 2020 onwards: If changes in BCF planning guidance moves from current position then the council could be at risk of a funding deficit of approximately £11m (including iBCF) for protection of ASC etc.	This is a national risk to all council's and council officers continue to work in partnership with health colleagues to develop integrated ways of working to improve outcomes whilst ensuring efficient services are delivered.

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

Consultees

30. 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 following consultation with Joint Commissioning Board (JCB) and submitted prior to the national deadlines.

31. The director for adults and communities will sign off the 2019/20 Integration and BCF plan on behalf of the Health and Wellbeing Board following consultation with the chairperson of the Health and Wellbeing Board and with the agreement of the CCG's accountable officer.

Appendices

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

Appendix 2 – Herefordshire Integration and Better Care Plan 2017/19

Background papers

None

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

Better Care Fund Templat

1. Cover

Version 1.0

Please Note:
- The BCF quarterly reports are categorised as 'Management Information' and are website. ***Narrative sections of the reports will not be published.*** *However as witl information including any narrative is subject to Freedom of Information requests*
- As noted already, the BCF national partners intend to publish the aggregated nc local level it is for the HWB to decide what information it needs to publish as part requirements. Until BCF information is published, recipients of BCF reporting infoi on the BCE) are prohibited from making this information available on any public c journalism or research without prior consent from the HWB (where it concerns a : information.
- This template is password protected to ensure data integrity and accurate aggr required if this is breached.

Health and Wellbeing Board:

Completed by:

E-mail:

Contact number:

Who signed off the report on behalf of the Health and Wellbeing Board:

Question Completion - when all questions have been answered and the vali template to england.bettercaresupport@nhs.net saving the file a

Complete

1. Cover
2. National Conditions & s75 Pooled Budget
3. National Metrics
4. High Impact Change Model
5. Income and Expenditure
6. Year End Feedback
7. Narrative
8. improved Better Care Fund: Part 1
9. improved Better Care Fund: Part 2

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

<< Link to Guidance tab

1. Cover

Health & Wellbeing Board
Completed by:
E-mail:
Contact number:
Who signed off the report on behalf of the Health and Wellbeing Board:

Sheet Complete:

2. National Conditions & s75 Pooled Budget

1) Plans to be jointly agreed?
2) Social care from CCG minimum contribution agreed in line with Planning Requ
3) Agreement to invest in NHS commissioned out of hospital services?
4) Managing transfers of care?
1) Plans to be jointly agreed? If no please detail
2) Social care from CCG minimum contribution agreed in line with Planning Requ
3) Agreement to invest in NHS commissioned out of hospital services? If no pleas
4) Managing transfers of care? If no please detail
Have the funds been pooled via a s.75 pooled budget?
Have the funds been pooled via a s.75 pooled budget? If no, please detail
Have the funds been pooled via a s.75 pooled budget? If no, please indicate whe

Sheet Complete:

3. Metrics

NEA Target performance
Res Admissions Target performance
Reablement Target performance
DToC Target performance
NEA Challenges
Res Admissions Challenges
Reablement Challenges
DToC Challenges
NEA Achievements
Res Admissions Achievements
Reablement Achievements
DToC Achievements
NEA Support Needs
Res Admissions Support Needs
Reablement Support Needs
DToC Support Needs

Sheet Complete:

4. High Impact Change Model

Chg 1 - Early discharge planning Q4 18/19
Chg 2 - Systems to monitor patient flow Q4 18/19
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19
Chg 4 - Home first/discharge to assess Q4 18/19

Chg 5 - Seven-day service Q4 18/19
Chg 6 - Trusted assessors Q4 18/19
Chg 7 - Focus on choice Q4 18/19
Chg 8 - Enhancing health in care homes Q4 18/19
UEC - Red Bag scheme Q4 18/19
Chg 1 - Early discharge planning, if Mature or Exemplary please explain
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain
Chg 5 - Seven-day service, if Mature or Exemplary please explain
Chg 6 - Trusted assessors, if Mature or Exemplary please explain
Chg 7 - Focus on choice, if Mature or Exemplary please explain
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain
UEC - Red Bag scheme, if Mature or Exemplary please explain
Chg 1 - Early discharge planning Challenges
Chg 2 - Systems to monitor patient flow Challenges
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges
Chg 4 - Home first/discharge to assess Challenges
Chg 5 - Seven-day service Challenges
Chg 6 - Trusted assessors Challenges
Chg 7 - Focus on choice Challenges
Chg 8 - Enhancing health in care homes Challenges
UEC - Red Bag Scheme Challenges
Chg 1 - Early discharge planning Additional achievements
Chg 2 - Systems to monitor patient flow Additional achievements
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements
Chg 4 - Home first/discharge to assess Additional achievements
Chg 5 - Seven-day service Additional achievements
Chg 6 - Trusted assessors Additional achievements
Chg 7 - Focus on choice Additional achievements
Chg 8 - Enhancing health in care homes Additional achievements
UEC - Red Bag Scheme Additional achievements
Chg 1 - Early discharge planning Support needs
Chg 2 - Systems to monitor patient flow Support needs
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs
Chg 4 - Home first/discharge to assess Support needs
Chg 5 - Seven-day service Support needs
Chg 6 - Trusted assessors Support needs
Chg 7 - Focus on choice Support needs
Chg 8 - Enhancing health in care homes Support needs
UEC - Red Bag Scheme Support needs

Sheet Complete:

5. Income and Expenditure

Do you wish to change your additional actual CCG funding?
Do you wish to change your additional actual LA funding?
Actual CCG Add
Actual LA Add
Income commentary
Do you wish to change your BCF actual expenditure?
Actual Expenditure

Expenditure commentary

Sheet Complete:

6. Year End Feedback

Statement 1: Delivery of the BCF has improved joint working between health and
Statement 2: Our BCF schemes were implemented as planned in 2018/19
Statement 3: Delivery of BCF plan had a positive impact on the integration of hea
Statement 4: Delivery of our BCF plan has contributed positively to managing the
Statement 5: Delivery of our BCF plan has contributed positively to managing the
Statement 6: Delivery of our BCF plan ihas contributed positively to managing rea
Statement 7: Delivery of our BCF plan has contributed positively to managing res
Statement 1 commentary
Statement 2 commentary
Statement 3 commentary
Statement 4 commentary
Statement 5 commentary
Statement 6 commentary
Statement 7 commentary
Success 1
Success 2
Success 1 commentary
Success 2 commentary
Challenge 1
Challenge 2
Challenge 1 commentary
Challenge 2 commentary

Sheet Complete:

7. Narrative

Progress against local plan for integration of health and social care
Integration success story highlight over the past quarter

Sheet Complete:

8. Additional improved Better Care Fund: Part 1

A1) Do you wish to revise the percentages provided at Q1 18/19?
A2) a) Revised meeting adult social care needs
A2) b) Revised reducing pressures on the NHS
A2) c) Revised ensuring that the local social care provider market is supported
A3) Success 1
A3) Success 2
A3) Success 3
A4) Other commentary 1
A4) Other commentary 2
A4) Other commentary 3
A5) Commentary 1
A5) Commentary 2
A5) Commentary 3

A6) Challenge 1
A6) Challenge 2
A6) Challenge 3
A7) Other commentary 1
A7) Other commentary 2
A7) Other commentary 3
A8) Commentary 1
A8) Commentary 2
A8) Commentary 3
B1) Initative 1: Progress
B1) Initative 2: Progress
B1) Initative 3: Progress
B1) Initative 4: Progress
B1) Initative 5: Progress
B1) Initative 6: Progress
B1) Initative 7: Progress
B1) Initative 8: Progress
B1) Initative 9: Progress
B1) Initative 10: Progress
B2) Initative 1: Commentary
B2) Initative 2: Commentary
B2) Initative 3: Commentary
B2) Initative 4: Commentary
B2) Initative 5: Commentary
B2) Initative 6: Commentary
B2) Initative 7: Commentary
B2) Initative 8: Commentary
B2) Initative 9: Commentary
B2) Initative 10: Commentary

Sheet Complete:

9. Additional improved Better Care Fund: Part 2

C1) a) Actual number of home care packages
C1) b) Actual number of hours of home care
C1) c) Actual number of care home placements
C2) Main area spent on the addition iBCF funding allocation for 2018/19
C3) Main area spent on the addition iBCF funding allocation for 2018/19 - Comm
Metric 1: D1) Additional Metric Name
Metric 2: D1) Additional Metric Name
Metric 3: D1) Additional Metric Name
Metric 4: D1) Additional Metric Name
Metric 5: D1) Additional Metric Name
Metric 1: D2) Metric category
Metric 2: D2) Metric category
Metric 3: D2) Metric category
Metric 4: D2) Metric category
Metric 5: D2) Metric category
Metric 1: D3) If other category, then detail
Metric 2: D3) If other category, then detail
Metric 3: D3) If other category, then detail
Metric 4: D3) If other category, then detail

Metric 5: D3) If other category, then detail
Metric 1: D4) Metric performance
Metric 2: D4) Metric performance
Metric 3: D4) Metric performance
Metric 4: D4) Metric performance
Metric 5: D4) Metric performance

Sheet Complete:

e Q4 2018/19

e planned for publishing in an aggregated form on the NHSE
h all information collected and stored by public bodies, all BCF
s.
ıtional quarterly reporting information on a quarterly basis. At a
: of wider local government reporting and transparency
rmation (including recipients who access any information placed
domain or providing this information for the purposes of
single HWB) or the BCF national partners for the aggregated

regation of collected information. A resubmission may be

Herefordshire, County of

Amy Pitt

apitt@herefordshire.gov.uk

07792 881896

Councillor Lester

idation boxes below have turned green you should send the
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	C10	Yes
	C12	Yes
	C14	Yes
	C16	Yes

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	C10	Yes
	C11	Yes
	D8	Yes
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	D11	Yes
	C15	Yes
	D15	Yes
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	G13	Yes
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	G19	Yes
	G23	Yes
	H12	Yes
	H13	Yes
explain	H14	Yes
	H15	Yes
	H16	Yes
	H16	Yes
	H17	Yes
	H18	Yes
	H23	Yes
	I12	Yes
	I13	Yes
	I14	Yes
	I15	Yes
	I16	Yes
	I17	Yes
	I18	Yes
	I19	Yes
	I23	Yes
	J12	Yes
	J13	Yes
s	J14	Yes
	J15	Yes
	J16	Yes
	J17	Yes
	J18	Yes
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	K16	Yes
	K17	Yes
	K18	Yes
	K19	Yes
	K23	Yes

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	G15	Yes
	H14	Yes
	H15	Yes
	D21	Yes
	E28	Yes
	C30	Yes

	D32	Yes

	Yes

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	Cell Reference	Checker
d social care	C10	Yes
	C11	Yes
alth and social care	C12	Yes
e levels of NEAs	C13	Yes
e levels of DToC	C14	Yes
ablement	C15	Yes
sidential admissions	C16	Yes
	D10	Yes
	D11	Yes
	D12	Yes
	D13	Yes
	D14	Yes
	D15	Yes
	D16	Yes
	C22	Yes
	C23	Yes
	D22	Yes
	D23	Yes
	C26	Yes
	C27	Yes
	D26	Yes
	D27	Yes

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	C24	Yes
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	E24	Yes
	C25	Yes
	D25	Yes
	E25	Yes

	C28	Yes
	D28	Yes
	E28	Yes
	C29	Yes
	D29	Yes
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	C30	Yes
	D30	Yes
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	C37	Yes
	D37	Yes
	E37	Yes
	F37	Yes
	G37	Yes
	H37	Yes
	I37	Yes
	J37	Yes
	K37	Yes
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	E20	Yes
	F20	Yes
	G20	Yes
	C21	Yes
	D21	Yes
	E21	Yes
	F21	Yes
	G21	Yes
	C22	Yes
	D22	Yes
	E22	Yes
	F22	Yes

	G22	Yes
	C23	Yes
	D23	Yes
	E23	Yes
	F23	Yes
	G23	Yes

	Yes

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Herefordshire Council

NHS Herefordshire Clinical Commissioning Group

Herefordshire Integration and Better Care Fund

Narrative Plan 2017/19

FINAL

Contents

1. Introduction
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3. The local vision and approach for health and social care integration
4. Progress so far
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    6.2 National condition 2: Social care maintenance
    6.3 National condition 3: NHS out of hospital services
    6.4 National condition 4: Managing transfers of care
    6.5 Continuing progress in other areas
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8. Overview of funding contributions
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10. Assessment of Risk and Risk management
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    11.2 Admissions to Residential care homes
    11.3 Effectiveness of reablement
    11.4 Delayed transfers of care (DToC)
12. Approval and sign off

Appendix 1– DFG plan 2017/19

Appendix 2 – Herefordshire planning template submission

Appendix 3– Risk register

Appendix 4– KLOE responses

1. Introduction

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

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

2. Background and context to the plan

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

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

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

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

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

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

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

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

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

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

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

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

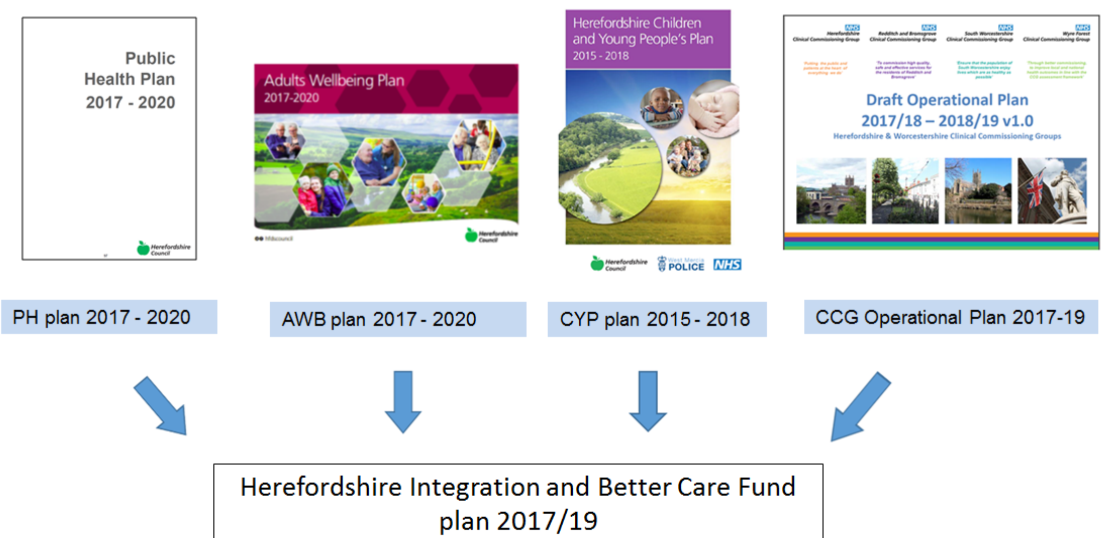
"The vision for the local health and care system in Herefordshire is one where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people".

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

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

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

Key Operational Plans



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

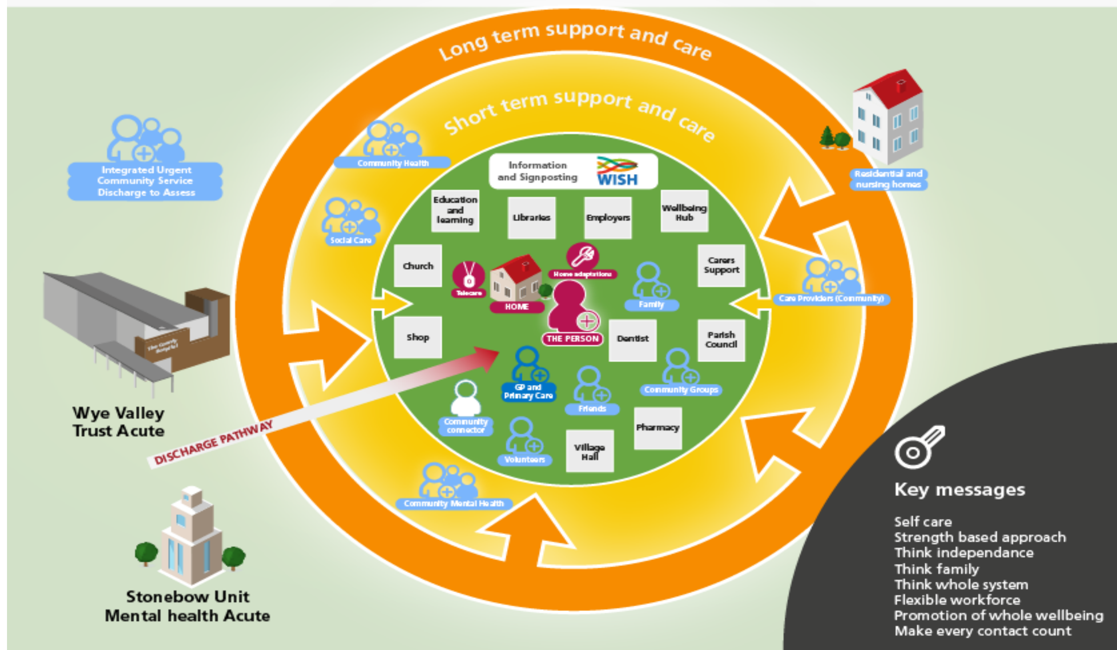
At a strategic level, the Integration and BCF plan intends to support the One Herefordshire alliance in achieving the following aims:

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

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

The Joint Blueprint

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



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

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

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

4. Progress so far

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

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

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

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

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

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

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

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

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

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

Local Priorities

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

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

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

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

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

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

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2 ONS mid-year estimates 2016

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

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

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

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

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

Evidence Base

Social Care

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

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

Domiciliary Care

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

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

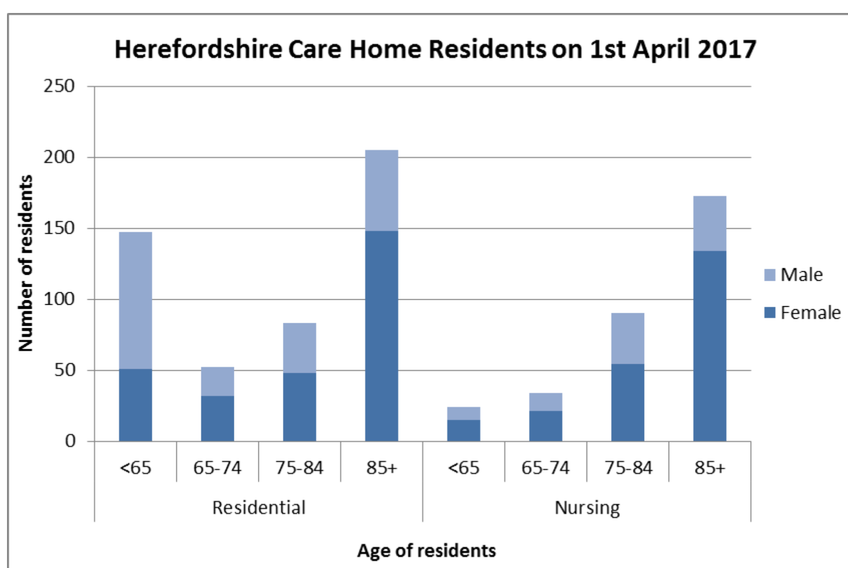
7 Goodwin et al. 2014. Providing integrated care for older people with complex needs: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/providing-integrated-care-for-older-people-with-complex-needs-kingsfund-jan14.pdf

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

Care homes

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

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



Health Care

GP Practice profiles

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

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

Hospital care

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

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

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

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

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

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

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

Local integration

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

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

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

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

6. National Conditions

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

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

6.1 National condition 1: Jointly agreed plan

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

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

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

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

6.2 National Condition 2: Social Care Maintenance

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

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

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

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

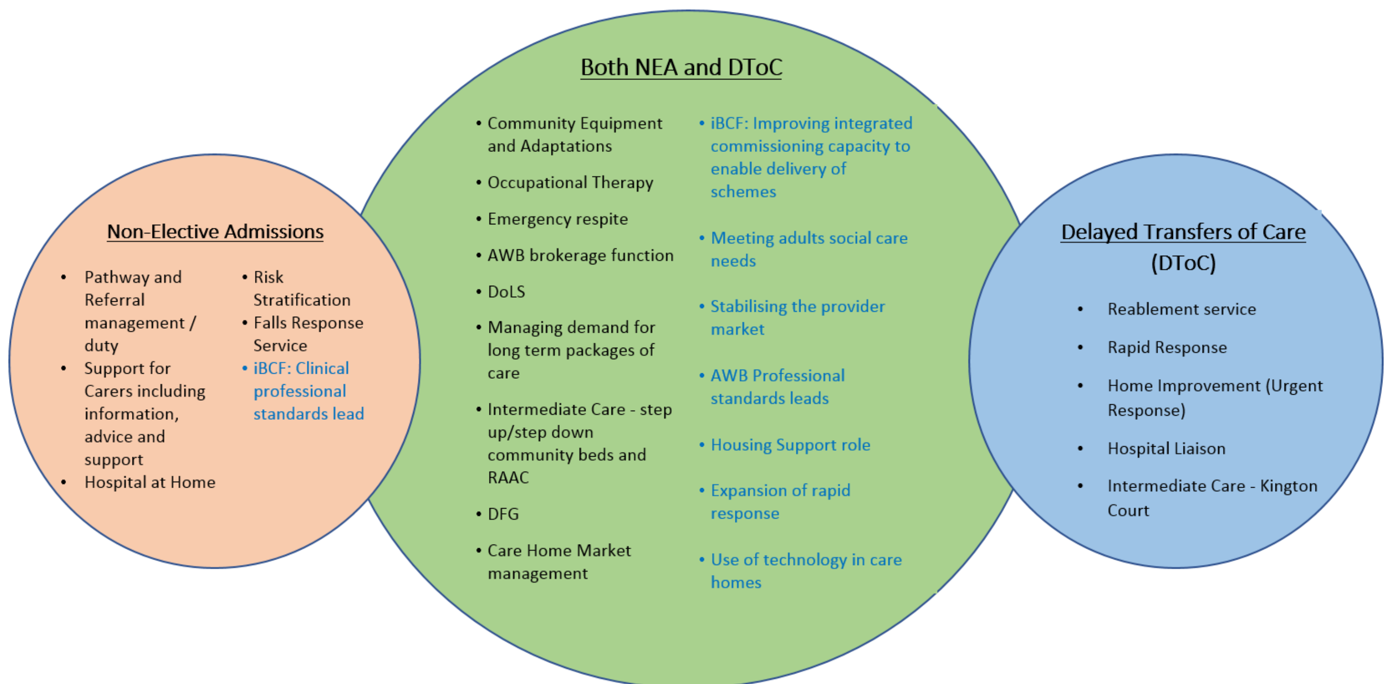
Scheme	Financial change from 16/17 to 17/18	Reason for change
RAAC	(94)	Reduction in budget to reflect historic underspend. Future system redesign.
Support for Carers	(244)	In line with commissioning intensions as detailed in Carers Strategy. Links to wider services-WISH/Community Connectors
Rapid Response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

Changes in PASC 2018/19

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

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

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



6.3 National Condition 3: NHS out of hospital services

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

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

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

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

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

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

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

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

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

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

<u>Remaining at Home</u>

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

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

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

Using Community resources more effectively

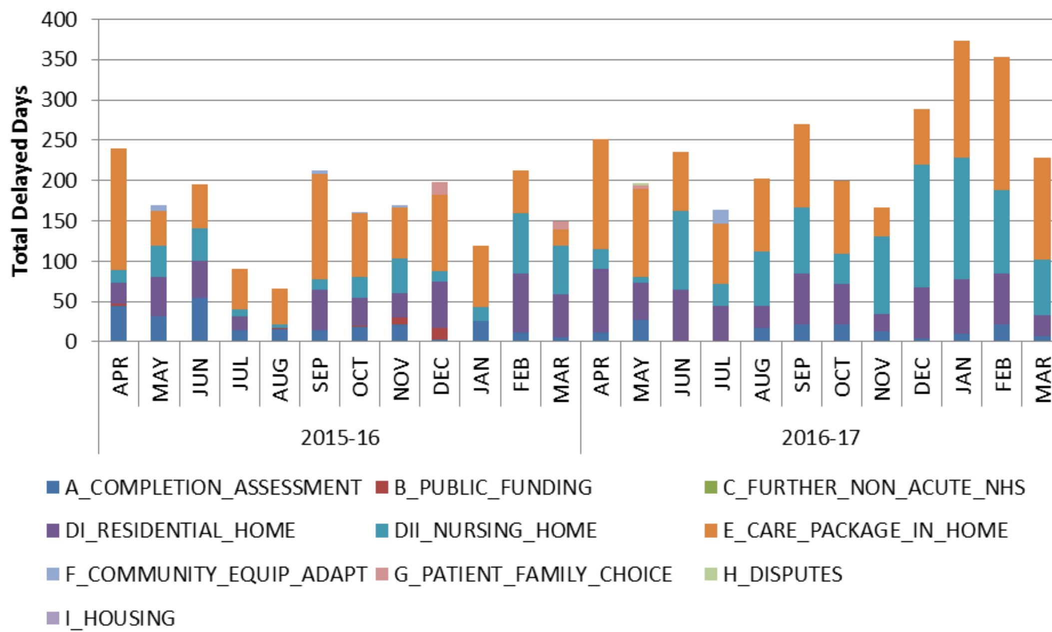
A co-designed model for intermediate care – Rapidly defining a model of intermediate bed based and non-bed based care that best utilises the extensive community hospital resources we have. This will include:

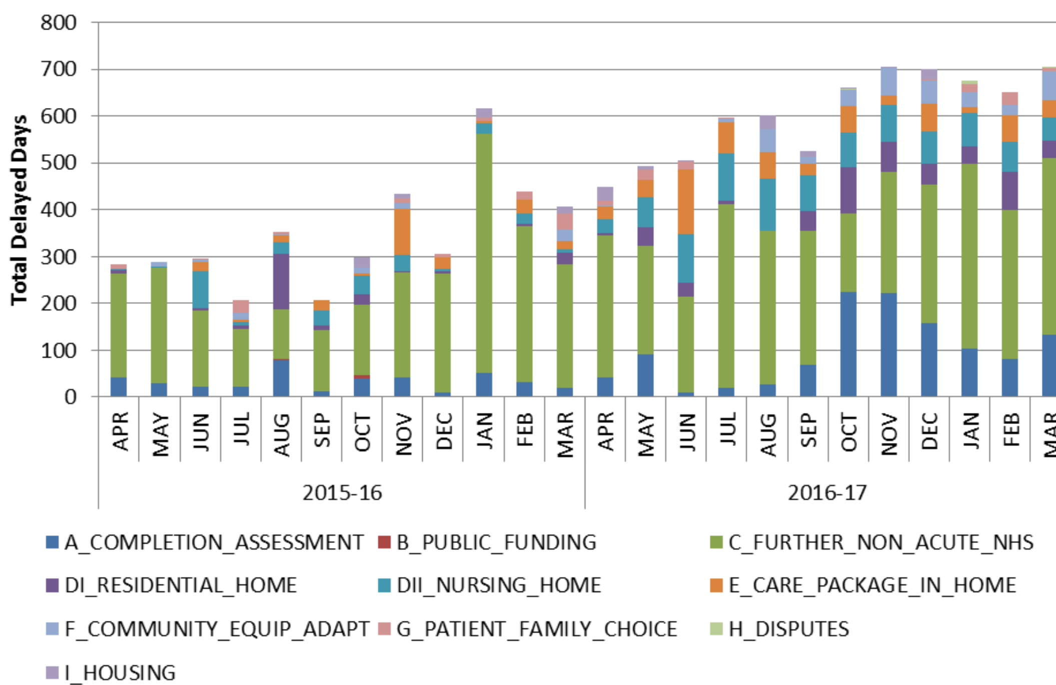
- Community Multi-Disciplinary Team supported admissions to bed based services (step up), including both the emerging Intermediate Rehabilitation Service and wider community beds to support ambulatory frailty assessment.
- Rapid discharge to 'your own bed' principles of management, with wraparound community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

6.4 National Condition 4: Managing Transfers of Care

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

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





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

Improvement Plan - Delayed Transfers of Care

A. Mapping and action plan - High Impact Interventions

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

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

BCF or iBCF schemes	**System response**

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

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

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

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

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

6.5 Continuing progress in other areas

Supporting progress on meeting the 2020 standards for seven day services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Falls Response Service

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

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

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

7. Plan: schemes and spending

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

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

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

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

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

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

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

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

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

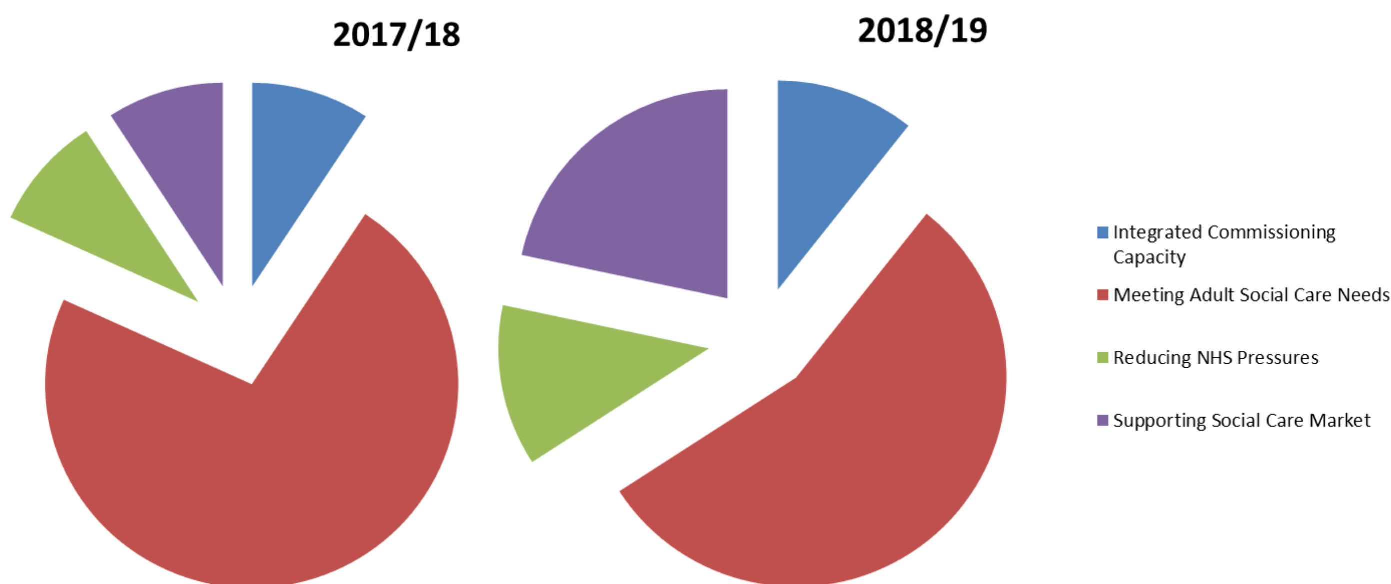
The investment in the falls response service has proved very successful since its commencement and has delivered more than double the target savings. This scheme is jointly funded by the CCG, council and the provider.

8. Overview of funding contributions

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

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

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



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

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

Primary Care Home)

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

9. Programme Governance

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

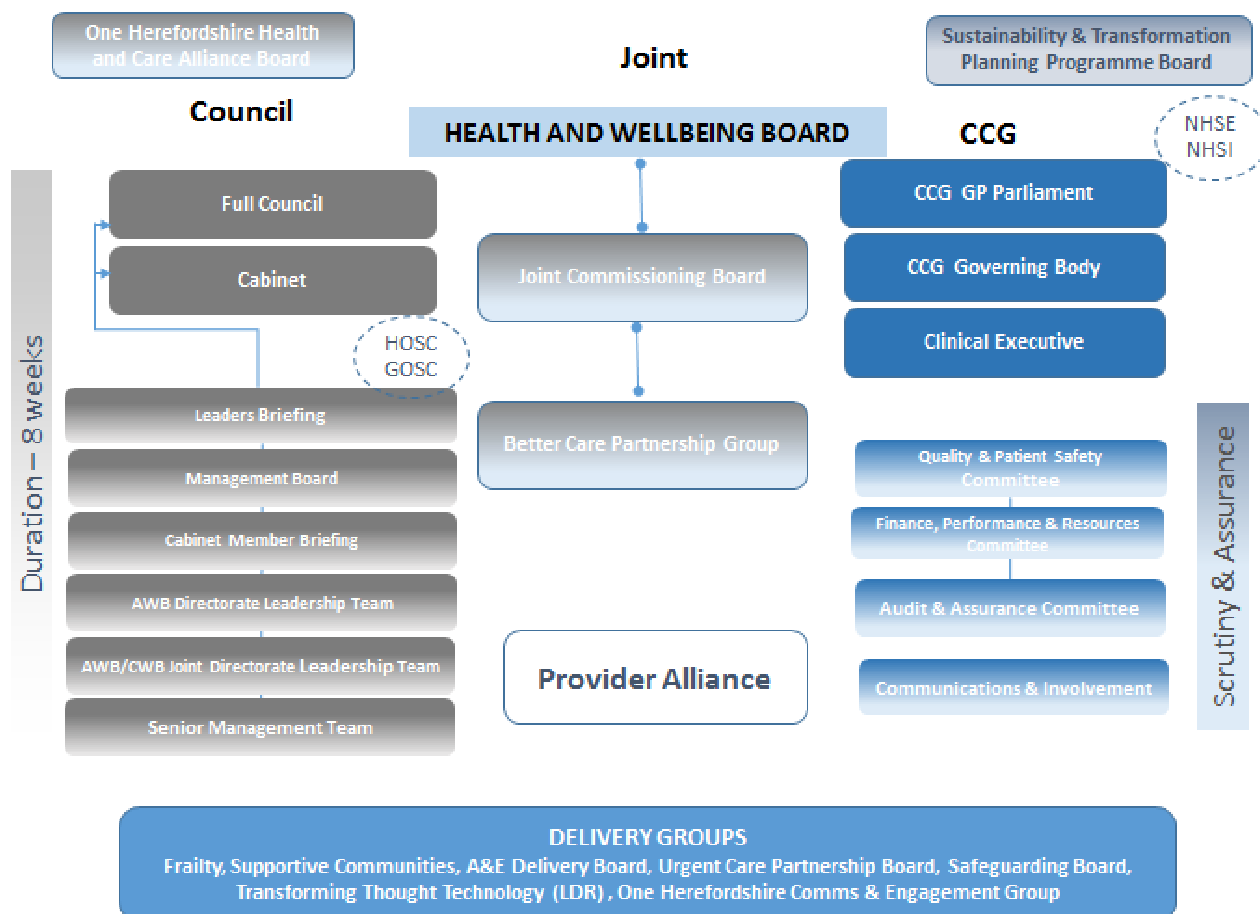
The Better Care Partnership Group (BCPG), which reports to the Joint Commissioning Group, includes representation from provider organisations and is responsible for overseeing implementation of the action plan and for the continuing review and development of the fund.

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

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

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

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



All partners are committed to equality and diversity using the Public Sector Equality Duty (Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity and foster good relations, and demonstrate that we are paying ‘due regard’ in our decision making in the design and delivery of services.

It is not envisaged that the content of this plan will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the act. This will by improving the health and wellbeing of people in

Herefordshire by enabling people to take greater control over their own health and the health of their families, and helping them to remain independent within their own homes and communities.

10. Assessment of Risk and Risk management

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

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

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

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

11. National Metrics

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

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

11.1 Non Elective Admissions (NEA)

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

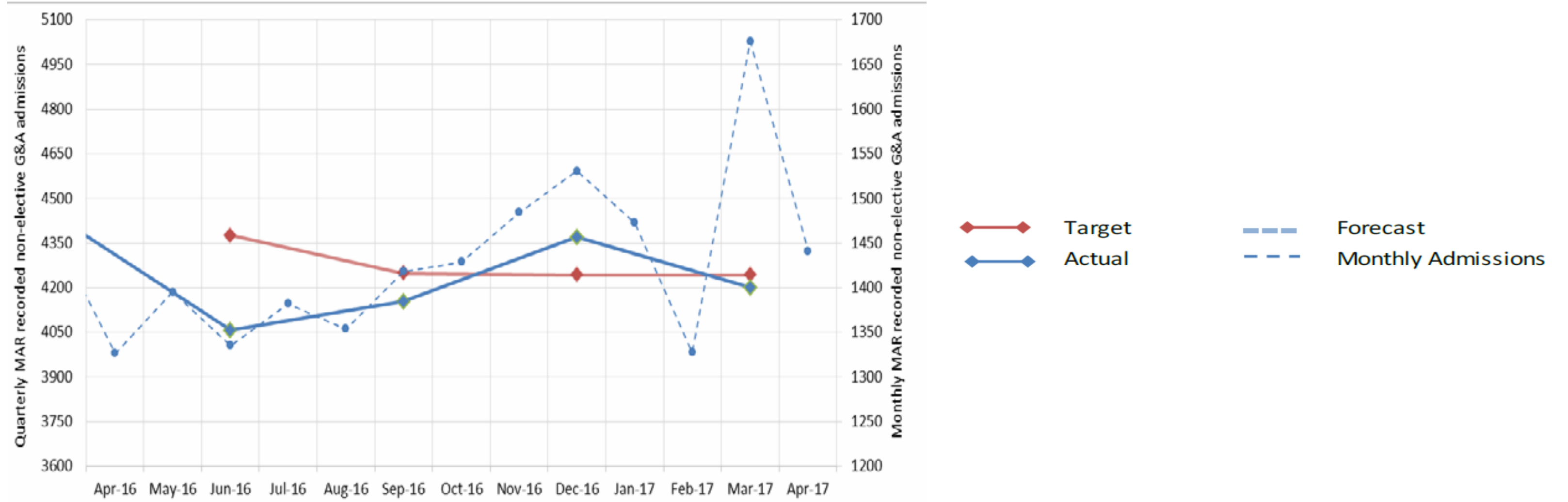
The BCF Planning Template shows an earlier version of Herefordshire's NEA plans- the figures presented above represent the most recent CCG plan submission of 30th August.

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

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

2016/17 performance

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



2017-19 target

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

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

11.2 Admissions to Residential care homes

Metric:

2016/17 target: **491.8**

2016/17 performance

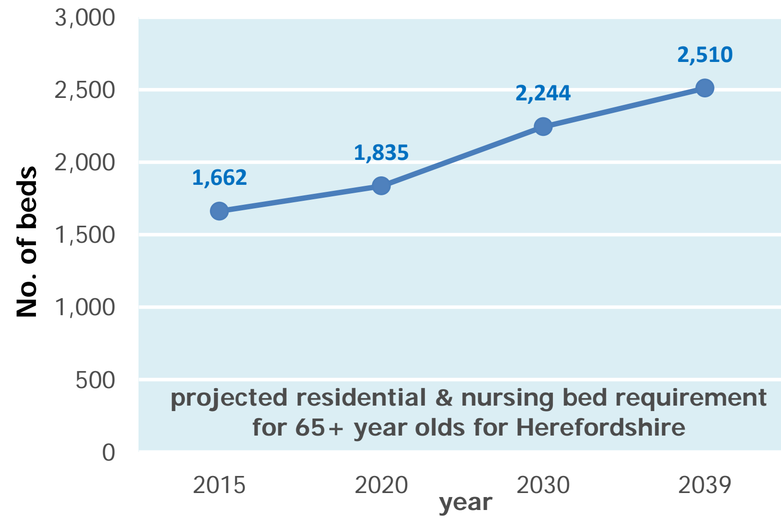
Permanent Admissions to Residential & Nursing Care													
		April	May	June	July	August	September	October	November	December	January	February	March
65+ Admissions (Month Alone)	2014/15	32	35	31	32	10	16	22	16	20	23	24	11
	2015/16	22	22	13	21	7	19	12	16	14	12	19	9
	2016/17	26	24	20	21	26	30	30	29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

2017-19 target

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

2017/18	2018/19
550.5	549.8

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



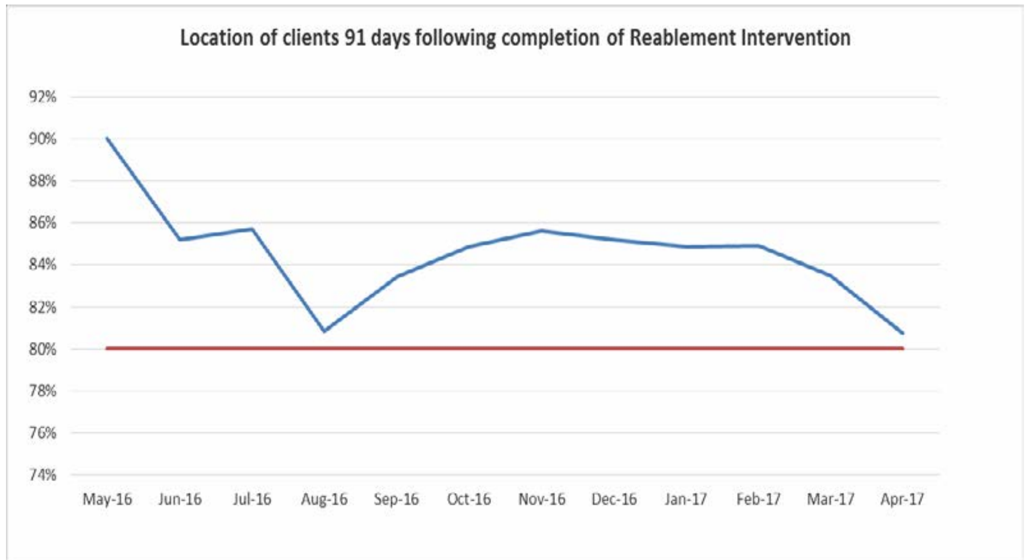
11.3 Effectiveness of Reablement

Metric:

2016/17 target	80%

2016/17 performance and update

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

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

11.4 Delayed transfers of care (DToC) plan

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

Metric:

2016/17 target

Q1	Q2	Q3	Q4
608.4	605.8	743.5	512.6

2016/17 performance and update
83

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

2017-19 target

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

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

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

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

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

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

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

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

12. Approval and sign off

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

Appendix 1 – DFG plan 2017/19

Herefordshire Disabled Facilities Grant Funding (DFG) 2017/2019

Background

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

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

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

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

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

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

DFG Funding

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

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

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

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

Key Outcomes Delivered in 2016/17

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

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

DFG plan 2017/19

DFG Outcomes expected for 2017-18:

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

discharge from 236 to 250
- Introduction of pilot project to focus on supporting people at the time of hospital discharge with wider housing related issues.

Key Objectives for 2017/18 include:

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

Appendix 2 – Herefordshire planning template submission

BCF 2017-19 Planning Template - H

Appendix 3 – Risk register

BCF risk register - v0.3 - FINAL.xlsx

Meeting:	Health and Wellbeing Board
Meeting date:	Monday 8 July 2019
Title of report:	One Herefordshire and Integration Briefing
Report by:	Director of adults and communities Director of Transformation for One Herefordshire

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

To provide an updated overview of the Sustainability and Transformation Programme (STP), One Herefordshire and Integration agenda for health and social care.

Recommendation(s)

That:

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

(b) the committee identify any items for inclusion in its future work-programme.

Alternative options

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

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

Key considerations

2. This paper and the attached background presentation provides an overview of the current plans for the Herefordshire and Worcestershire STP, One Herefordshire and the Integration plan delivered by the Better Care Fund Plan (BCF). More information on STPs, Herefordshire and Worcestershire STP, One Herefordshire and the BCF can be found on the following links:

https://www.england.nhs.uk/integratedcare/stps/faqs/

https://www.england.nhs.uk/integratedcare/stps/view-stps/herefordshire-and-worcestershire/

https://www.herefordshireccg.nhs.uk/who-we-are/publications/strategies-and-plans/sustainability-and-transformation-plan

https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

3. The evolving landscape of STPs and Integration has been cemented in the recently published NHS Long Term Plan (https://www.england.nhs.uk/long-term-plan/) where the key five themes include:

- A new service model for the 21st Century
- People will get more control over their own health and personalised care when they need it
- Local NHS organisations will increasingly focus on population health and fulfilling their duties in reducing health inequalities whilst, moving to Integrated Care Systems everywhere
- Digitally-enabled primary and outpatient care will go mainstream across the NHS
- Reducing pressure on emergency hospital services

4. The new service model for the 21st Century describes a change for General Practice, moving to Primary Care Networks (PCNs) to deliver care to a population of 30-50k. In Herefordshire this would be 5 PCNs across 4 localities (2 PCNs in Hereford city) . The plan commits funding to the networks for additional resources to support the vision to improve population health, support self-care and reduce the length of stay in hospitals by providing more support in locality areas.

5. STPs have been evolving over the past few years, and developed across Herefordshire and Worcestershire based on an NHS footprint. The next step is STPs transitioning into Integrated Care Systems (ICS) across the country by April 2021. This will involve a shift of decision making to a partnership approach across commissioners and providers, to drive integrated care delivery, better utilise resources, improve population health and reduce inequalities.

6. Key changes are also emerging for CCGs, to streamline commissioning arrangements which could typically involve a single CCG for each ICS/STP area. CCGs will become leaner and more strategic, and will support providers to partner with local authorities and other organisation on population health, inequalities and service redesign.

7. The priorities in the NHS Long Term Plan are areas we are already working, both within the Herefordshire and Worcestershire STP and the work of One Herefordshire.

8. During 2019/20 the Herefordshire and Worcestershire STP will be transitioning into the new ways of working, and developing to absorb NHSE/NHSI responsibilities as these are devolved. This includes developing partnership forums – that enable us to work through a partnership approach whilst recognising that accountability and responsibility of individual organisations won't change.

9. As part of the development of STPs into ICSs the local 'place' will need to be developed, as the NHS seeks to engage in a meaningful manner with the council and local communities to address wider wellbeing, population outcomes and inequalities. This concept of 'place' is best described as being co-terminous with Health and WellBeing Board boundaries, making One Herefordshire our local vehicle to drive this forward. This will include supporting the development of PCNs at more local level, as well as working with the council and local communities to address wider wellbeing .

10. One Herefordshire is our place based partnership, and we are currently developing our five year "integration" plan. Our vision is for Herefordshire to be a county of healthy individuals living within healthy communities:

    - Herefordshire residents will be supported and enabled to keep themselves well at home.

    - When needed they will have joined up care and support, underpinned by specialist expertise, delivered in the best place by the most appropriate people.

    - Our services will be clinically and financially sustainable, working in partnership to make best use of the 'Herefordshire pound' within the Herefordshire and Worcestershire Integrated Care System (ICS).

11. There are a number of priority areas that are being developed within One Herefordshire for the next two years and these are:

Year 1 Priorities

- Community resilience
- Integrated Primary, Community and Mental Health services
- Urgent Care, including Frailty, Dementia and End of Life
- Elective Care: musculoskeletal, Ophthalmology, Dermatology and Outpatient redesign
- Digital and population health management

Year 2 Priorities

- Prevention
- Psychological interventions
- Complex mental health needs
- Back office and infrastructure
- Estates

12. The Better Care Fund and Integration plan is an integral part to the delivery of the One Herefordshire programme. The plan was refreshed last year to provide an overview of the key areas of focus for partners. The 2019/20 national guidance is yet to be published, however the national framework is available for the BCF which explains that 2019/20 will

be a transition year where the BCF will be reviewed and full details expected for 2020 and beyond later in the year.

13. The quarterly performance report for BCF shows that delayed transfers of care (DToC) and the urgent care system remains a challenge for health and social care, this includes providing the appropriate level of support to keep people at home and admissions into care homes, which is an area the committee could consider in the future work plan.

14. The adults and wellbeing scrutiny committee considered these reports at the 24 June meeting, the recommendations arising in relation to the proposed CCG merger are in appendix 3.

Community impact

15. The changes described are aligned and integral to delivering the NHS Long Term Plan and by providing services at a locality level also supports the local authorities corporate objective to 'enable residents to live safe, healthy and independent lives.'

16. The plans are intended to move our health and social care system to a new service model in which patients get more options, better support and properly joined up care at the right time in the optimal care setting will support communities to remain within their own homes and reduce the need for hospitalisation and long term care. This will support our objectives of building community resilience and tackling health inequalities.

17. One Herefordshire recognises 'Talk Community', the community plan that the Adults and Communities Directorate, as a critical underpinning component of One Herefordshire and its 5 year strategy. It will support One Herefordshire partners in improving wider wellbeing and population outcomes, as well as addressing their statutory duties around health inequalities. Citizens have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community."

Equality duty

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

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

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

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

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

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

that we are paying ‘due regard’ in our decision making in the design of policies and in the delivery of services. The STP is developing a more joined up approach to its equality duties, and has an STP equality work stream which is developing a robust and uniform approach to equality impact assessment across Herefordshire and Worcestershire.

20. 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.

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

22. The 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 homes and communities. There are no negative impacts for looked after children or with respect to the council’s corporate parenting role.

Resource implications

23. The One Herefordshire 5 year ‘integration’ plan is currently in development, and will demonstrate how we will work to collectively use our resources more efficiently.

24. The BCF is considered within this programme of work however the guidance has yet to be published for 2019/20 and the BCF has clear national conditions and metrics on the funding and allocations of the budget.

25. Additional funding has been committed by the Department of Health to support the development of the PCN’s, increasing resources across the networks for a number of professional roles.

Legal implications

26. Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. The board will carry out the statutory functions as required by the Health and Social Care Act 2012, and any other functions delegated to it, as set out in part 3 section 5 of Herefordshire Council’s constitution.

27. There are no specific legal implications in the recommendations of the report.

Risk management

28. There are a number of risks associated with the changes described and these will be managed through the One Herefordshire Executive body (the One Herefordshire Health and Care Partnership), the Integrated Care Alliance Board and within the council via the directorate and/or corporate risk register.

29.

Risk / opportunity	Mitigation
STP and NHS undertaking timely and appropriate engagement with stakeholders and key partners on key issues. Often due to conflicting priorities this can result in limited time for consultation/engagement on key issues.	Where possible the local transformational programme and timescales is being carefully scoped to ensure full engagement/consultation is undertaken.
The STP focusses on a Herefordshire and Worcestershire integrated care system model rather than placed based solutions.	Development of the place based model through One Herefordshire will ensure that local people continue to receive the appropriate level of care. It will also ensure care is more joined up for service users, and that we are supporting prevention and wider wellbeing .
Unable to recruit to the planned posts to deliver the PCN model, in the context of local and national workforce challenges.	Recruitment campaign is underway and this will continue until posts are filled. Portfolio careers and shared roles across organisations will support recruitment.
Planning guidance for the BCF is delayed further resulting in lack of assurance of future funding and uncertainty of the future programme and funding for BCF	Council officers continue to work with local health partners to develop a local health and social care integration plan to mitigate where possible.

Consultees

30. There is a national requirement to engage with the public and stakeholders on the NHS Long Term Plan. The engagement process is set out to seek views and comments on the local priority areas in the LTP. Engagement activity, face-to-face and through online survey is ongoing and is being undertaken by Healthwatch Herefordshire (on behalf of Healthwatch Herefordshire and Worcestershire) and STP engagement teams. See appendix two for details of engagement activity to 30 April 2019. All feedback will be published on the STP website in July/August 2019 and scrutiny is asked to consider how they would like to use the information to inform their work

31. There has not been a need to undertake consultation on this paper as there are no specific service change proposals to be consulted on. Any changes resulting from implementation of specific areas of the presentation will be consulted on fully with the Council and other key stakeholders.

Appendices

Appendix one – presentation

Appendix two – STP-LTP engagement summary

Appendix three – Adults and Wellbeing Scrutiny Committee recommendations

Background papers

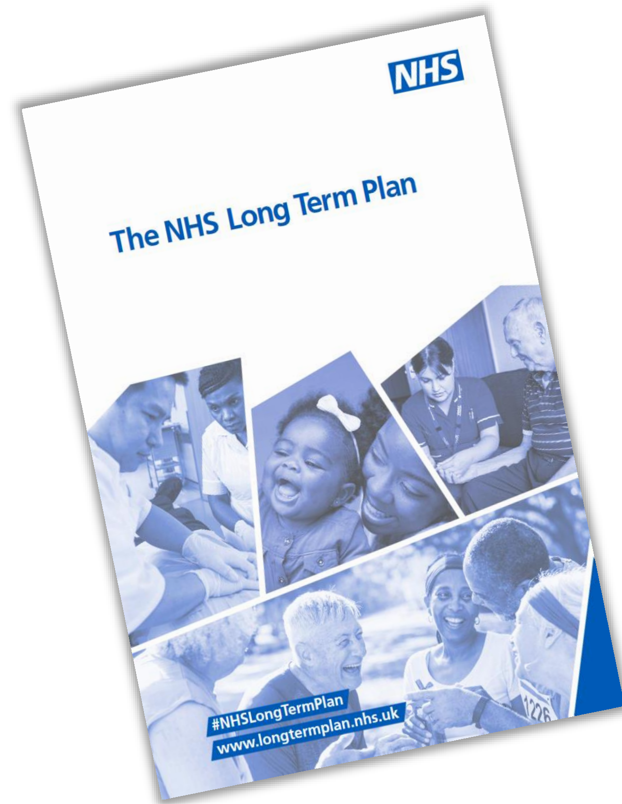
None

The NHS Long Term Plan Integrated Care Systems and One Herefordshire

Herefordshire Health and WellBeing Board

8th July 2019

The NHS Long Term Plan



The NHS Long Term Plan

- Main themes -
  1. 'Local NHS organisations will increasingly focus on population health and reduction of inequalities, moving to Integrated Care Systems everywhere'
  2. 'People will get more control over their own health and personalised care when they need it'
  3. 'Digitally-enabled primary and outpatient care will go mainstream across the NHS' – avoiding a third of face to face outpatient appts within 5 years
  4. 'A new service model for the 21st Century' – breaking down the divide between primary and community services and reducing pressure on emergency hospital services'
  5. Changes for General Practice - Primary Care Networks (PCNs) for 30-50k population – working with other providers at locality level

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Integrated Care Systems (ICSs)

- Evolution of STPs - ICSs to cover the whole country by April 2021

  'Commissioners will make shared decisions with providers on how to use resources, design services and improve population health'

- Streamlined commissioning arrangements:
  - 'typically involving a single CCG for each ICS/STP area'
  - 'CCGs will become leaner, more strategic organisation'
  - CCGs will support providers to partner with local government and other organisations on population health, inequalities and service redesign. This is their role 'at place'

- 'Funding flows and contract reform will support the move to ICSs'
  - Local alliance contracts or giving one provider lead responsibility
  - 'we expect [these] contracts would be held by public statutory bodies'

- Full review of the Better Care Fund concluding in early 2019

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NHS Action on Prevention

- ‘the NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+’
- New targeted NHS funded smoking cessation offer
- ‘hospitals with the highest rate of alcohol dependence-related admissions will be supported to establish Alcohol Care Teams’
- Reduce the NHS carbon footprint by 20% with less travelling
- Mental health ambulance transport vehicles that reduce inappropriate conveyance

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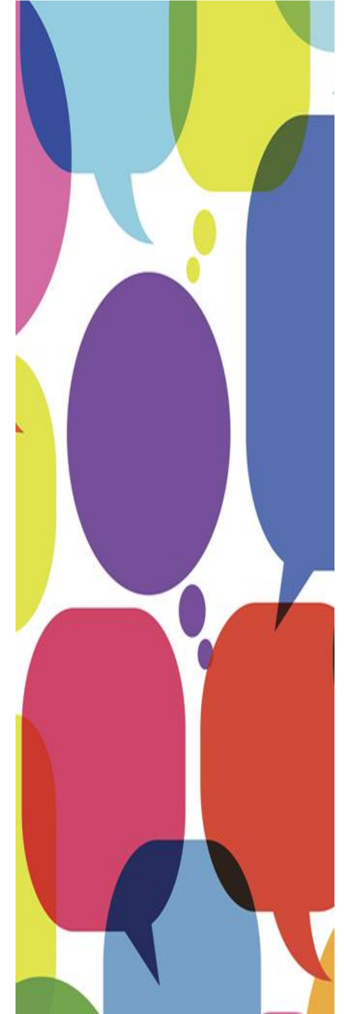
Stakeholder engagement

- Long Term Plan presents opportunity for wider staff and stakeholder engagement on our local priorities
- Activity will build upon engagement carried out in 2016 which informed the development of the Herefordshire and Worcestershire STP plan
- Focus on system-wide interpretation of Long Term Plan across our local health and care systems and what it might mean for residents
- Working very closely with Healthwatch who will support this engagement by targeting ‘hard to reach’ areas of our communities to ensure voices are heard at all levels
- Views will inform the development of our local Long Term Plan for Herefordshire and Worcestershire



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Questions?

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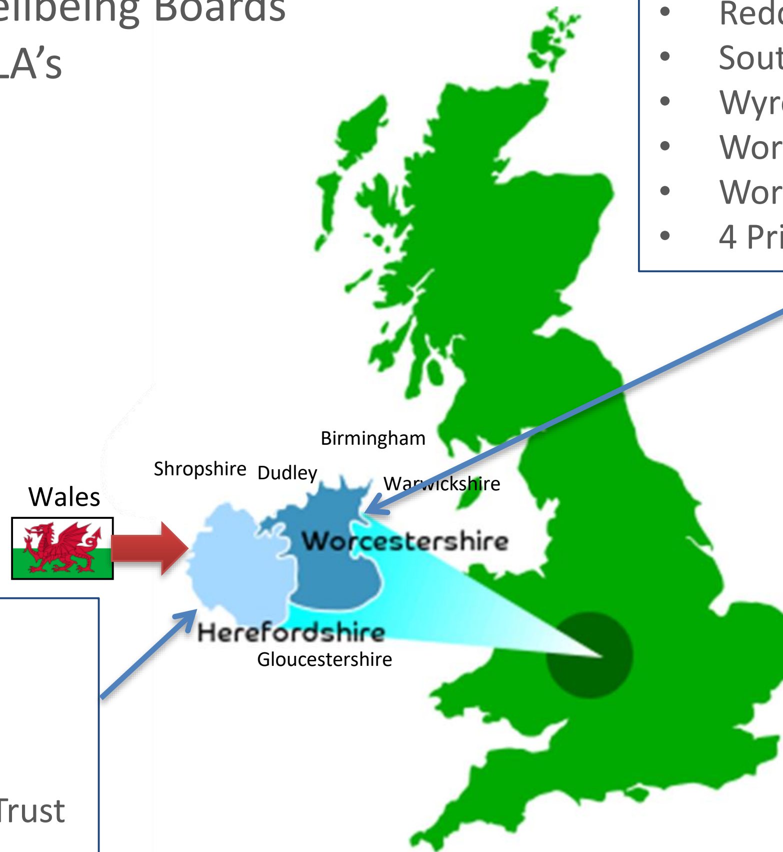
HEREFORDSHIRE AND WORCESTERSHIRE INTEGRATED CARE SYSTEM (ICS) DEVELOPMENT

Herefordshire and Worcestershire STP

- Big geography, small population - Rurality
- 785,000 people (smallest in West Midlands)
- Two Health and Wellbeing Boards
- Coterminous with LA's

- Worcestershire County Council
- Redditch and Bromsgrove CCG
- South Worcestershire CCG
- Wyre Forest CCG
- Worcestershire Acute Hospitals NHS Trust
- Worcestershire Health and Care NHS Trust
- 4 Primary Care Collaborations



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'One Herefordshire'

- Herefordshire Council
- Herefordshire CCG
- Wye Valley NHS Trust
- 2gether NHS Foundation Trust
- Taurus GP Federation

H&W STP Vision

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

From

Through our integrated approach

To

A system too reliant on emergency access and beds where people believe that hospital is the best place to be when you are unwell

Invest in primary, community and mental health services

Improve resilience, capacity and sustainability of general practice

Put prevention, self care and personal resilience at the heart of our plans

Reduce pressure on hospital beds and slow the loss of independence

Use our capacity better across all key services

Reduce unwarranted variation across primary and secondary care

Reduce the volume of work that has limited clinical benefit or marginal return

Improve health outcomes and support independence for longer

Improve access and performance by better use of capacity

Return the system to financial balance

A system that is built around care close to home, where hospital beds are only used where somebody cannot be cared for safely in their own environment

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Building on our ICS Commitment Statement

STP partner organisations signed our ICS Commitment statement during 2018, this provides a platform for us to build on whilst developing our shadow ICS, key principles included in this are ;

We recognise that strong system leadership including the active involvement of our clinical leaders is crucial to our success.

We will adopt a unitary approach to seeing through difficult decisions once we have collectively agreed them.

It is recognised that the changes above will impact on the current partner organisations. We are however committed to putting local people before organisations.

Our shadow ICS Board whereby the local health and care system will work collaboratively to plan and deliver needs assessed, health and social care for our population.

We will be ambitious in our timelines to progress this agenda in accordance with national requirements. We will work together at pace to challenge ourselves and each other to deliver our aims.

Integrated Care Systems (ICS)

- What is an ICS:
  - Commissioners and Providers making shared decisions
  - Optimising resource use to redesign services around service users (integrated care)
  - Working in partnership with Local Authorities and other key partners
  - Focusing on improvements in population health and wider wellbeing, and the reduction of inequalities

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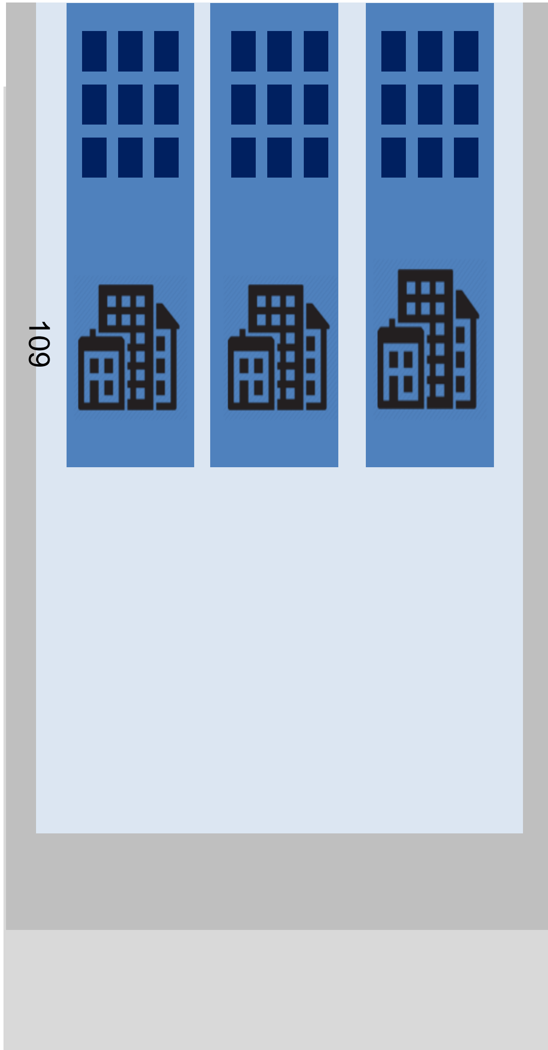
(Work In Progress) The Tiers in an ICS

NHS



Neighbourhood (PCN)

~50k

- Integrated multi-disciplinary teams
- Strengthened primary care through PCNs – working across practices and health and social care
- Proactive role in population heath and prevention
- Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).

Place

~250k

- Typically council/borough level
- Integration of hospital, council and primary care teams / services
- Develop new provider models for 'anticipatory' care
- Models for out of hospital care around specialties and for hospital discharge and admission avoidance

System-wide

~1m

- System strategy & planning
- Develop governance and accountability arrangements across system
- Implement strategic change
- Manage performance and collective financial resources
- Identify and share best practice across the system; to reduce unwarranted variation in care / outcomes

Hereford and Worcestershire STP/Emerging ICS 19/20 As a Transition Year

- STP and ICS infrastructure will be developed to absorb NHSE/NHSI responsibilities as these are devolved

- Developing partnership forums – but the accountability and responsibility of individuals won't change

- Developing 'place' – partnership with Local Authorities and Providers

- Developing PCNs with system partners

- This is a journey, not all areas of the operating model will go live in April 2019

Emerging ICS Operating Model

Partnership

Herefordshire Health and Wellbeing Board

Worcestershire Health and Wellbeing Board

ICS Partnership Board
Forum for joint discussions, partnership work & consensus building

Decision making

4 CCGs Joint Commissioning Committee in Common
Strategic commissioning/system management decision making

ICS Executive
Executive decision making and oversight group

Managing the business

ICS Financial Leadership Forum
System wide financial recovery and cost out/ delivery of system control total as per MOU

Clinical Strategy Group
leads clinical strategy

ICS Quality Forum
System wide quality monitoring, merging existing CCG & Trust quality monitoring groups

ICS System Performance Forum
Proactively monitors & reports system performance issues

‘PLACE’
ONE HEREFORDSHIRE INTEGRATION

Hereford and Worcestershire
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One Herefordshire

- Our ‘Place Based’ Integration Plan – within the Herefordshire and Worcestershire ICS
- Herefordshire Partners ‘Whole System Plan’
- ‘Functional Integration’:
  - Integrating at the point of delivery
  - Looking for shared efficiencies
  - Not about Shifting Risk
- This is a 5 Year Plan

Herefordshire and Worcestershire Safe and effective health and care services

One Herefordshire: Our Vision

Our vision is for Herefordshire to be a county of healthy individuals living within healthy communities:

- Herefordshire residents will be supported and enabled to keep themselves well at home.
- When needed they will have joined up care, underpinned by specialist expertise, delivered in the best place by the most appropriate people.
- Our services will be clinically and financially sustainable, working in partnership to make best use of the 'Herefordshire pound' within the Herefordshire and Worcestershire Integrated Care System (ICS).

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Place: Why Is It Important

- National Attention on ICSs and PCNs
  - Place - The 'Bit in the Middle'

- The 'Delivery Mechanism' for ICSs
  - Links with Local Authorities and wider wellbeing
  - Mechanism for engaging with local government and local politicians
  - Delivery of Integrated Care across organisations
  - Critical enabler for PCN delivery

- The Aim of Place:
  - Prevention and population health – improving outcomes and reducing inequalities
  - Improved quality and performance
  - Financial efficiency

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A (DRAFT) Working Definition of 'Place'

- The concept of 'Place' is about a move away from operating as individual organisations, to convening around a defined population.

- This is about behaving as a system, and being able to engage meaningfully with local authorities and other partners around integration and wider wellbeing for a defined population.

- It does need to recognise LA level identity, in order to address the wider wellbeing and prevention agendas, but also to be able to demonstrate alignment to local accountability through local authorities – in some areas district but in others borough level. (it may straddle STP boundaries).

- At the heart of place is the operational delivery of integrated care models, across PCNs, community (health and mental health) and acute services, integrating with local authority and even wider public sector services.

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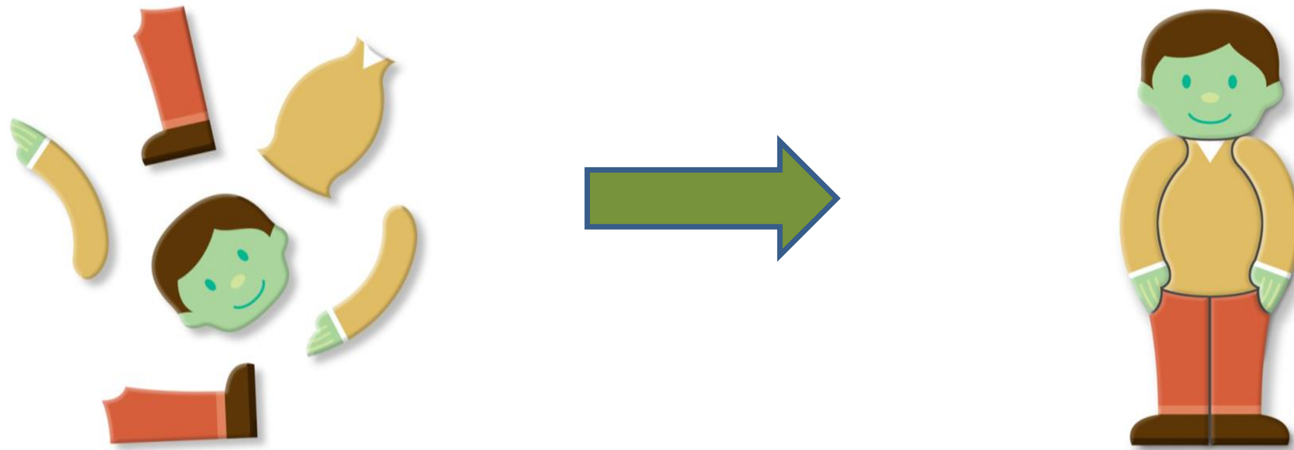
Integration at Place



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Building on Engagement
What Local People Have Told Us About Integrated Care

Me

Care Navigation

Help me to know what's available locally

And across the wider system

1 Care Plan

Developed with me

Help me to help myself

And my carer....

1 point of contact

Especially in crisis

1 team working together

Including my specialists

Our Strategy – Delivering Our Vision

- We will embed prevention into all our work:
  - Providing a 'healthy environment'; linking with public sector and wider partners on policy and planning for housing, transport, education, economic regeneration etc to shape a 'healthy place'
  - Ensuring our locality/emerging primary care networks are focused on prevention, through proactive anticipatory care and a strengths based approach to support self-management, as well as targeted health improvement activities
  - Re-energising 'making every contact count' (MECC), to systematically address lifestyle behaviours
  - Integrating community resilience into our models, as well as working with the voluntary and community sector around key priorities

- We will deliver the NHS 'Triple Integration', of health and mental health; primary and specialist care; and health and social care:
  - Developing locality working based around PCNs and 'whole pathways of care'
  - Redesigning our governance and operating models, driving seamless working across organisational boundaries
  - Creating 'joined up services' for patients, at the same time reducing duplication and improving system efficiency

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Our Strategy – Delivering Our Vision

- We will redesign our clinical and operating models to:
  - Support people to live well at home, on the principle that 'own bed is best'
  - Support the local delivery of acute (health and mental health) services as close to home as possible, working with neighbouring providers to develop sustainable collaborative services
- We will redesign our infrastructure to support our care models:
  - Integrating our back office and support functions to provide economies of scale
  - Utilising technological innovations to deliver improved care and efficiencies
  - Becoming an 'intelligence led system' – developing our strategy, care models and services on population need and evidence of best practice through a population health management approach
- We will embed the STP People's Strategy – valuing and developing our workforce to provide clinical and social care sustainability as well as improving financial efficiency:
  - Improving recruitment and retention
  - Embracing the multidisciplinary team approach and developing new roles across specialties and professions

Herefordshire and Worcestershire
Safe and effective health and care services

Herefordshire Council

INTEGRATED CARE IN HEREFORDSHIRE

NHS

QUALITY IMPROVEMENT

INTEGRATION

STRATEGIC PRINCIPLES

Resilient Communities

Helping People Live Healthier for Longer

'Home First' Mind Set

Technology Enabled

Engaged, Passionate & Capable Workforce

Efficient & Financially Resilient

Well Led

Innovative

Urgent GP Services

Ambulance Services

Integrated Community Teams

24/7

Urgent Care

Specialist Care

HOSPITALS

HELPING YOU TO HELP YOURSELF

SCHOOLS

Reablement & Recovery

Residential and Domiciliary Care

Children, Young People & Family Services

Maternity Services

Health

Wellbeing

Prevention

GPs

Mental Health Services

Charities & Volunteers

Social Care

Education

Public Health

PARTNERSHIPS

Primary Care Networks

Herefordshire Council

Wye Valley NHS Trust

2gether NHS FT

St Michael's Hospice

Taurus Health Care

SUSTAINABILITY

WORKFORCE AND LEADERSHIP

PUBLIC AND PATIENT ENGAGEMENT

Wye Valley NHS Trust • 2gether NHS FT

Herefordshire Clinical Commissioning Group

Our Priority Areas

Year 1 Priorities
Community Resilience – Talk Community
Integrated Primary, Community, Mental Health and Social Care Services
Urgent Care, including Frailty, Dementia and End of Life
Elective Care: MSK, Opthalmology, Dermatology and Outpatient Redesign
Digital and Population Health Management

Year 2 Priorities
Prevention
Psychological Interventions
Complex Mental Health Needs
Back Office and Infrastructure
Estates

Herefordshire and Worcestershire
Safe and effective health and care services

The Better Care Fund

- BCF and Integration plan 2019/20 approved and refreshed last year

- Awaiting guidance for 2019/20 – expected mid June – July, with this being a transition/review year

- Could be changes for 2020/21 depending on review

- Key deliverables and schemes:

➢ Integrated hospital function

➢ Alignment of Homefirst and Hospital at Home

➢ Integrated care home quality team

➢ Digital solution for integrated working

➢ Increased funding in urgent care and care home market

Herefordshire and Worcestershire Safe and effective health and care services

Questions?

Herefordshire and Worcestershire
Safe and effective health and care services

Herefordshire STP/LTP engagement activity update January-April 2019

Engagement activity is currently ongoing and being undertaken by Healthwatch Herefordshire (on behalf of Healthwatch Herefordshire and Worcestershire) and STP engagement teams. Engagement will be completed and reports submitted to STP Boards in July. Below is the activity update to April 2019.

1. **Online Survey**

   An online survey was launched in March at www.yourconversationhw.nhs.uk across both counties to gather feedback on eight topics as outlined in the LTP. It is being promoted by all STP partners online, and at face to face community groups and events until the end of May 2019. Responses to survey as at 30 April 2019: 236

2. **Face to face engagement**

   Face to face engagement March-30 April 2019:

Stakeholders	Audience	Number of people	Dates
Partner staff events (HCCG, 2g, WVT)	All NHS partners	All through regular face to face briefings and electronic bulletins	Jan 2019
Wye Valley Trust Stakeholder Forum	Wye Valley NHS Trust	18	28.03.19
*Children's wellbeing networking event	Professionals who work with children across a range of statutory, private and voluntary and community sectors	45	26.03.19
*Ledbury community health event	Older people, PPG members, councillors and community volunteers	28	26.03.19
*Carers in Mind	Carers of people with mental health conditions	10	06.03.19
*Mental health forum	Mental health service users & Carers of people with mental health conditions	11	02.04.19
*Yarpole community	Over 65's	15	19.03.18
*Deaf Direct	Hearing impaired service users	13	03.04.19
*Our news our views	Learning disability service users	5	28.03.19
*Tea potters Moreton on Lugg March	Over 65's	10	27.03.19

*Undertaken by Herefordshire Healthwatch

Recommendations:

1. The committee would like to see benchmarking and performance/delivery data (as set out in the Draft Operational Plan 2019/20) brought back to this committee in 12 months’ time; exploring current and future commissioning outcomes, including tracking of the amount and spend in each of the four CCG footprint areas

2. The committee recommends that the CCG are invited back in April 2020 to outline their detailed funding and implementation plans for the proposed new CCG footprint.

3. The committee would like to see built in to the new arrangements the commitment to keep a Herefordshire office presence in the new future single footprint area.

4. The committee welcomes and would expect to see Herefordshire place based clinical and lay representation at the appropriate level within the new CCG administration.

5. The committee recommends that when there is significant variations of service delivery, including significant financial changes, the appropriate scrutiny committee is consulted and given adequate time to review these changes.