Agenda

Health and wellbeing board

Date:	**Monday 6 December 2021**
Time:	**2.30 pm**
Place:	**Herefordshire Council Offices, Plough Lane, Hereford, HR4 0LE**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Democratic Services** Tel: 01432 261699 Email: governancesupportteam@herefordshire.gov.uk

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Agenda for the Meeting of the Health and wellbeing board

Membership

Chairperson	Councillor Pauline Crockett	Cabinet Member, Health and Adult Wellbeing
Vice-Chairperson	Dr Ian Tait	Chair of NHS Herefordshire and Worcestershire Clinical Commissioning Group
	Darryl Freeman	Corporate Director for Children and Young People
	Hayley Allison / Julie Grant	Assistant Director of Strategic Transformation / Head of Delivery and Improvement at NHS Improvement, NHS England
	Dr Mike Hearne	Managing Director, Taurus Healthcare
	Councillor David Hitchiner	Leader of the Council, Herefordshire Council
	Rebecca Howell-Jones	Acting director of public health , Herefordshire Council
	Jane Ives	Managing Director, Wye Valley NHS Trust
	Ivan Powell	Chair of the Herefordshire Safeguarding Adults Board
	Christine Price	Chair of Healthwatch, Herefordshire
	Jonathon Pryce	Chief Fire Officer, Hereford & Worcester Fire and Rescue Service
	Paul Smith	Acting Director for Adults and Communities, Herefordshire Council
	Dr Ian Tait	Chair of NHS Herefordshire and Worcestershire Clinical Commissioning Group
	Neil Taylor	Interim Director for Economy and Place
	Councillor Diana Toynbee	Cabinet Member for Children and families, Herefordshire Council
	Simon Trickett	Chief Executive/STP ICS Lead, NHS Herefordshire and Worcestershire CCG
	Councillor Ange Tyler	Herefordshire Community Safety Partnership / Cabinet member housing, regulatory services, and community safety
	Superintendent Edd Williams	Superintendent for Herefordshire, West Mercia Police
	Mark Yates	Chair of Herefordshire and Worcestershire Health and Care NHS Trust

Agenda

Pages

THE PUBLIC'S RIGHTS TO INFORMATION AND ATTENDANCE AT MEETINGS 5 - 8

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 in respect of schedule 1, schedule 2 or other interests from members of the board in respect of items on the agenda.

4. MINUTES 9 - 16

To approve and sign the minutes of the meeting held on Monday 26 July 2021.

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 30 November 2021 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 30 November 2021 at 5.00 pm, unless the question relates to an urgent matter.

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

7. HEREFORDSHIRE SAFEGUARDING CHILDREN PARTNERSHIP REPORT TO HWBB RE CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND SUICIDE DURING 2020 17 - 32

For the Health and Wellbeing Board (HWBB) to consider the report at appendix 1 by the Herefordshire Safeguarding Childrens Partnership (HSCP).

8. COUNTYWIDE APPROACH TO BECOME A SUSTAINABLE FOOD PLACE 33 - 46

The purpose of this report is to inform and gain support from Health and Wellbeing Board on a county-wide approach to becoming a Sustainable Food Place, and on the Food Vision for Herefordshire developed by Herefordshire Food Alliance.

9. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2021 47 - 114

To approve the summary of the 2021 Joint Strategic Needs Assessment (JSNA) for Herefordshire.

10. HEREFORDSHIRE AND WORCESTERSHIRE MENTAL HEALTH AND WELLBEING STRATEGY 115 - 214

To review and endorse the draft Herefordshire and Worcestershire Mental Health Strategy.

11. HEREFORDSHIRE'S BETTER CARE FUND (BCF) AND INTEGRATION PLAN 2021-22 215 - 300

To approve Herefordshire's Better Care Fund (BCF) plan 2021-22.

12. DATE OF NEXT MEETING

The next scheduled meeting is Monday 28 March 2022.

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In view of the continued prevalence of covid-19, we have introduced changes to our usual procedures for accessing public meetings. These will help to keep our councillors, staff and members of the public safe.

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We will review and update this guidance in line with Government advice and restrictions. Thank you for your help in keeping Herefordshire Council meetings safe.

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- Attend all Council, Cabinet, Committee and Sub-Committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.
- Inspect agenda and public reports at least five clear days before the date of the meeting. Agenda and reports (relating to items to be considered in public) are available at www.herefordshire.gov.uk/meetings
- Inspect minutes of the Council and all committees and sub-committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
- Access to a public register stating the names, addresses and wards of all Councillors with details of the membership of Cabinet and of all Committees and Sub-Committees. Information about councillors is available at www.herefordshire.gov.uk/councillors
- Have access to a list specifying those powers on which the Council have delegated decision making to their officers identifying the officers concerned by title. Information about councillors is available at www.herefordshire.gov.uk/councillors
- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage).
- Access to this summary of your rights as members of the public to attend meetings of the Council, Cabinet, Committees and Sub-Committees and to inspect and copy documents.

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The location of the office and details of city bus services can be viewed at:
http://www.herefordshire.gov.uk/downloads/file/1597/hereford-city-bus-map-local-services-

The Seven Principles of Public Life

(Nolan Principles)

1. **Selflessness**

   Holders of public office should act solely in terms of the public interest.

2. **Integrity**

   Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. **Objectivity**

   Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. **Accountability**

   Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. **Openness**

   Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. **Honesty**

   Holders of public office should be truthful.

7. **Leadership**

   Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Minutes of the meeting of Health and wellbeing board held at Three Counties Hotel, Belmont Road, Belmont, Hereford, HR2 7BP on Monday 26 July 2021 at 2.30 pm

Members	Rebecca Howell-Jones	Acting director of public health , Herefordshire Council
	Councillor Felicity Norman	Cabinet member - young people's education and attainment
	Paul Smith	Acting Director for Adults and Communities, Herefordshire Council
	Dr Ian Tait (Vice-chairperson)	Chair of NHS Herefordshire and Worcestershire Clinical Commissioning Group
	Councillor Diana Toynbee	Cabinet Member for Children's Services, Safeguarding and Corporate Parenting, Herefordshire Council

In attendance:	Ewen Archibald	Interim Assistant Director, All Ages Commissioning	
	Ben Baugh	Democratic services officer	
	John Coleman	Democratic services manager	
	Kate Coughtrie	Deputy solicitor to the council	
	Anna Davidson	Assistant Director (Prevention), Hereford & Worcester Fire and Rescue Service	Via Zoom
	Sarah Duggan	Chief Executive, Herefordshire and Worcestershire Health and Care NHS Trust	Via Zoom
	Marie Gallagher	Project Manager, Adults and Wellbeing	Via Zoom
	Adrian Griffiths	Finance business partner and joint strategic finance lead for the council and CCG	Via Zoom
	Dr Mike Hearne	Managing Director, Taurus Healthcare	Via Zoom
	Councillor David Hitchiner	Leader of the Council, Herefordshire Council	Via Zoom
	Jane Ives	Managing Director, Wye Valley NHS Trust	Via Zoom
	David Mehaffey	Director of ICS Development, NHS Herefordshire and Worcestershire CCG	Via Zoom
	Amy Pitt	Assistant director Talk Community programme	Via Zoom
	Jenny Preece	Democratic services officer	
	Rachael Skinner	Associate Director of Nursing and Quality, NHS Herefordshire and Worcestershire CCG	Via Zoom
	Ian Stead	Chair of Healthwatch, Herefordshire	Via Zoom

Councillor Elissa Swinglehurst	Chairperson of adults and wellbeing scrutiny committee	Via Zoom
Supt Edd Williams	Superintendent for Herefordshire, West Mercia Police	Via Zoom

1. APPOINTMENT OF VICE-CHAIRPERSON

The council's constitution required that one of the board members representing NHS Herefordshire and Worcestershire Clinical Commissioning Group be appointed vice-chairperson annually by the board. Dr Ian Tait was nominated as the vice-chairperson.

Resolved: That Dr Ian Tait be appointed vice-chairperson of the board for the remainder of the municipal year.

2. APOLOGIES FOR ABSENCE

Apologies for absence had been received from: Cllr Crockett (Chair of the board), Cllr Tyler (Herefordshire Community Safety Partnership), Chief Fire Officer Jonathon Pryce (Hereford & Worcester Fire and Rescue Service), Simon Trickett (NHS Herefordshire and Worcestershire CCG), Mark Yates (Herefordshire and Worcestershire Health and Care NHS Trust), Julie Grant / Hayley Allison (NHS England and NHS Improvement) and Mandy Appleby, Richard Ball, and Neil Taylor (Hereford Council)

3. NAMED SUBSTITUTES (IF ANY)

The following named substitutes were present: Cllr Norman for Cllr Crockett (Hereford Council).

The following named substitutes were in attendance virtually and therefore were able to participate in the debate but not cast a vote:
Anna Davidson for Chief Fire Officer Jonathon Pryce (Hereford & Worcester Fire and Rescue Service). David Mehaffey for Simon Trickett (NHS Herefordshire and Worcestershire CCG) and Sarah Duggan for Mark Yates (Herefordshire and Worcestershire Health and Care NHS Trust).

4. DECLARATIONS OF INTEREST

Dr Ian Tait reminded the board that he was a member of Worcestershire's health and well-being board.

Sarah Duggan representing the Herefordshire and Worcestershire Health and Care NHS Trust registered she was also a member of Worcestershire's health and well-being board.

5. MINUTES

The minutes of the previous meeting were received.

Resolved: That the minutes of the meeting held on 8 March 2021 be approved and be signed by the chairperson.

6. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been received from members of the public.

7. QUESTIONS FROM COUNCILLORS (Pages 9 - 10)

Questions received and responses given are attached as appendix to the minutes.

8. HEREFORDSHIRE AND WORCESTERSHIRE LEARNING FROM LIVES AND DEATHS- PEOPLE WITH LEARNING DISABILITY (HW LEDER) ANNUAL REPORT 2020/21

The Associate Director of Nursing and Quality (ADNQ), NHS Herefordshire and Worcestershire CCG, introduced the annual report, the principal points of the presentation included:

- The report reflects the past 12 months and how the Covid19 Pandemic has impacted on people with learning difficulties. Herefordshire has been in a strong position where it was reported that no single confirmed Covid related death for somebody with a learning disability has been registered.

- The report reflects the third full year of data for Herefordshire and Worcester and for the first year provides clear understanding of the context for people living in Herefordshire compared to other areas. This has given some helpful reflections in particular: The mean age of death for Men is significantly better than the England average. The percentage of younger people, particular those aged 24 and younger with a learning disability who die within Herefordshire is better than the England average.

- The programme is a quality improvement program and is founded in listening to and working with experts with lived experience in local communities to understand their perspective.

- The priorities highlighted in the annual report will be taken in to a strategy which is required to be produced by March 2022, it will be a three year strategy and will provide much more details of how we are collectively working together to improve outcomes for people.

Board members were invited to comment, the principal points included:

- It was queried where links could be made in terms of social care for people with learning difficulties. One of the priorities in the report focused on obesity along with mental health and the prospect of combining this with opportunities to exercise, walking etc. was raised. The example was given of a programme in Leominster "Walking for Health programme" for people for learning.

The ADNQ explained that the strategy would go into much more detail in terms of how priorities were taken forward. A Learning action group existed represented by all agencies, from health and social care, public health, family carers and people with lived experience. The group reviewed themes as they arose and discussed how best priorities can be taken forward, address best practices, identify gaps and propose solutions.

- It was noted that Health Watch supported the document and were closely involved in groups looking at the right kind of investment into the future.

- It was queried whether work was ongoing with hospices and if the service had enough resources to do everything they wanted to do.

The ADNQ confirmed that although hospices are not directly linked to the LeDeR programme they are working closely with the end of life network across Herefordshire

and Worcestershire. It was highlighted that Herefordshire may be one of the best areas in the region for people not dying in an acute hospital bed. There have been a number of examples where people have utilized hospice beds appropriately, or have been supported to have really good end of life care at home and to learn much more about how that has been enabled for it to be shared within Worcestershire. In terms of resources, the programme was working really well together to make absolute best use of the resources that they have available to get the best outcomes for people. A national policy has just been published on the LeDeR programme and there is a review coming up. Commissioners are very much involved in the conversations to make sure that the resources go to the right places to address the priorities.

- It was suggested that a recommendation could be formed to address opportunities for upstream and preventative information, interventions around health and well-being for example: exercise, mental health and wellbeing.

In addition to the recommendation suggested in the report and reflecting upon the comments from the board surrounding the opportunities for people with learning difficulties' to take part in activities such as walking and exercise. The resolution below was then approved by the board.

Resolved: That

a) **the Health and Wellbeing Board note the Herefordshire and Worcestershire Learning from Lives and Deaths- People with Learning Disability Annual Report for 2020/21 and the programmes key findings for people with a learning disability in Herefordshire.**
b) **The board encourages collaborative working between the LeDeR working group and the HWBB for looking at upstream prevention and participation opportunities.**

9. CARERS STRATEGY

The Board received a report from the senior commissioning officer concerning the Carers Strategy. The Interim Assistant Director, All Ages Commissioning (IADAAC) introduced the report and outlined: the extensive engagement that had taken place; the vision of the strategy, its overarching/cross cutting themes and 5 key points; the establishment of a board to oversee the implementation of the strategy; and the timeline for the strategy's approval and publication.

During the course of the debate the Board raised the following points and questions:

- The funding that would be available for the strategy and the importance of parity with other areas.

The IADAAC *explained that there would be no change to the funding arrangements locally;*

- The importance of a focus on providing support to young carers.

The IADAAC explained *that the strategy sought to support vulnerable carers. The strategy co-ordinated help from early help and family support services at Herefordshire Council with existing third sector organisations to support young carers. All-family assessments would identify support needs for young carers including educational/training, primary care and social needs;*

- The support of the Adult and Wellbeing and Children and Young People Scrutiny Committees for the strategy was noted;

- The wide-ranging and extensive consultation undertaken for the strategy was commended. In particular it was noted that the engagement had taken place during the difficult circumstances of the pandemic;

- It was noted that the strategy was the first element of the Integrated Care System (ICS) to be publicised and progressed which provided a whole-system approach to be delivered with the coordination of all partners;

- The importance of the *Think Carer* initiative was highlighted to address a lack of awareness of young carers and the challenges they faced;

- It was queried what support could be provided by members of Board to assist the strategy.

The IADAAC explained that support would be provided through the ICS.

- A query was raised regarding additional resource that might be necessary to support some of the initiatives in the strategy, including the *check-in* proposed for carers, or whether teams existed that would take on the work.

The IADAAC explained that teams were already in place to take the work forward and there would be monitoring of the take-up of the check-ins by carers.

- It was highlighted that a proactive approach was necessary to raise awareness among carers of entitlement to support revenue and benefits.

The Acting Director for Adults and Communities highlighted the money on your mind website which provided awareness to people of available support.

- The fundamental importance of the interaction of the strategy across the system with other pathways was raised.

The Acting Director for Adults and Communities explained that the ICS would ensure that themes in the strategy would be embedded in the whole-system approach.

- The strategy was welcomed by the Board.

The Board agreed a change to recommendation (b) in the report to include the words *as a system*. The change reflected the emphasis placed upon the whole system approach which had been highlighted by the Board during the debate.

The recommendations, as amended above, were proposed and seconded and approved unanimously.

RESOLVED:

That the Health and Wellbeing Board:

(a) considers the draft carers strategy for 2021 to 2026 (appendix A) by the adults and communities directorate; and

(b) determines any recommendations it wishes to make to the council or relevant health bodies to improve the strategy and action plan alignment to the health and wellbeing strategy and/or to improve integration as a system between health and social care.

10. BETTER CARE FUND (BCF) YEAR END REPORT 2020-2021

The Board received a report from the Acting Director for Adults and Communities concerning the Better Care Fund (BCF) year-end report 2020-21.

The report was introduced by the Interim Assistant Director, All Ages Commissioning and the council's finance business partner and joint strategic finance lead for the council and CCG, who explained the impact that the COVID-19 pandemic had upon reporting arrangements and spending through the programme during the 2020-21 year. The requirement for regular reporting of performance throughout the year had been greatly reduced and underspends had occurred in some areas of the BCF including long-term placements and recruitment. In Herefordshire the BCF had been compliant with national requirements during 2020-21.

The Board raised the principal points below in the discussion that followed:

- It was queried what learning had occurred through the reduced need for performance reporting and if this had enhanced a more localised approach in Herefordshire.

The acting director for Adults and Communities and the council's finance business partner responded to explain that the previous year had been exceptional. It was likely that requirement for more detailed reporting would return in future however a reduced requirement may continue in the current year due to the ongoing response to COVID-19. It was noted that the BCF was currently subject to review which might change the priorities of the fund but was likely to still require detailed reporting.

- The social care settlement was raised and the potential impact it could have upon the BCF.

The acting director for Adults and Communities and the council's finance business partner explained that the announcement had been delayed until the autumn and that funding through the BCF had become a significant proportion of the core budget to support adult social care services. The BCF may change following review but it was unlikely to be withdrawn due to its central importance to the adult social care budget.

The recommendations in the report were proposed and seconded and agreed unanimously.

Resolved: It is recommended that

a) the Better Care Fund (BCF) 2020-2021 year-end template at appendix 1, as submitted to NHS England, be reviewed and the board determine any further actions necessary to improve future performance.

11. MEETING SCHEDULE FOR 21-22

No concerns were raised with the proposed schedule of meeting dates 2021/22. The next meeting will be held on Monday 18 October 2021.

Resolved: The schedule of meeting dates are confirmed for the municipal year.

Message of appreciation

On behalf of the committee, the chairperson expressed his gratitude to Councillor Crockett for her enormous contributions to the board over the years.

The meeting ended at 4.00 pm **Chairperson**

Title of report: Herefordshire Safeguarding Children Partnership Report to HWBB re Children and Young People's Mental Health and Suicide during 2020

Meeting: Health and wellbeing board

Meeting date: Monday 6 December 2021

Report by: Democratic services officer

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose

For the Health and Wellbeing Board (HWBB) to consider the report at appendix 1 by the Herefordshire Safeguarding Childrens Partnership (HSCP).

Recommendation(s)

That:

a) **The Health and Wellbeing Board considers the report at Appendix 1 and provides comments with regard to the HSCP's recommendations and request for assurance.**

Alternative options

1. It is a function of the HWBB to consider reports from Local Health Organisations.
2. The Board could choose not to consider this report, however given the importance of the subject matter it is presented to this meeting.

Further information on the subject of this report is available from
Jenny Preece, , email: jennypreece@herefordshire.gov.ukl

Key considerations

3. The HSCP produced the attached report in September. A draft report was provided to the Board at a Private Workshop following which the item was placed on the work programme for the current meeting. The report is for the Board to consider and to take account of the request for assurance posed by the HSCP.

4. Appendix 1 contains the HSCP's report in full for the board to consider.

Community impact

5. In accordance with the adopted code of corporate governance, Herefordshire Council achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining the right mix of these is an important strategic choice to make sure outcomes are achieved. The council needs robust decision-making mechanisms to ensure its outcomes can be achieved in a way that provides the best use of resources whilst still enabling efficient and effective operations and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review.

Environmental Impact

6. There are no general implications for the environment arising from this report.

Equality duty

7. 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.

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

Resource implications

9. There are no resource implications associated with the recommendation. The resource implications of any recommendations made by the committee will need to be considered by the responsible NHS body or the executive in response to those recommendations or subsequent decisions.

Legal implications

10 Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.

11 Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.

12. The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution.

Risk management

13. There are a number of risks inherent within appendix 1 and the challenges it identifies, including those of capacity and demand. The Health and Wellbeing Board may wish to make recommendations to certain health partners with a view to mitigating these risks.

Consultees

None

Appendices

Appendix 1 - Herefordshire Safeguarding Children Partnership Report to HWBB re Children and Young People's Mental Health and Suicide during 2020

Background papers

None identified.

Report Reviewers Used for appraising this report:

Governance	Sarah Buffrey	Date 16/11/2021
Finance	Louise Devlin	Date 12/11/2021
Legal	Kate Coughtrie	Date 16/11/2021
Communications	Luenne Featherstone	Date 12/11/2021
Equality Duty	Carol Trachonitis	Date 10/11/2021
Procurement	Mark Cage	Date 17/11/2021

Risk	Paul Harris	Date 19/11/2021

Approved by	Darryl Freeman	Date 25/11/2021

Please include a glossary of terms, abbreviations and acronyms used in this report.

HWBB Health and Wellbeing Board
HSCP Herefordshire Safeguarding Childrens Partnership

6 December 2021

Agenda item 7

Herefordshire Safeguarding Children Partnership Report to HWBB re Children and Young People’s Mental Health and Suicide during 2020

Report author	Ellen Footman (HWCCG-Head of Quality and Safeguarding) on behalf of Herefordshire Safeguarding Partners Board
Presented by	Heather Manning (CCG) and Darryl Freeman (Herefordshire Council)
Recommendation	The Herefordshire Safeguarding Children Partnership are seeking assurance from the HWBB that effective processes are in place to prevent further deaths in relation to deaths by suicide and self-harm; and that the HWBB seek assurance regarding the resilience of, and access to Mental Health Services locally.
Purpose	Assurance ☒ Decision ☐ Approval ☐ Information/noting ☐

Introduction

The purpose of the report is for the three Safeguarding Children Partners to inform the Health and Well-Being Board, (HWBB) of the *Children and Young People’s Mental Health in Herefordshire during COVID-19* report (May 2021) and the *West Midlands Regional Themed Child Death Overview Panel (CDOP) in relation to deaths by suicide and Self harm - April/May 2021*; and to request that the HWBB review the resilience of Mental Health Services locally and access to them.

The Safeguarding Partners wish to highlight the increase in ‘apparent suicides/self-harm deaths’ across Herefordshire and Worcestershire during 2020-2021. During this reporting period there were 4 apparent suicides/self-harm deaths reported to Herefordshire and Worcestershire CDOP (*N.B. cannot be confirmed as suicide until signed off by Coroner’s Court at Inquest). This compares to 5 child suicides for the reporting period 2017-2020.

HSCP also highlight to the HWBB, the apparent shortage of Tier 4 beds nationally, the national shortage of Secure Welfare Beds (for those children deemed not to meet the criteria for tier 4 beds); and the impact these shortages have locally on Mental Health services to young people; and what services are in place to support children and young people whilst they await beds. The *Children and Young People’s Mental Health in Herefordshire during COVID-19* report (May 2021) and the *West Midlands Regional Themed Child Death Overview Panel (CDOP) in relation to deaths by suicide and Self harm - April/May 2021* (See Embedded documents- Appendices), highlight concerns locally and regionally.

The following issues have also been formally reported to HSCP:

- The quality and effectiveness of the Mental Health pathway between services.

- The service response for children who do not engage with emotional help and well-being support services, and who require a more assertive engagement by local services to prevent escalation of risks,

- Unmet need for children experiencing severe emotional and mental health issues as well as at point of step down from Tier 4.

West Midlands Regional Themed Child Death Overview Panel (CDOP) in relation to deaths by suicide and Self harm - April/May 2021

The West Midlands Regional Child Death Review Network in December 2020 undertook a regional themed review focusing on deaths by suicide. All CDOPs in the region were invited to submit cases for consideration with a view to identifying common themes across the region and potential learning to prevent further deaths. For each theme, the panel identified challenges and questions for all the Safeguarding Partnerships in relation to seeking and providing assurance that effective processes are in place to prevent further deaths.

Children and Young People's Mental Health in Herefordshire during COVID-19 report (May 2021)

The report highlights the increase in demand on services locally during the Covid-19 pandemic. Specifically, there has been a significant increase in the acuity and demand in relation to eating disorders and those CYP experiencing crisis. This has led to an increase in the requirement for Tier 4 beds. There has also been an increase in CYP presenting to A&E in crisis. The CCG are leading a Tier 4 Task and Finish group which is STP wide. This group has representation from HWHCT, WVT, Worcestershire Acute, Worcestershire Children's First and Herefordshire Council as well as NHSE representation. The aim of this group is to analyse data and the needs of the young people that are presenting crisis and to explore options for solutions and potential alternatives to Tier 4 and to admission on to paediatric wards. Assurance from the group regarding options should be sought by HWBB and shared with the Safeguarding Partners.

Recommendations

The Herefordshire Safeguarding Children Partnership are seeking assurance from the HWBB regarding the findings from the *West Midlands Regional Themed Child Death Overview Panel (CDOP)* Report - *April/May 2021 in relation to deaths by suicide and Self harm* and that effective processes are in place to prevent further deaths; and that the HWBB seek assurance regarding the resilience of, and access to, local Mental Health Services. (*Children and Young People's Mental Health in Herefordshire during COVID-19 report (May 2021)*.

Appendices (below)

Appendix 1

Learning summary and challenges identified by West Midlands Regional Themed Child Death Overview Panel (CDOP) in relation to deaths by suicide and Self harm - April/May 2021

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1.0 Background

The 2018 Child Death Review Statutory and Operational Guidance suggests that '*Some child deaths may be best reviewed at a themed meeting. A themed meeting is one where CDR partners arrange for a single CDOP, or neighbouring CDOPs, to collectively review child deaths from a particular cause or group of causes. Such arrangements allow appropriate professional experts to be present at the panel to inform discussions, and/or allow easier identification of themes when the number of deaths from a particular cause is small*'. The guidance suggests suicide as a theme that might be reviewed at a regional level.

The guidance also states *'Themed panels will demand a customised approach and an experienced chair. Consideration might be given to experts attending from a neighbouring clinical network or region. Themed panels should occur within 12 months of the child's death. Designated doctors for child death should work together to decide which cases might best benefit from review at a themed panel.'*

1.1 Methods

At a meeting of the West Midlands Regional Child Death Review Network in December 2020, it was agreed to trial a regional themed review focusing on deaths by suicide. All CDOPs in the region were invited to submit cases for consideration with a view to identifying common themes across the region and potential learning to prevent further deaths.

The themed panel met virtually on 29 April 2021. All CDOPs in the region were invited to send two representatives, with representatives from mental health services, public health, paediatrics, education, children's safeguarding and a lay member.

The panel reviewed deaths of children aged less than 18 years from suicide or self-harm that had occurred across the West Midlands during 2019-2020 where coroner's inquests had been completed. A total of nine deaths were reviewed. Two deaths occurred during the COVID pandemic. Other deaths that occurred during the pandemic could not be reviewed as inquests were awaited. Members of the panel met again on 27 May 2021 to analyse the findings and key learning points arising from the panel discussion; and to draw up this summary.

1.2 Limitations

The themed panel acknowledges that a small sample of deaths was reviewed; and that some issues identified may be unique although common learning points in relation to the context of the children's lives were identified. It was recognised that despite the best efforts of professionals,

families and friends, some deaths may be unpreventable. Nonetheless, that should not stop every effort being made to identify common issues and to improve professional processes and practice.

2.0 Findings

For each theme, the panel identified challenges and questions for all of the Safeguarding Partnerships in relation to seeking and providing assurance that effective processes are in place to prevent further deaths.

2.1 Theme – Young people seeming to thrive prior to suicide

2.11 Learning point 1

Most of the young people whose deaths were reviewed had experienced adverse childhood experiences. Some appeared to be thriving at school and home while struggling with issues of self-identity and belonging. Family, friends and schools were unaware of some of the young people's turmoil.

2.12 Learning point 2

Several of the young people had not previously indicated any suicidal intent and their deaths were precipitated by a sudden crisis such as a relationship breakdown or argument.

2.13 Challenges

How do all partner agencies create a supportive environment for young people to talk about mental health? How might that be improved?

How are crisis services for young people in need promoted to partner agencies, parents/carers and young people?

How can partner agencies help young people to recognise their feelings and seek appropriate support?

How can partner agencies ensure that children who may have mental health needs that are masked by high academic performance and achievement have those needs identified and addressed?

How are partner agencies addressing online safety and the potential online and social media triggers of self-harm and suicide?

2.14 Question for local Safeguarding Partnerships:

How can education (including early years and further education) providers reassure partners that children are being taught how and supported to identify early warning signs of vulnerability in themselves and others and how to identify networks of trusted adults (at home, in school and in the community) who they might talk to in the event of concerns about themselves or any of their peers?

2.2 Theme – Access to mental health services

2.21 Learning point 3

Some young people had experienced difficulty in accessing and engaging with mental health services in a timely manner. There were disparities in access to mental health support between young

people presenting to primary care or hospital; and professionals struggled with pathways for referring young patients for mental health support.

2.22 Challenges

How can partner agencies ensure ease of access to the most appropriate mental health services for young people, their families and professionals who work with and support them?

How can partner agencies improve the sharing of information about self-harm and suicide attempts, particularly between universal agencies such as GPs, school nurses and education providers so that children can be supported more effectively?

2.23 Questions for local Safeguarding Partnerships:

How can local health providers reassure safeguarding partners that there are consistent risk assessments and clear pathways in place for referrers to use when they are worried that a child's mental health needs have not been addressed?

How can local Safeguarding Partnerships support the development of a common language between children's mental health services and other agencies to facilitate a greater recognition of shared responsibility in supporting and meeting the needs of children with mental health challenges?

How can children's mental health services reassure their local safeguarding partners that children are not discharged from services because of non-engagement without adequate consideration of risks and potential alternative strategies?

2.3 Theme – Optimising learning from suicides

2.31 Learning point 4

CDOP and safeguarding reviews of suicides focus on more recent events leading up to deaths but those reviews may miss key information about children's earlier adverse experiences that may limit learning and prevention of further deaths.

2.32 Challenges

How do we maximise learning from deaths of children as a result of suicide and self-harm?

2.34 Question for local Safeguarding and Child Death Review Partnerships:

How can partners ensure that reviews of children's deaths as a result of suicide and self-harm include consideration of the child's full life history?

3.0 Conclusions

The regional review identified common themes across several deaths, which may not have been recognised had deaths only been reviewed at local CDOPs, showing the benefit of this process. It is now for local safeguarding partnerships and agencies to take this learning forward to help reduce risk of future deaths.

West Midlands Thematic Suicide Review Learning Summary

Appendix 2

Children and Young People's Mental Health in Herefordshire during COVID-19

Heather Manning Deputy Designated Safeguarding Nurse, HWCCG May 2021

Introduction -

COVID-19 has brought with it pressures specific to Mental Health in all age groups. Service provision specifically for Children and Young People (CYP) and support can be accessed in a variety of ways and this has continued throughout COVID-19. This report summarises some of the increased demand on current services and gives some oversight of the intended improvement plans.

CAMHS –

There has been a significant increase in the acuity and demand in relation to eating disorders and those CYP experiencing crisis. This has led to an increase in the requirement for Tier 4 beds. It has also been noted that CYP with Autistic Spectrum Disorder (ASD) crises have increased with the ASD sometimes being undiagnosed until the crisis occurs.

Referral rates have now reverted to more usual levels, but there has been a higher than usual acceptance level due to their nature and therefore suggesting that CYP are in need of specialist CAMHS services. If this trend of acceptance rates continues, capacity against demand would need to be reconsidered.

Kooth is an online counselling and emotional well-being platform for children and young people, accessible through mobile, tablet and desktop and free to use. Kooth activity has increased month on month since the service started in April 2020. The reach was slow to start with due to launch issues but in Q3 2020-2021 there were over 1600 logins to the online service.

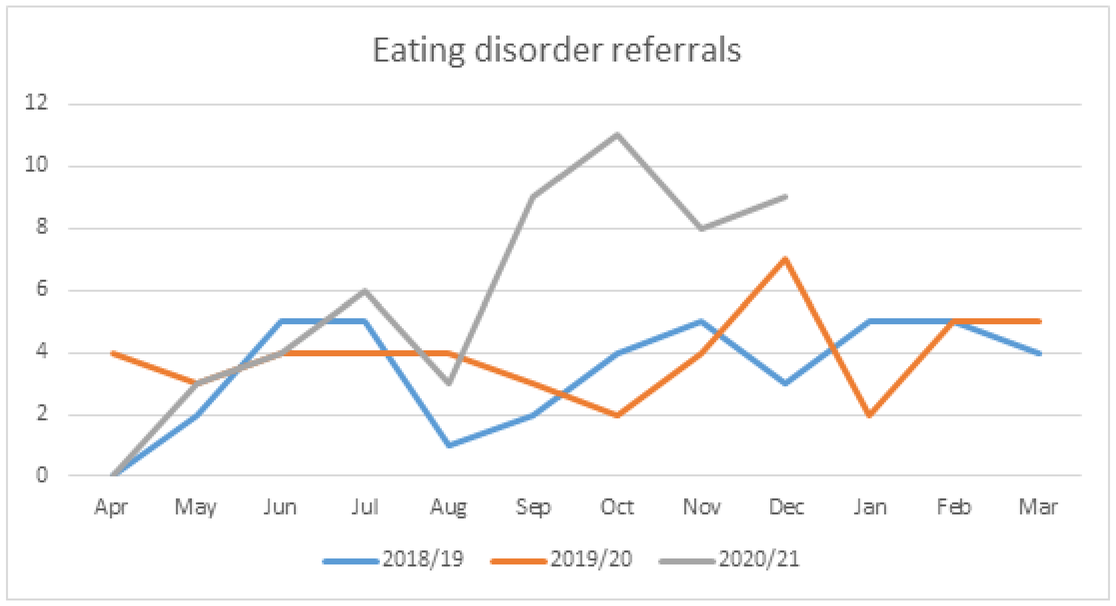
There has also been an increase in CYP presenting to A&E in crisis. These children are seen in A&E to try to divert admission, but when presenting out of hours, they are admitted to the Paediatric Ward as per NICE guidance. There has been an increase in attendance recently with a significant increase noted in November and December 2020.

The CCG are leading a Tier 4 Task and Finish group which is STP wide. This group has representation from HWHCT, WVT, Worcestershire Acute, Worcestershire Children's First and Herefordshire Council as well as NHSE representation. The aim of this group is to analyse data and the needs of the young people that are presenting crisis and to explore

options for solutions and potential alternatives to Tier 4 and to admission on to paediatric wards. The group will have an options appraisal by July 2021.

In addition to this work there is also significant investment into eating disorders and crisis from NHSE for 21/22 as part of the NHS LTP. The children and young people's eating disorder service in Herefordshire is having significant investment to increase capacity and increase early intervention. The team will grow from 2.4 WTE to 6.6 WTE.

There has been a year-on-year increase in the number of eating disorders referrals accepted by the Hereford CAMHS team: 41 in 2018/19 and 47 in 2019/20. It is expected that referrals for 2020/21 will also be higher – 44 up to end of November 2020 in the first 8 months of the current financial year. The pattern of referrals has been affected by Covid 19 with a dip in referrals in March and April in line with the first lock-down. The team has experienced a significant increase in referrals in September, October, and November. This is in line with reports from NHS England reporting an increase in reported eating disorders in children nationally, and this increase in referrals is predicated to continue. (Data up to Jan 2021)



Plans have been submitted to NHSE for the development of a 7 day a week home treatment team for Herefordshire CAMHS to provide intensive interventions to CYP to prevent crisis/divert from presentation at WVT/reduce need for T4. As part of this additional investment, plans have been submitted to NHSE to recruit a transitions team who will 'broker' transitions between CYP and adult services to improve the quality of the transition. Irrespective of thresholds, a response will be given for all referrals.

The Mental Health in Schools (MHST) programme now has one team in Hereford, with a go live date of November 2021. The staff appointed to these roles are currently in a training year. This team will provide evidence-based interventions to CYP experiencing mild to moderate mental health difficulties. The Hereford MHST will target the secondary age population. A bid has gone to NHSE for a 2nd team, targeting the primary age population.

There is ongoing work to enhance First Episode in Psychosis services to provide a CAMHS specific worker in the Early Intervention in Psychosis team and looking at ways to enhance support to CYP who experience Complex Emotional Needs with focus on transition to adult services.

Wye Valley Trust School Nursing –

The school nursing service routinely offer emotional well-being support to CYP via A&E follow ups. Comparison data is shown below -

March 2020		**March 2021**	
Self-harm	5	Self-harm	9
Depression	0	Depression	5
Mental health	0	Mental health	32
April 2020		**April 2021**	
Self-harm	6	Self-harm	14
Depression	0	Depression	1
Mental health	1	Mental health	13

It is concerning is that the numbers of CYP being referred to the school nursing service has decreased during COVID-19. There were 523 contacts for emotional support in Q4 2019-2020 compared with only 369 for Q4 2020-2021. It is therefore recognised that these children are not being identified by other services and referred for early support with a school nurse.

To compound the current difficulties, the school nurse drop-in service at schools is currently being run by appointment only to ensure COVID safe working at this time. This has reduced the number of CYP accessing the support as planning an appointment in advance does not

appear to work for this cohort. The old model of a drop-in service had much larger numbers of young people self-presenting. The school nursing service is looking to see how this aspect can be managed differently

Children Looked After (CLA) -

This cohort of CYP have continued to be seen either via video link or via telephone for Initial and Review Health Assessments during the last year. The CLA health team have completed the Strengths and Difficulties Questionnaire (SDQ) with children and their carers for some years. It is recognised that whilst high SDQ scores may raise concerns for the emotional health and well-being of the CYP, it is not viewed in isolation. The scores are discussed with the child's SW and the overall context looked at. Some children may have a high SDQ but be in a better place emotionally than previously. CAMHS referrals are made where required but it is recognised that a child may be referred by another agency such as the GP if they have presented outside of health assessments. If such referrals are made and the CLA health team are made aware, they will also monitor and liaise with the relevant professionals.

CLD Trust (Counselling, Learning, Development)

The CCG commission the CLD Trust to provide an emotional wellbeing service for children and young people across Herefordshire. They offer a variety of counselling therapy including brief sessional therapy and Cognitive Behavioural Therapy (CBT). This service works with young people who don't meet the criteria for CAMHS but are experiencing issues such as anxiety and low mood. The CCG is working with the CLD Trust to change the referrals to self-referral as well as referral from professionals. There has also been an increase in investment during 2021-2022 to increase the capacity of this service.

Conclusion –

This report is an assurance of the holistic picture of mental health support for CYP in Herefordshire.

Close monitoring of all referrals across the system will remain a priority and progress monitoring against the new provisions and services will continue.

Title of report: Countywide approach to become a Sustainable Food Place

Meeting: Health and wellbeing board

Meeting date: Monday 6 December 2021

Report by:
Health Improvement Practitioner

Classification

Open

Decision type

This is not an executive decision

Wards affected
All

Purpose
The purpose of this report is to inform and gain support from Health and Wellbeing Board on a county-wide approach to becoming a Sustainable Food Place, and on the Food Vision for Herefordshire developed by Herefordshire Food Alliance.

Under this umbrella, partners across Herefordshire work together to influence, change and support the food system and food environment such that they promote health, wellbeing and sustainability and reduce inequalities by -

- Improving health & wellbeing by increasing healthy life expectancy and reducing health inequalities
- Supporting a thriving local food economy and sustainable food procurement
- Creating environmental sustainability

Recommendation(s)
That:

a) **Health and Wellbeing Board supports the work on Sustainable Food Places in Herefordshire, including the local vision, aims and actions set out in the plan**

b) **Health and Wellbeing board member organisations actively promote and engage in activity across the sustainable food places framework; Including the food charter**

Further information on the subject of this report is available from
Kristan Pritchard, Tel: 01432383144, email: Kristan.Pritchard@herefordshire.gov.ukl

Alternative options

1. Health and Wellbeing board does not support the vision or implementation of programme of work based on the Sustainable Food Places framework. This is not recommended as it would reduce the effectiveness in tackling many of the root causes of poor health and inequalities, limiting opportunity to tackle obesity within the County and support key Council priorities around the environment, communities and economy.

Key considerations

2. In Herefordshire, we recognise that food has a key role in economic, environmental and social challenges. This includes obesity, diet related ill health, food poverty, waste and climate change. Food is a key driver of health inequalities. COVID-19 has further shown the vulnerabilities of the food system. The food system has changed both locally and nationally, with increased availability of cheaper processed foods which are often high in fat, sugar and salt and consumption of food cooked outside the home. A healthy diet can be expensive, meaning less affluent people are less able to access or afford healthier foods. Locally the number of people in food poverty is increasing and obesity rates continue to rise as consequences of poor diet.

3. Many factors affect the food we consume. Our consumption is driven by food systems (e.g. how food is grown, made and distributed); the community we live in; our individual behaviours and drivers of these behaviours; and economic factors. The quality of an individual's diet can therefore be affected by poverty and the causes of poverty; low or lack of income, competing expenditures (such as heating), access to food (including geography) and the food environment, education, family life and food skills of individuals, families and communities.

4. Improving the food system and diets often has synergistic and broader impacts on wellbeing through wider determinants of health. For example, changes in diet to include greater consumption of healthier foods, and lower consumption of unhealthy foods, would generally improve environmental sustainability, whilst community initiatives to increase skill sharing or local growing schemes can positively impact communities for example through reducing loneliness and improving connectedness.

5. Sustainable Food Places provides a well developed and tested model on which to build our work to ensure a healthier and more sustainable food environment for all in Herefordshire. The SFP framework for strategy and action plan is structured around six key issues:

    a. Taking a strategic and collaborative approach to good food governance and action

    b. Building Public awareness, active food citizenship and a local good food movement

    c. Tackling food poverty, diet related ill-health and access to affordable healthy food

    d. Creating a vibrant, prosperous and diverse sustainable food economy

    e. Transforming catering and food procurement and revitalizing local and sustainable food supply chains

    f. Tackling the climate and nature emergency through sustainable food and farming and an end to food waste

6. The Herefordshire Food Alliance brings together key partners focused on food is leading the local implementation of the SFP framework. The alliance has been supported through a funded co-ordinator role. It has developed a Food Vision for Herefordshire. This vision is:

   'Herefordshire has a thriving, healthy and environmentally benign local food economy, where those on low incomes and in rural areas have access to affordable, healthy food; where food production, processing and distribution systems contribute to landscape and wildlife diversity, minimise waste and consider the impacts of climate change; and where local communities are actively engaged in healthy living and have an increased understanding of the links between food and personal and planetary well-being.'

7. Herefordshire's rural setting provides opportunities as well as challenges. There is a strong agriculture industry (agriculture accounts for 24% of businesses[1]); however, the food system operates above county level with the majority of food travelling out of the county for processing. Community engagement in the county is strong, shown for example through high volunteering rates, and there are a large number of small enterprises, social enterprises and voluntary organisations.

8. The COVID pandemic increased communities support for local produce and retailers. It has shown us how resilient food systems can work and more important than ever that we have our own local food systems in place, with the ability to buy locally and support the local economy.

9. The SFP approach has been successfully adopted in other local authorities including Bristol, Cardiff and Brighton and Hove, and provides a network with whom to share ideas and generate change.

10. Nationally, the recent publication of the National Food Strategy has further highlighted the need for a focus on food environments and recommendations include the establishment of active local food partnerships and food strategies.

11. Locally, the strategic setting for this work has been building over a number of years:

    a. In 2011, the Herefordshire Food Strategy, From Field to Table, was published. This strategy, developed by a wide group of stakeholders, identified that a systematic approach addressing food sustainability was required within the county, but unfortunately lack of resource prevented full implementation. Nonetheless this work has laid a solid foundation and good partnerships which can now drive forward change.

    b. A Food Poverty Alliance was established by Brightspace Foundation in January 2019, which led on the food poverty risk mapping for the county.[2] Following this, it was agreed that the Food Poverty Alliance would become the Herefordshire Food Alliance (HFA) to incorporate a broader sustainable food agenda. HFA will oversee the delivery of the food vision within the SFP model.

       The organisations/networks represented on the Food Alliance include - Brightspace Foundation, Food Banks, Hereford Diocese, Borderlands Rural Chaplaincy, Herefordshire Green Network, Voluntary sector, Herefordshire Wildlife Trust, Data Orchard, Herefordshire Council, Connexus, HOPE, Ignite CiC and local NFU.

       During 2020 and COVID emergency response, Public Health played a key role in the co-ordination and support of the Hereford Food Alliance (HFA).

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[1] https://understanding.herefordshire.gov.uk/economy-place/topics-relating-to-the-economy/industry-and-business/

c. In January 2021, the HFA was successful with a grant application to fund a Sustainable Food Places development co-ordinator for 6 months (Jan – July 2021). Public Health match-funded the grant and a local co-ordinator employed by New Leaf Sustainable Development CIC supported HFA to develop its network, working towards becoming a member of Sustainable Food Places.

d. In June 2021 Herefordshire Food Alliance achieved the set criteria and were accepted as Sustainable Food Places members. Additionally in July 2021, HFA was successful with a further 2 year co-ordinator grant, again match funded by Public Health.

e. HFA participated in a national research study to review local responses to food vulnerability pre and during covid.[3] It has also led on the 'food' aspect of the county carbon plan and proposed activity within it.

12. The impact of food on health is multifactorial. In England, diet is the one of the biggest factors affecting health. For example, consuming too much salt is the biggest cause of high blood pressure and obesity (which at its most basic is the result of an imbalance between energy consumption (food and drink) and energy expenditure) is the second biggest cause of cancer and being overweight or obese is the main modifiable risk factor for type 2 diabetes and the driver behind the increase in type 2 diabetes prevalence.[4] Key outcomes related to food for Herefordshire include:

    a. Overweight and obesity: being overweight continues to be the 'norm' in society for adults and a significant issue for children. Whilst generally prevalence estimates in Herefordshire are similar to England averages, they are of concern in the county and show no signs of decreasing. In 2019/20, 10% of reception year children in Herefordshire were obese, while the combined proportion of obese and overweight children was 26%5. For year 6 children, the prevalence of obesity was 19%, while the combined figure for obese and overweight children was 33%. In 2019/20, 61% of adults in Herefordshire were estimated to be overweight or obese.

    b. The standard of children's oral health in Herefordshire is poor, and is poorer than both the regional and national picture: just under a third of 5 year olds locally experienced preventable tooth decay in 2016/2017. Significantly this figure has remained broadly unchanged in the last 10 years.

    c. Food poverty and subsequent malnutrition impact upon outcomes such as obesity and diabetes; use of primary and secondary health care services; mental health; and pupil learning outcomes. There is a link between food insecurity and lower quality of diet and food insecurity has been associated with higher rates of being overweight.[3] Whilst there is no easy way to count the number of people living in food poverty, in Herefordshire, as in other areas, we have seen increasing numbers of people in crisis situations: in 2020, 10,889 food parcels were distributed across five food banks.[5] The use of food banks is only the tip of the iceberg with many more individuals and families being at risk of food poverty.

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[2] Herefordshire Food Poverty map https://www.dataorchard.org.uk/case-studies/food-poverty-mapping-project
[3] Local responses to food during covid, Food vulnerability during COVID-19 | SPERI (shef.ac.uk)
[4] Public Health England. Adult obesity and type 2 diabetes. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/338934/Adult_obesity_and_type_2_diabetes_.pdf
[3] Yang TC, Sahota P, Pickett KE, Bryant M,, Association of food security status with overweight and dietary intake: exploration of White British and Pakistani-origin families in the Born in Bradford cohort, Accessed through: https://www.ncbi.nlm.nih.gov/pubmed/29690871, Accessed 15.1.20
[4] Personal Communication Peplar.C, Hereford Diocese, Food bank data Herefordshire 2020

13. It is important to recognise that improving the food system and diets often has synergistic and broader impacts on wellbeing through wider determinants of health. These include:

    a. Environmental impacts: overall health and environmental outcomes associated with food align and a healthier diet tends to be a more sustainable one. Foods associated with the largest environmental impacts - unprocessed and processed red meat - are consistently associated with the largest increases in disease risk, whilst foods that are better for our health have a lesser impact on the environment. Therefore, changes in diet to include greater consumption of healthier foods, and lower consumption of unhealthy foods, would generally improve environmental sustainability too.

    b. Loneliness adversely affects people's health and wellbeing and, whilst seen across age-groups and society, can particularly affect elderly and physically isolated people (e.g. those in rural locations). Food affects everyone and it can have a positive impact across communities e.g. Growing food in a community garden involves people in a collective and eating together helps build relationships and strengthen communities. There are great wellbeing benefits for people of all ages coming together to share skills and knowledge with food as a common link. A common local theme of intergenerational lack of skills and knowledge is also concern which community growing helps to address.

14. The complexity of the situation requires that we work in partnership and consider the whole food system, its various impacts on health and wellbeing, and the multiple interventions that can be applied within that system. Sustainable Food Places provides a framework for a whole-system approach and Herefordshire Food Alliance provides the platform for partnership working towards the common goal articulated through the vision and actioned through the action plan (Appendix 1).

15. The next steps in the action plan are to continue to increase engagement activity and develop a food charter in collaboration with key stakeholders.

Community impact

16. SFP implementation plan has partnership working at its core. HFA has already proven to be an important networking and information sharing forum and has led the development of the Food Vision for Herefordshire. The HFA has developed in partnership with key external stakeholders who are embedded in relevant strategic networks in the county, providing chair or expert support, including:

    - Farm Herefordshire: an alliance of 12 organisations working with the land-based sector delivering training and advice. This is a conduit to the farming community.
    - Herefordshire Green Network: a network of 80+ organisations and more than 300 individuals interested in "green" issues. This is a conduit to community groups.
    - Herefordshire Tourism Partnership, which has promoted a county-wide food strategy and works with the tourism sector.
    - Herefordshire's zero carbon plan and nature rich plan[5], specifically the food section. This is a conduit to influence strategic policies. Members are also linked into the work of Talk Community.

- Food poverty support through the Diocese of Hereford, independent Food Banks, Hfds Council, and existing growing projects.

17. Herefordshire's county Plan[6] sets Herefordshire Council's ambition for Herefordshire 2020-2024 and outlines the priority areas as;

    - Environment: protect and enhance our environment and keep Herefordshire a great place to live
    - Community: strengthen communities to ensure everyone lives well and safely together
    - Economy: support an economy which builds on the county's strengths and resources

    The SFP implementation plan contributes to each of these priority areas, from minimising waste and supporting sustainable living (environment) to ensuring children are healthy, protecting vulnerable people (community) and spending public money in the local economy (economy).

18. SFP aligns with the vision and will impact upon the five priorities and cross-cutting themes set by HWBB, as well as aligning with the Talk Community approach and contributing to the Herefordshire zero carbon and nature rich plan[5] .

19. Herefordshire and Worcestershire Long Term plan for the NHS also includes commitments on tackling obesity. This includes as system focus on healthy weight across the lifecourse; healthy staff, activity levels and healthy communities.

Environmental Impact

20. The decision will contribute to the delivery of the council's environmental policy commitments and align to the following success measures in the County Plan.

    - Increase flood resilience and reduce levels of phosphate pollution in the county's river
    - Reduce the council's carbon emissions
    - Work in partnership with others to reduce county carbon emissions
    - Improve the air quality within Herefordshire
    - Improve residents' access to green space in Herefordshire

21. Herefordshire Council provides and purchases a wide range of services for the people of Herefordshire. Together with partner organisations in the private, public and voluntary sectors we share a strong commitment to improving our environmental sustainability, achieving carbon neutrality and to protect and enhance Herefordshire's outstanding natural environment.

22. The development of this project has sought to minimise any adverse environmental impact and will actively seek opportunities to improve and enhance environmental performance. The project includes as specific work strand to 'Tackle the climate and nature emergency through

[5] Herefordshire's zero carbon plan and nature rich plan, Home - Herefordshire Zero Carbon and Nature Rich
[6] https://www.herefordshire.gov.uk/download/downloads/id/1500/county_plan_2020-24.pdf

sustainable food and farming and an end to food waste' as well as encouraging food growing and buying local, seasonal produce.

Equality duty

23. The equality duty is in section 149 of the Equalities Act 2010. It ensures that public bodies consider the needs of all individuals in shaping policy, in delivering services and in relation to employees. The duty requires that when exercising public functions, public service providers must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it.

24. 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 Sustainable Food Places approach will support the council in delivering on the equality duty by providing opportunities for learning, having a positive impact on those with a protected characteristic, bringing communities together and increasing partnership working. As the approach develops we will manage and assess the equality impact, and if required we will complete an impact assessment.

Resource implications

25. Public Health has been and will continue to provide resource for strategic oversight of the project within the Food Alliance. Matched funding allocated to the project is provided by the PHRFG at £10,000 per annum. The Food Alliance will apply for grants and other funding to support specific projects and developments.

26. An evaluation of the programme in 2019 showed that Sustainable Food Places represents a return of £2 for every £1 investment by Esmèe Fairbairn Foundation. The multiplier effect is greater when assessed at city level, with a total SFC grant funding of £493,359, over 3 years to 31 city members generating £7 for every £1 invested[7].

Legal implications

27. This report is informative and therefore there appear to be no legal implications.

[7]University of the West of England, Sustainable Food Cities, Phase 2 Evaluation Report, May 2019.

Risk management

Risk / opportunity	Mitigation
Community and partner organisations do not work together with Herefordshire Council to tackle these issues.	Partnership working is at the centre of the plan and the action plan has been developed together with key stakeholders and informed by workshop and attendance at key networks.
The issues are engrained and complex and require large-scale change.	An action plan has been developed which will identifies achievable actions which can be undertaken which will start to tackle components of the complex food system. The limit of our influence, and the timescale of its impact, is recognised in our measures for success.
Insufficient funds are available to make headway with ideas and initiatives.	Grant funding will be a key focus of the alliance, across the alliance partners there is a lot of experience in grant applications.

28. Risks will be managed through Public Health risk register and escalated as required.

Consultees

29. Consultation has taken place and has informed the development of the implementation plan. This has included:
    a. The SFP model has been discussed with a wide range of partner organisations and in a number of networks
    b. Stakeholders have been involved from across different aspects of the food system
    c. A mapping exercise has taken place alongside partner consultation which has identified gaps and areas of focus
    d. In October 2019 a Sustainable Food Places event was delivered which gained input from partners on current activities, identifying gaps and priorities for action.

30. Working with partners and stakeholders will be key throughout the lifetime of the plan, as the work evolves, further actions will be developed and opportunities identified and/or created.

Appendices

31. Appendix 1 – Sustainable Food Places implementation plan

The implementation plan outlines how Herefordshire Council and its partners will work to improve the food system and food environments in Herefordshire with the aim to improve the health of the population and reduce health inequalities, over the next two years. We have set out a shared

vision, aim and objectives and an action plan, based on the Sustainable Food Places (SFP) framework.

Background papers
None identified.

Report Reviewers Used for appraising this report:

Governance	Sarah Buffrey	Date 16/11/2021
Finance	Kim Wratten	Date 17/11/2021
Legal	Sharon Bennett-Matthews	Date 11/11/2021
Communications	Luenne Featherstone	Date 12/11/2021
Equality Duty	Carol Trachonitis	Date 19/11/2021
Procurement	Mark Cage	Date 12/11/2021
Risk	Kevin Lloyd	Date 17/11/2021

Approved by	Rebecca Howell-Jones	Date 25/11/2021

Please include a glossary of terms, abbreviations and acronyms used in this report.

HWBB – Health and wellbeing board
SFP – Sustainable Food Places: used to describe the framework and approach itself.
HFA – Herefordshire Food Alliance
SFC – Sustainable Food County: used to describe the local implementation of the SFP framework at a county level which is our approach in Herefordshire.

Herefordshire Council

HEREFORDSHIRE SUSTAINABLE FOOD COUNTY PLAN

JULY 2021 - JUNE 2023

- Improving health & wellbeing by increasing healthy life expectancy and reducing health inequalities
- Supporting a thriving local food economy and sustainable food procurement
- Creating environmental sustainability

Pritchard, Kristan 26/11/21

Version number 4

Aim – To create a more sustainable local food system in Herefordshire.

Objectives –

- **Foster, support and develop projects and initiatives that work towards the Sustainable Food system**
- **To achieve Sustainable Food Places Bronze award.**

In order to achieve the above aim and objectives, the following activity is planned –

	Delivered activity	Planned activity	Deliverer	By when
A cross sector food partnership developed	Food alliance meeting since July 2020	Continue to meet & expand representatives	Sustainable Food Places co-ordinator	Ongoing
6 monthly reports provided to SFP	October report	Report writing Dec 2021 & June 2022	Sustainable Food Places co-ordinator	Dec 2021 June 2022 Dec 2022 June 2023
HWBB Endorsement & support of SFP & HFA activity	HWBB briefing under development	Briefing taken to HWBB Dec 2021	Kristan Pritchard/Public Health (PH)	December 2021
Food vision and charter	HFA agreed vision	Organisational sign-up to charter, Develop charter, engagement with population	Food Alliance, Sustainable Food Places co-ordinator	Initial plan/strategy Sept 2021, annual review
Maintain and extend communication channels with all partners/initiatives	WhatsApp & Info sharing platform set-up	Continue linking to new plans	All	Ongoing
Assess feasibility of web presence and networking with wider public	Initial review of options taken place	Review, research and develop cost options	Sustainable Food Places co-ordinator	Dec 2021
Food hub; feasibility hub research and options development	Conversations with relevant partners started, initial meeting taken place	Discuss models and options	Sustainable Food Places co-ordinator	Dec 2021
Raise awareness of food, health & sustainability and opportunities to learn share and enjoy incl. promotion Healthy start	Support/ connect existing local activity - PH campaign calendar Growing local activity Life & soul café The Living room Healthy Lifestyle Trainer Service cooking skills delivery, meal planning	PHE campaign promotion Growing local project delivery Link to new waste strategy and activity Support Healthy start scheme update	PH, Healthy Lifestyle Trainer Service, Growing local	Ongoing development

	Delivered activity	Planned activity	Deliverer	By when
Develop plans for food monitoring within educational settings, hospitals, public places	Initial discussions taken place	Local research to take place, review of other areas approaches, existing local delivery and facilities.	HFA partners & Sustainable Food Places (SFP) co-ordinator	January 2022
Support local producers with increased opportunities to promote and sell their produce direct to consumers	Research existing networks e.g Local e-sourced,Online Christmas market, Farmers markets. COVID recovery funds link economic recovery, visit Herefordshire	Establish pilot with key anchor organisations	SFP co-ordinator	June 2022
Identify further potential spaces for community growing	Discussions with planning emerging	Link with covid recovery grants made and meetings planned	HFA	June 2023
Focus on public sector healthy sustainable food	Discussions taken place with WVT	Ensure high level support and buy-in to SFP and vision	Public Health SFP co-ordinator	Dec 2022
Establish a local cross-sector sustainable food procurement group or equivalent forum	Initial discussions taken place	To be developed	Public Health & SFP co-ordinator	June 2022
Deliver the food actions within county carbon plan	HC waste working in collaboration with and represented on FA	Continue to develop activity/plans within carbon food plan	HFA	Dec 2023
Seek resources and funding	HFA co-ordinator funded until June 2023	HFA to establish links to relevant COVID recovery funds projects Resource for specific HFA projects to be identified	HFA	Ongoing
Raise awareness of food waste and consider food waste collection schemes	County carbon plan food chapter written and activity plan developed Ongoing discussions with HC waste and contribution to the implementation of new waste strategy Current development of food waste scheme pilot	Continue to align carbon reduction plan activity & SFP Continue waste transformation discussions and link in relevant partners	Food Alliance, Waste transformation team	Ongoing
Ensure the effective collection of consumable surplus food from all stages in the supply chain and redistribute.	Consider existing activity; Ethos are collecting surplus supermarket food in city Foodbanks in market towns collecting surplus food from local supermarkets Discussions taking place	Look at wider food chain to re-distribute surplus food and engage relevant partners in a 'local approach'	Ethos Food Alliance SFP co-ordinator Foodbanks Waste transformation team Food retailers Fairshare	Dec 2022

This action plan will require regular review and updates in line with local activity.

Title of report: Joint strategic needs assessment (JSNA) 2021

Meeting: Health and wellbeing board

Meeting date: Monday 6 December 2021

Report by: Director of Public Health

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose

To approve the summary of the 2021 Joint Strategic Needs Assessment (JSNA) for Herefordshire.

It is a statutory requirement for a JSNA – a continuous assessment of the current and future health, care and well-being needs of the population – to be produced on behalf of the Health and Wellbeing Board. The JSNA should provide an evidence base to inform the priorities of the board, and service planning and commissioning decisions of stakeholders.

Herefordshire's JSNA is co-ordinated by the council's Intelligence Unit, and takes the form of a live evidence base (the Understanding Herefordshire website) which is supplemented by a holistic summary every three years.

This report seeks approval for the 2021 summary, and aims to ensure the JSNA is used to inform the strategic planning and commissioning of relevant services pertinent to addressing the wider determinants of health and wellbeing by the council, Clinical Commissioning Group (CCG) and other stakeholders.

Recommendation(s)

That:

a) **The Key Findings of the 2021 Joint Strategic Needs Assessment (at appendix 1) be approved;**

b) **The board agrees to consider the findings of the JSNA in the development of their priorities and future health and well-being strategies;**

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

c) **the board members agree to facilitate the dissemination and use of the JSNA within their organisations and other system networks.**

d) **The priorities for theme-based analysis for 2022/23 be agreed as**

   i. **continued assessment of the longer-term impacts of the Covid-19 pandemic on the health and well-being of Herefordshire's people and place**

   ii. **system-wide understanding of need and demand for mental health services in the county**

   iii. **research into the drivers of Herefordshire's low economic productivity**

   iv. **continued strengthening of the evidence base by considering how to:**

   - **bring together partners' insights about vulnerabilities, safeguarding and community safety**
   - **measure the impact of environmental changes on people's well-being locally**
   - **gain a more complete understanding of what poverty and financial insecurity look like in Herefordshire**

Alternative options

1. There are no alternative options. Herefordshire Council and the Clinical Commissioning Group (CCG) have a joint statutory responsibility to produce the JSNA on behalf of the Health and Wellbeing Board.

Key considerations

2. The JSNA is a continuous assessment of the current and future health and well-being needs of the population of Herefordshire, in their widest possible sense. Its core statutory purpose is to inform the priorities of the Health and Well-being Board and the strategic planning and commissioning of services. However, it is also intended to be accessible for all stakeholders in the local area: community groups, businesses, and members of the public.

3. JSNAs should not only provide evidence for decisions about meeting health and social care needs directly, the obligation is to address the issues that affect all aspects of our health and well-being: the 'causes of the causes' of poor outcomes. This includes the place as well as the people that live and work here.

4. The aims of the JSNA are synonymous with the population health management approach which uses data to drive the 'planning and delivery of proactive care to achieve maximum impact' in improving the health of a population. Population health is

the focus of the NHS shift towards integrated care and place-based systems (ICSs), particularly in terms of prevention and reducing inequalities.[1]

5. Since approval from the Board in 2018, Herefordshire's JSNA has taken the form of a live evidence base (a range of topic and area-based evidence published on the Understanding Herefordshire website), with a holistic overarching summary every three years. The last overarching summary was produced in 2018, so an update is due in 2021.

6. The JSNA cannot be completed by analysts in isolation. Critical to its success in informing decisions is the input of subject matter experts – the service managers, commissioners and others who can apply meaning and local context to the information, and whose insights can help analysts identify what is really important.

7. The 2021 summary was developed between September and November 2021. Engagement began in May, via a mixture of sessions with established groups and boards (included external stakeholders such as the Business Board and Community Leaders' group), and 1-2-1 conversations with key subject matter experts.

8. Reflecting the change in the way intelligence has been consumed during the pandemic and feedback from stakeholders on what is most immediately useful, the 2021 JSNA Key Findings are presented as a set of slides (at appendix 1). There will also be a supplementary written report containing more of the detail that has contributed to the findings, to be completed by January 2022.

9. The 2021 JSNA summary is structured to emphasise the importance of the wider determinants as risk and protective factors to everyone's health and wellbeing, especially in the context of the climate crisis and the wider impacts of the Covid-19 pandemic. Starting at the macro level of the environment, infrastructure and the economy; then focusing in on community and individual circumstances like getting a good start, financial security and lifestyles – before ending with the health outcomes that are a result of all these factors.

10. Particular emphasis has been given to the 'golden threads' of inequalities and understanding the impacts of the pandemic, especially where it has widened existing inequalities.

11. Therefore evidence that has informed the summary is heavily weighted to the last 20 months, but it is also an opportunity to highlight some important and still relevant pieces of work completed before the pandemic, e.g. the housing stock condition modelling and the rural inequalities DPH report 2019.

12. Two surveys undertaken in 2021 provide much of the basis of our current understanding of life in Herefordshire: the Talk Community Wellbeing Survey of households (January to March) and the school-based Children and Young People's Quality of Life Survey (summer term).

13. Across all topics, four common themes emerge:

---

[1] See *The NHS long-term plan explained*, King's Fund and *Population Health Management*, PCC (10 November 2021)

a. Overall, Herefordshire is still a good place to live, with relatively low levels of poverty and deprivation, and the majority of people are happy:

   - For example, nine out of 10 people are happy with their area as a place to live and think that people get on well together; mental well-being is higher than nationally and skewed towards higher scores.

b. Covid-19 has impacted all aspects of life; increasing risks and worry for some, and widening pre-existing, deep-rooted inequalities:

   - For example, some areas of the city and market towns have been amongst the most deprived in England since the Indices of Deprivation were created two decades ago, and people who live in these areas are consistently shown to be more likely to have risk factors that lead to worse outcomes (across a wide range of different measures - from lifestyle choices to less of a sense of community).

   - Already disadvantaged people, wherever they live, have been hardest hit by the wider implications of the pandemic – one manifestation locally is that in general the areas with the highest unemployment rates pre-covid have seen the highest increases in unemployment since March 2020.

c. The headline figures mask some important minorities of people, who are at the biggest risk of poor outcomes:

   - For example the 3% of people who struggled to cope financially during 2020, the 4% who had to cut back on food and 5% on heating; the 10% who feel lonely most of the time; the 10% of primary school pupils who are likely to have poor mental health – and especially the estimated 150 people who have multiple complex vulnerabilities

d. There are also some significant risks to consider for the future – including the baseline health of many people as well as the environment:

   - Clearly, the impacts of climate change are a real threat hanging over the whole of society. Also the future risks to health posed by lifestyles – the fact that the majority of adults are overweight, for example. And the fact that we don't really know how many families are 'just about managing' and could tip over into poverty in the near future.

14. The JSNA also tries to draw out how interconnected all of the determinants of wellbeing are, and how the cumulative impact of multiple risk factors leads to widening inequalities and ultimately worse health outcomes for our most vulnerable and disadvantaged residents.

15. Key messages / priority areas can be grouped into three broad categories: place, economic and financial, and people. These are presented on slides 10 to 12 of Appendix 1.

16. The summary also considers gaps in the evidence base, and recommends that priority areas for theme-based JSNA analysis in 2022/23 should be the longer-term impacts of Covid-19, demand for mental health services, and the drivers of economic productivity.

17. Dissemination and communication plans:

    e. The 2021 JSNA Key Findings and supplementary report will be published on the Understanding Herefordshire website. Subscribers to the website will be notified via a news release;

    f. Inclusion in bulletins to staff and members, and newsletters such as Talk Community, Spotlight and Herefordshire Now;

    g. Dissemination to all of the groups who were engaged in the development of the JSNA via presentations to meetings, for example the Business Board, Community Leaders (now Community Partnership);

    h. Other opportunities as identified by board members and stakeholders to be considered, including the potential for JSNA 'champions' to share the findings with their own networks to maximise the reach.

Community impact

18. The JSNA provides an overview of the key issues affecting Herefordshire's communities. It informs the development of the Health and Wellbeing Strategy and provides evidence to inform the wide range of plans and strategies that seek to improve outcomes for Herefordshire and its population.

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

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

21. One of the main purposes of the JSNA process is to highlight inequalities between different groups of people, and this includes looked after children and care leavers where information is available. Doing so will enable other services to understand the inequalities and work to address them.

Environmental Impact

22. The JSNA is about the wider determinants of health and wellbeing, including the environment in which people live.

23. This year's summary has sought to fill gaps in the evidence base regarding the environment. The structure has also been designed to emphasise the importance of the natural environment for the health and well-being of individuals and society.

24. It includes content related to all of the environmental success measures in the County Plan.

- Impacts of flooding and levels of phosphate pollution in the county's rivers
- Carbon emissions
- Air quality
- Access to green space in Herefordshire
- Fuel poverty and cold homes
- Sustainable travel

Equality duty

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.

25. One of the purposes of the JSNA is to highlight existing inequalities across various sections of the community and to enable the commissioning of services that are equitable and accessible for all residents.

Resource implications

26. The recommendations have no direct financial implications, but the JSNA findings are intended to play a significant role in guiding the allocation of resources by all partners in their commissioning plans.

Legal implications

27. Producing a JSNA is a legal requirement of the Public Involvement in Health Act 2007.

28. The Health and Wellbeing Board has a statutory function to prepare a health and social care Joint Strategic Needs Assessment for the county.

29. The constitution at paragraph 3.5.24(e) provides that one function of the Health and Wellbeing Board is to prepare a Joint Strategic Needs Assessment for the county

30. Recommendations in the report ensure that the board complies with its legal duties and acts in accordance with the constitution and Terms of Reference for the Board.

Risk management

31. There is a reputational risk to the council if it fails to discharge its public health responsibilities as set out in the Health and Social Care Act 2012.

32. In the absence of a robust JSNA, decisions on the allocation of resources would be based on a weaker evidence foundation, such that these might not be directed towards the areas of highest priority.

Consultees

33. Emerging key messages were tested with members of the Health and Wellbeing Board at a workshop in private on 1 November 2021, and based on feedback minor wording changes were made to clarify the meaning behind the points about lifestyles and access to health services.

34. Also based on feedback during this workshop and Cabinet Briefing on 28 October 2021, plans for the summary output have changed to focus first on the delivery of an impactful slideset of key messages, to be followed by a more detailed report.

35. Requests were also made for the JSNA to include assessment of progress against the Board's priorities. The JSNA presents evidence on the 'causes of the causes' – trends and inequalities in the wider determinants of health and well-being that are a result of complex interactions between different policy decisions. As such, it is not possible to directly attribute changes in outcomes to individual priorities, but the summary includes observations about long-term trends in key indicators, as defined by the Public Health Outcomes Framework and presented on Public Health England's *Fingertips* data tool.

Appendices

Appendix 1. 2021 JSNA Key Findings

Background papers

None identified

Report Reviewers Used for appraising this report:

Governance	Sarah Buffrey	Date 11/11/2021
Finance	Kim Wratten	Date 16/11/2021
Legal	Kate Coughtrie	Date 15/11/2021
Communications	Luenne Featherstone	Date 12/11/2021
Equality Duty	Carol Trachonitis	Date 12/11/2021

Procurement	Mark Cage	Date 12/11/2021
Risk	Kevin Lloyd	Date 17/11/2021

Approved by	Rebecca Howell-Jones & Paul Smith	Date 26/11/2021 / 23/11/2021

Understanding Herefordshire
People and places

Appendix 1

Herefordshire's Joint Strategic Needs Assessment (JSNA): Key Findings 2021

DRAFT v0.012, Nov 2021

About / contents

This document presents the Key Findings of the 2021 JSNA for Herefordshire. It has been compiled by Herefordshire Council's Intelligence Unit on behalf of the Health and Well-being Board, with contributions from colleagues across the One Herefordshire Partnership.

1. About the JSNA: purpose, form and structure of this 3-yearly summary
2. Overall key messages: common themes across all topics and main strengths and challenges
3. Inequalities and interconnectedness of vulnerabilities: including impacts of rurality and impacts of Covid-19
4. Section summaries: for environment, infrastructure, economy, community, protecting vulnerable people, housing, financial security, getting a good start, lifestyles and health outcomes
5. Appendix: some of the detail behind the key findings

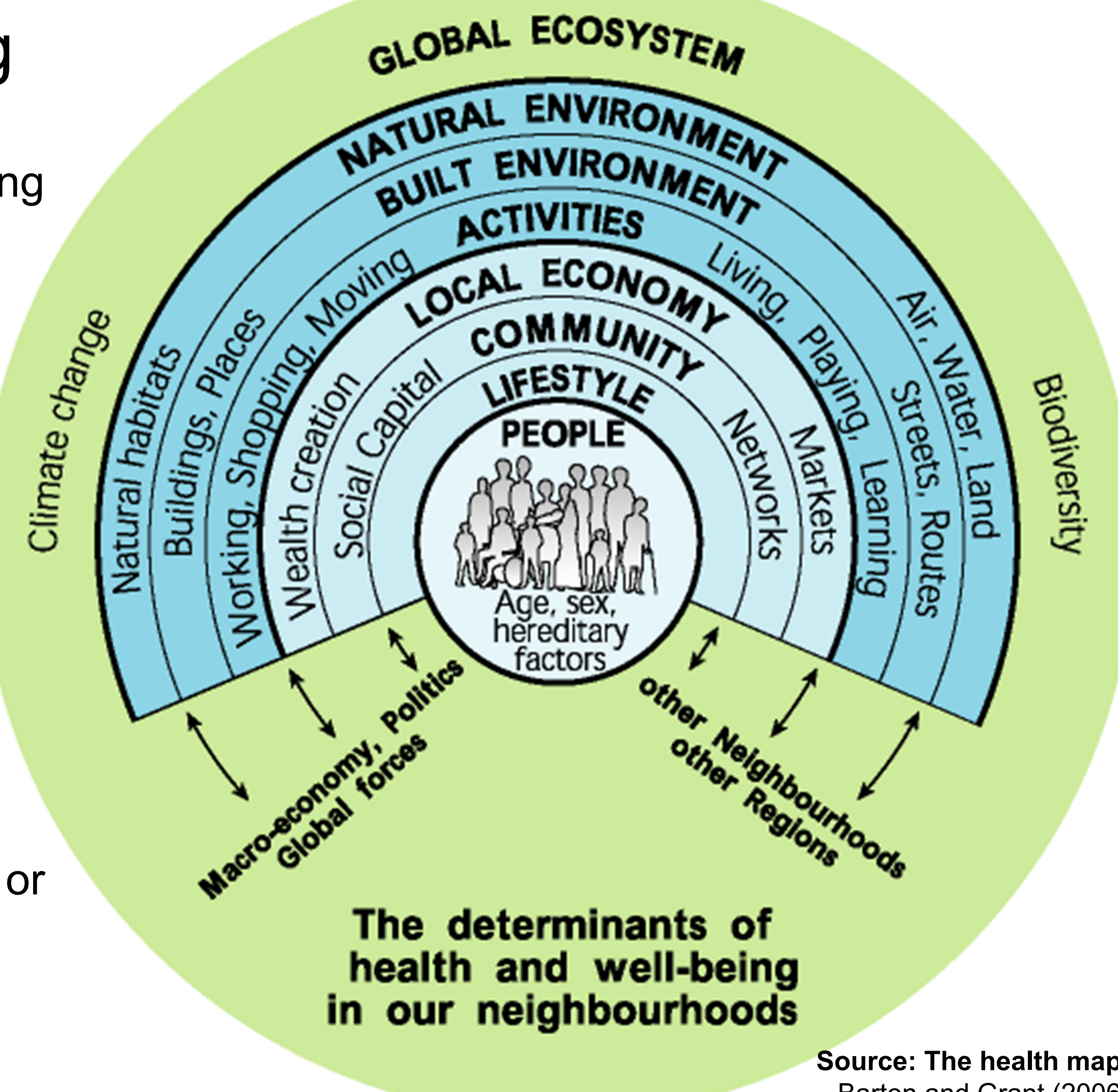
If you need help to understand this document, or would like it in another format or language, please contact us on 01432 261944 or e-mail researchteam@herefordshire.gov.uk

1. About the JSNA

Purpose and form of Herefordshire's JSNA, and structure of the 2021 summary

The JSNA: everything about everything

- ✓ Statutory purpose: inform priorities of Health and Well-being Board, but should be accessible to all
- ✓ Continuous assessment of current and future health, care and well-being needs of the population
- ✓ Wider determinants: the causes of the causes
- ✓ People *and* places
- ✓ Synonymous with Population Health Management: *data driven planning and delivery of proactive care to achieve maximum impact*
- ✓ Highlight gaps and **inequalities** between different groups or communities - so this year includes particular attention to impacts of Covid-19



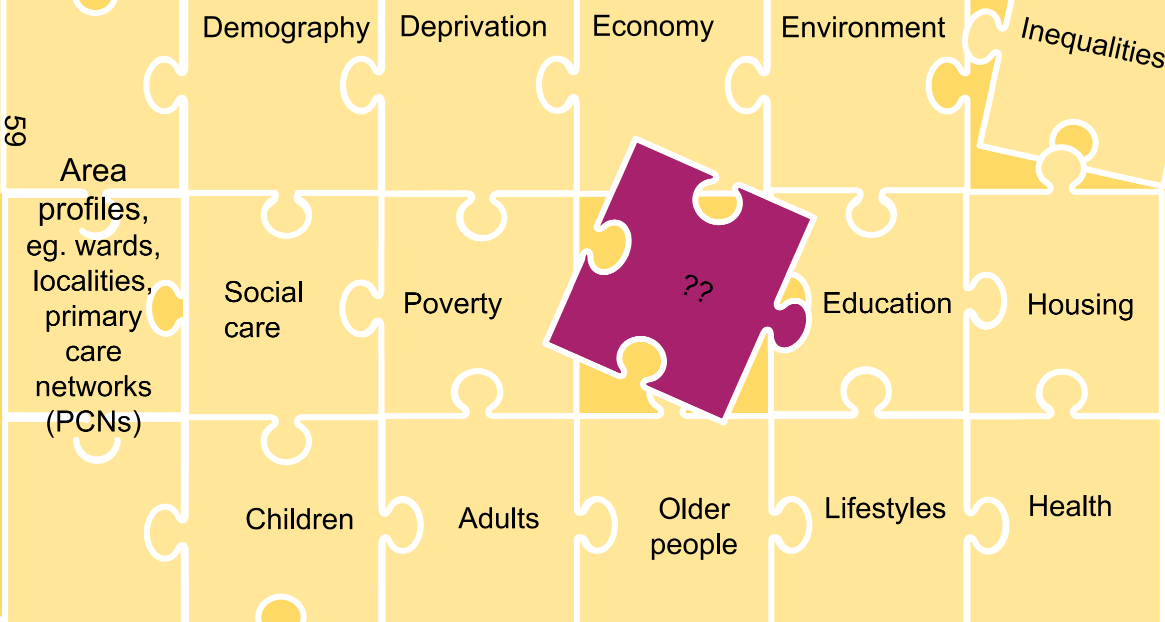
Source: The health map, Barton and Grant (2006)

Herefordshire's JSNA

Understanding Herefordshire: people and place

Live website publishing all JSNA outputs and evidence

Programme of place- and topic-based outputs



Summary of key findings (3 yearly)

Regular intelligence bulletins

New resources / data: subscribe for updates

- ✓ Provide the basis for service planning and commissioning decisions for the system
- ✓ Jigsaw of disparate evidence: JSNA is opportunity to bring it all together
- ✓ Anyone making sense of any of this information is part of the JSNA

- Corporate plan & delivery plan
- Covid recovery plans
- Health and well-being strategy
- Integrated care strategy
- PCN priorities
- … etc…..

JSNA and system priorities

Understanding Herefordshire
People and places

- These key findings summarise evidence of the main issues for Herefordshire, aiming to draw it together into a holistic picture of the county.
- JSNAs provide a strategic overview to inform strategies, plans and priorities. They focus on the 'causes of the causes' of poor health and inequalities, which are the result of complex interactions and complex systems.
- JSNAs are not intended to be tools to monitor progress against the many plans and strategies across systems, but should be used alongside such plans to provide the wider context.
- The Public Health Outcomes Framework includes many indicators of health and well-being. *Fingertips* includes the latest data for these and a wide range of other profiles (including trends and comparisons).

- In addition to the impact of COVID-19 pandemic, this JSNA covers a period of significant change for the health and social care system. Ways of working have been transformed due to COVID-19 and the establishment of the Herefordshire and Worcestershire Integrated Care System and the One Herefordshire Partnership.
- The Health and Well-being Board published priorities in late 2017, and had started to review them as the pandemic began.
- 2022 will bring a statutory requirement for an Integrated Care Strategy, which will link with the Health and Well-being Strategy.

Health and Well-being Board priorities: the current picture

JSNAs play a particular role in informing HWBB strategies. Herefordshire's HWBB published four priorities in late 2017.

- **Giving our children a good start in life by maintaining a healthy weight and looking after their teeth.** *Levels of dental decay and excess weight haven't changed. See Getting a good start and Healthy lifestyles.*
- **Supporting people with dementia to remain as independent as possible within their community, ensuring that people are well cared for when nearing the end of life.** *Dementia diagnosis rates remain significantly below the national, and haven't changed between 2017 and 2021. See Health services and prevention.*
- **Supporting the development of resilient communities, where people help each other to remain independent and in control of their own lives.** *The 2021 Community Well-being Survey confirmed that there are high levels of community cohesion and support. See Community.*
- **Keeping people warm so they are less likely to develop enduring health problems and become acutely ill when it is cold.** *Excess cold is not routinely measured, but in 2019 a higher proportion of Herefordshire homes were at risk than nationally. Fewer households were estimated to be in fuel poverty in 2018 (10,700) than 2015 (13,300); a new measure now suggests the figure was 13,900 in 2019 . See Housing.*

Structure of the 2021 JSNA summary

To emphasise the importance of the wider determinants on health and wellbeing, this summary:

- starts at the macro level of the environment, infrastructure and the economy
- moves on to community and individual circumstances like getting a good start in life, financial security and lifestyles
- ends with the health outcomes that are influenced by all these factors.

Environment
Infrastructure
Economy
Community
Protecting the vulnerable
Housing
Financial security
Getting a good start
Lifestyles
Health outcomes

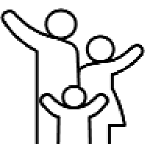
Golden threads:

Inequalities

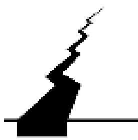
Impacts of Covid-19

2. Overall key messages

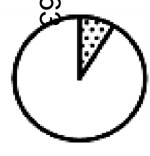
Common themes across all topics



Overall, Herefordshire is still a good place to live, with relatively low levels of poverty and deprivation, and the majority of people are happy



Covid-19 has impacted all aspects of life; increasing risks and worry for some, and widening pre-existing, deep-rooted inequalities



The headline figures mask some important minorities of people, who are at the biggest risk of poor outcomes

There are also some significant risks to consider for the future – including the baseline health of many people as well as the environment

Interconnections between risk factors and inter-generational factors

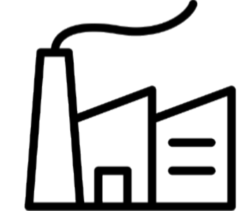
Key messages: place

- Double edged sword of rurality: natural environment vs challenges of service delivery; ‘urban flight’ and boost to economy vs affordability
- Threat of climate change and associated ecosystem breakdown

- Strong, resilient and cohesive communities – but there are significant local variations, with people in the city less likely to feel this way
- Areas of persistent deprivation in some urban areas and other hidden pockets
- Nature of housing stock and its implications on affordability; condition in the private rented sector particularly in relation to excess cold and fall hazards; and fuel poverty

Key messages: economic & financial

- **Low productivity**, with its likely (but unclear) link to low wages and dependence on agriculture and manufacturing.
- Signs of a **strong recovery** amongst businesses, but don't yet know what the low take-up of support has meant for the relatively high number of **self-employed.**



- **Skills gaps**: nursing and social care in high demand, the latter hard-to-fill; as are a range of skilled manufacturing jobs.
- **Jobs**: fared relatively well during pandemic but areas that already had the highest unemployment worst hit. Older workers out-of-work or furloughed for 6 months+ can struggle to return to employment, for younger workers long-term impact on earnings & progression and quality of entry-level jobs.
- **Social mobility cold spot** in terms of the chances that disadvantaged children will do well at school and go on to get a good job and secure housing. Driven by low wages, but there are also persistent **gaps in educational attainment** for these children – as well as for those with additional needs.

- **Financial security**: Covid has widened gap between rich and poor; unclear how many 'just about managing' families might fall into poverty in near future; more people seeking advice on problem debt.
- **Homelessness:** still small numbers, but increasing numbers of families; impact of end of eviction ban unclear.

Key messages: people

- Continuing implications of an **ageing population**, many of whom are living longer but not necessarily in good health.

- **Digital divide**: acceleration of digitisation due to COVID-19 risks leaving the 17,000 people who don't use the internet regularly; impacts on isolation, access to services and employment opportunities.

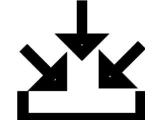
- **Loneliness and isolation**: increasingly affecting younger people; more likely amongst disadvantaged groups.

- **Mental well-being** is generally good, but Covid increased anxiety for substantial minorities (adults and children). Disproportionate risk amongst social renters, women and teenage girls, financially insecure, disabled people.

- **Lifestyles**: some positive news on smoking, but it remains a significant cause of disease - along with obesity, oral health, alcohol consumption and physical inactivity. Lockdowns had significant impacts on those most at risk of substance misuse.

- Male total and healthy **life expectancy** is no longer better than average, and health inequalities persist. Males born in the most deprived areas can expect to live 9.4 years less than those in the least deprived; females 7.7 years less.

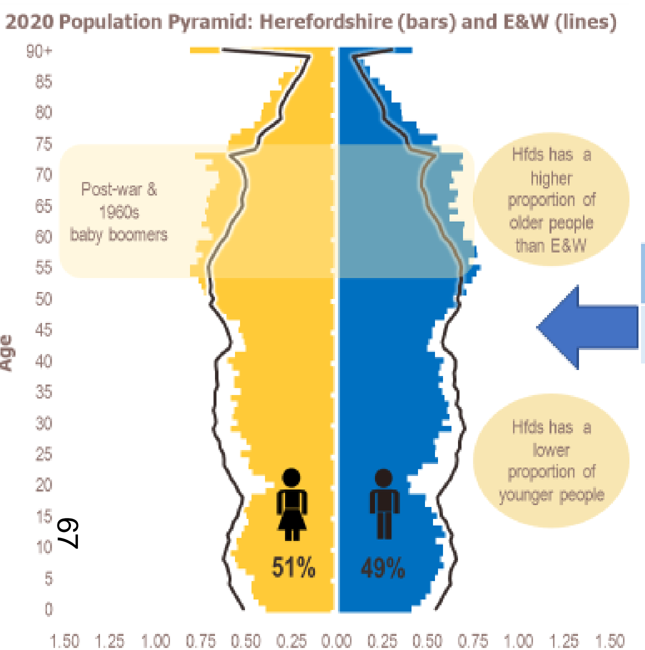
- Impact of people whose diagnosis/treatment was delayed during the pandemic now being in need of more **urgent care**, particularly for cancer and other long-term conditions. Both on their quality of life and for services.



- Interconnections between risks to both physical and mental well-being (generational, adverse childhood experiences (ACEs), substance misuse, exploitation, crime, financial insecurity): ~150 people with **multiple complex vulnerabilities** are most at risk.

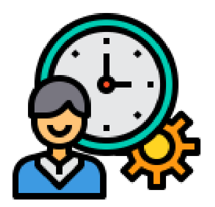
Fundamentals about Herefordshire

An ageing population



	2020	2025
65+	48,500	+11%
85+	6,500	+12%

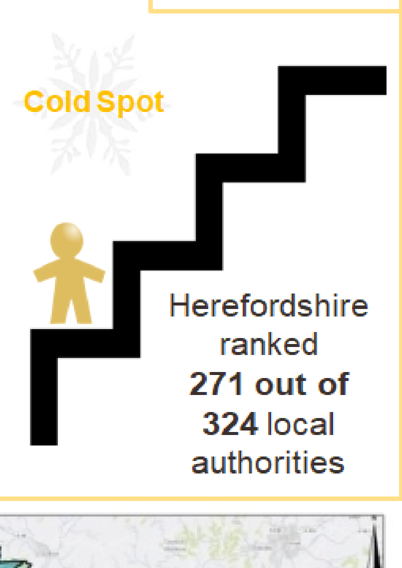
Overweight/Obese	
4-5 years	26%
10-11 years	33%
Adults	63%



1 in 3 jobs pay less than the living wage

Relatively low productivity

Social Mobility



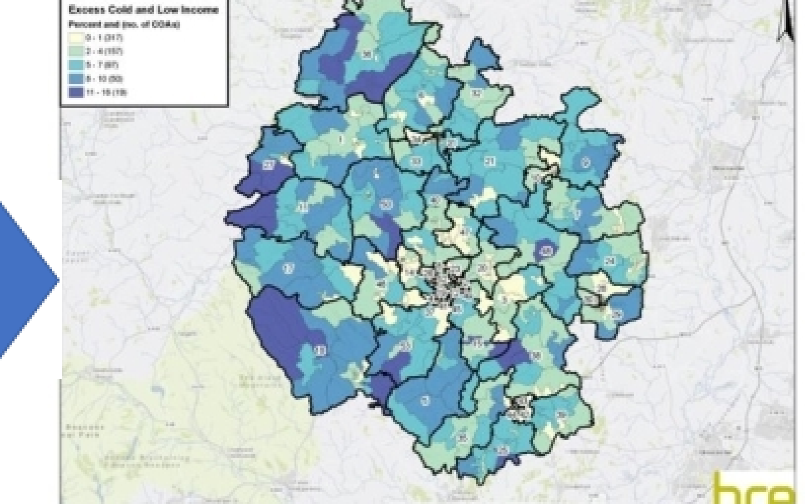
Small population in large rural county

- 193,600 residents scattered over 842 sq miles
- 4th lowest density in England
- 95% rural; 9% designated for nature conservation
- 2 AONBs; 685 local wildlife sites

- 2nd worst **housing affordability** in West Mids in 2020 (after Solihull).
- High proportion of detached houses (40% vs 23% across England)
- Many were built pre-1900 (39% vs 8% nationally)
- Private housing: significantly worse than England for **excess cold** (19% vs 4%)

Fuel Poverty:

- 17% (14,000) of households in 2019 (higher than England's 13%) on new 'low income, low energy efficiency' measure
- Rural households more at risk of combination of excess cold and low income



Gaps in the evidence base: recommendations

Based on the analysis to inform the 2021 JSNA summary, it is recommended that priorities for theme-based analysis for 2022/23 are:

- continued assessment of the longer-term impacts of the Covid-19 pandemic on the health and well-being of Herefordshire's people and place
- system-wide understanding of need and demand for mental health services in the county
- research into the drivers of Herefordshire's low economic productivity

Also to continue strengthening the evidence base by considering how to:

- bring together partners' insights about vulnerabilities, safeguarding and community safety
- measure the impact of environmental changes on people's well-being locally
- gain a more complete understanding of what poverty and financial insecurity look like in Herefordshire

3. Inequalities and interconnectedness of vulnerabilities

Golden threads running throughout all topics

Inequalities in Herefordshire

INEQUALITIES IN HEREFORDSHIRE 2021

Children and young people

- Emotional well-being and resilience appears lower for some, including disadvantaged children, those living with one parent, young carers
- Pupils who live with one parent are less likely to have been to a dentist in the last year, or to clean their teeth at least twice a day
- 4,450 under 16s are living in absolute poverty. Highest rates (>25%) in parts of Hereford, Leominster and Ross
- Persistent gaps in educational attainment for disadvantaged children, and for those with EHCP/SEND

Health

- People living in the most deprived areas are more likely to be overweight, to smoke and to be admitted to hospital due to alcohol consumption
- People living in the most deprived areas are 1.5 more likely to die prematurely of cancer, twice as likely to die of circulatory diseases and 2.5 times more likely to die of respiratory disease
- Take-up of COVID-19 vaccination is lower amongst the 30% most deprived areas
- Males born in the 10% most deprived areas of Hfds can expect to live 9.4 fewer years than those in the least deprived; for females the gap is 7.7 years
- Life expectancy measures for males are no longer significantly better than the English average (whilst they still are for females)

Older people

- Over 65s are almost 3 times as likely as <65s to provide 50+ hours' unpaid care to family/friends a week. Many unpaid carers don't have enough: time to do things they enjoy, control over their lives, social contact, encouragement & support.
- There is no significant difference in the rate of emergency admissions due to falls amongst the over 65s between the most and least deprived areas
- Older people living in the most deprived areas are three times as likely to be living in income deprivation as those in the least deprived

Community

- Over 75s, people who are economically inactive, people in housing association rented accommodation are significantly less likely to use the internet regularly
- Women and people living in the most deprived areas are less likely to feel safe in their local area after dark
- People living in rented accommodation are more likely to report struggling financially during COVID

Employment

- People accessing mental health services or who have learning disabilities are much less likely to be in employment than others
- Out-of-work benefit claimants increased the most during the pandemic in areas with already high numbers
- Women's average earnings are 4% lower than men's – a smaller gap compared to the West Midlands region (10%) and England (9%)

The impact of rurality

- 4th most sparsely populated county in England; 95% of land area is 'rural' and over ½ live in rural areas
- Better health and longer life expectancy on average, but hidden pockets of multiple deprivation
- Some health problems and domestic violence are under-reported in rural communities
- Deprived rural households can face different challenges to urban
- Geographical barriers can exacerbate inequalities, eg. transport costs, digital exclusion
- Living costs 10-20% higher for rural households, so thresholds for poverty might be different

Types of deprivation affecting rural Herefordshire are very different to urban

Overall IMD
Indoor living environment
Access to services
Income
Outdoor living environment
Housing
Crime
Health
Employment
Children's education
Adult qualifications
20% most deprived in England
Urban
Rural

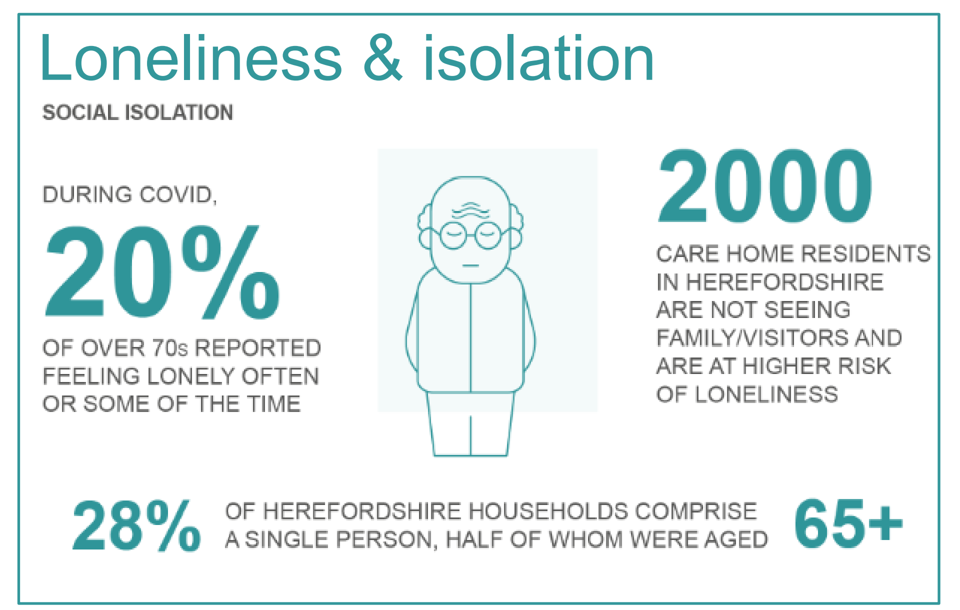
Find out more: Rural Herefordshire – what does it mean for health and well-being?

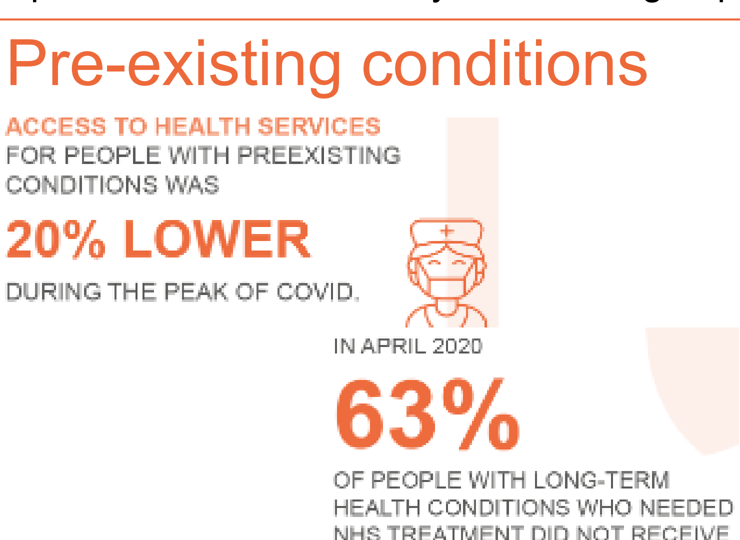
Herefordshire.gov.uk

Widening inequalities due to COVID-19 pandemic

“We are all in the same storm, but not in the same boat”*

These statistics from late 2020 (some of which are now out of date) illustrate the disproportionate effect the pandemic had on already vulnerable groups





Mental well-being

OF THE 700 HEREFORDSHIRE CHILDREN AND YOUNG PEOPLE WHO RESPONDED TO A SURVEY IN MAY/JUNE 2020

ALMOST HALF

FELT THAT THEIR OVERALL MENTAL HEALTH AND WELLBEING WAS WORSE SINCE THE START OF THE CORONAVIRUS OUTBREAK. ALTHOUGH 15% SAID IT HAD GOT BETTER.

Find out more in the Director of Public Health Report 2020: *Impacts of Covid-19*, and in our monthly *Economic Impacts of Coronavirus* updates

*Quote: Mental Health Foundation

Interconnected & compounding vulnerabilities

Understanding Herefordshire
People and places

- Many of the risk factors to wellbeing are linked to each other, and experiencing some can lead to others – compounding their effects.
- Not only can early preventative action to address these multiple complex vulnerabilities improve people's lives, it also has clear cost benefits in terms of changing their trajectory before they require intensive interventions across many services.
- Estimates suggest annual cost across statutory services in the region of:
  - £14,000 for someone who is homeless or rough sleeping with no additional needs
  - £39,000 for someone who is homeless with complex entrenched needs (mental health, health and offending).

Common risk factors

Low physical activity
Care leavers
Insecure, low-paid work
No qualifications
Unemployment
Problem debt
Homeless
Poor dental health
Obesity & poor diet
Poverty – food, fuel, struggling to make needs meet
Problem gambling

Multiple complex vulnerabilities = high risk of premature death

Project BRAVE* individuals of concern

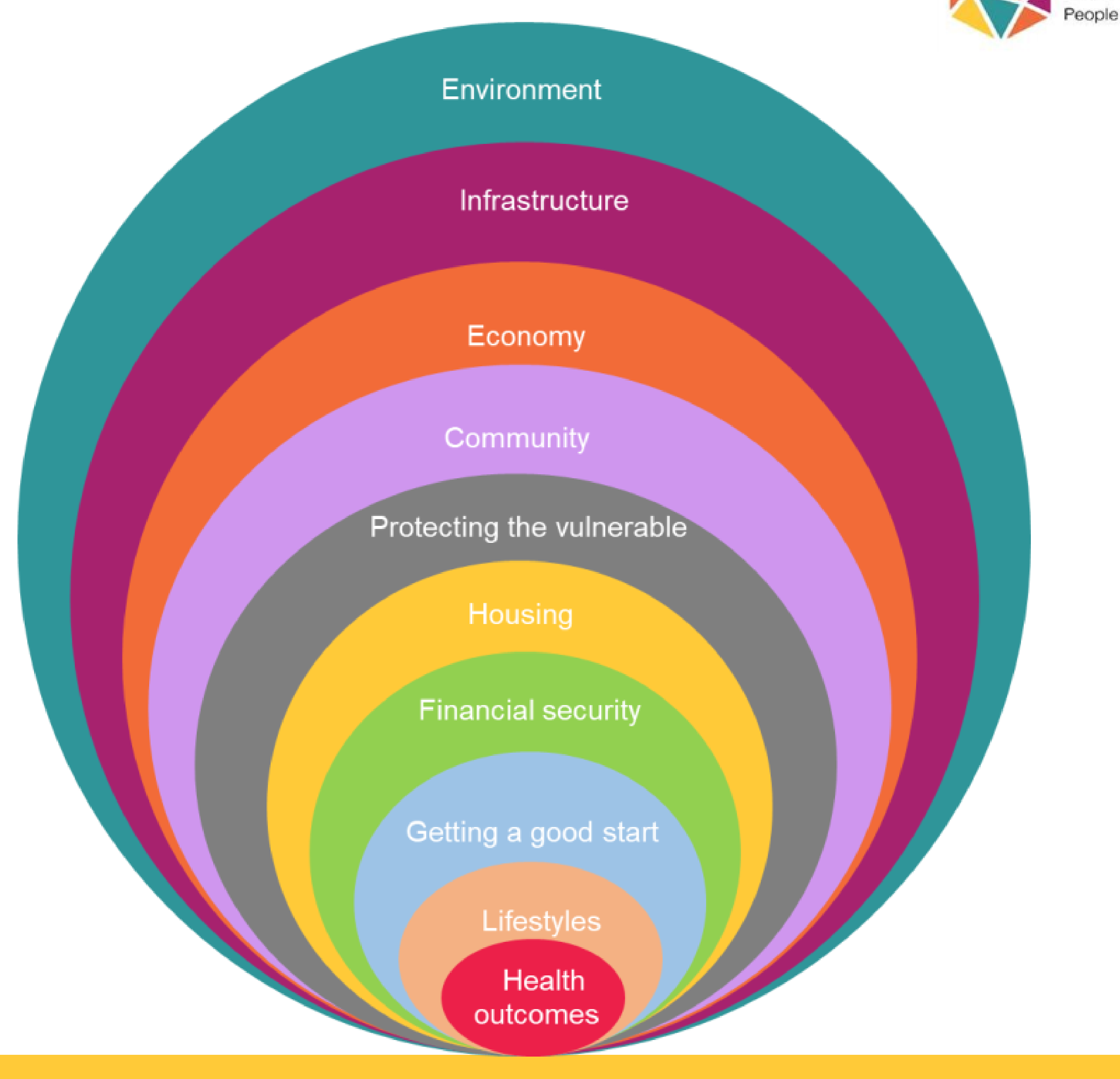
Rough sleepers & sofa surfers
People with learning difficulties
Children experiencing neglect
Self-neglect and hoarding
Mental ill-health
Substance & alcohol misuse
Offending
Exploitation
Domestic abuse
Regular emergency services contact
Supported by Families First programme

* Project BRAVE: a multi-agency response to meet the 'Everyone In' lockdown requirement, which has since expanded its strategic ambition to ''make rough sleeping rare, infrequent and non-reoccurring''.

5. Section summaries

Sections

1. Environment
2. Infrastructure
3. Economy
4. Community
5. Protecting the vulnerable
6. Housing
7. Financial security
8. Getting a good start
9. Lifestyles
10. Health outcomes

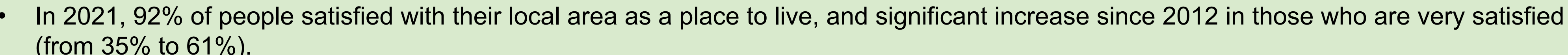


Understanding Herefordshire
People and places

Environment

Rich, varied and supports a wealth of healthy outdoor activities and interests.

An important protective factor for health and wellbeing.



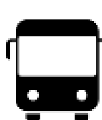
- In 2021, 92% of people satisfied with their local area as a place to live, and significant increase since 2012 in those who are very satisfied (from 35% to 61%).
- In 2018, pre-covid, 78% of people said they'd visited a natural heritage place (park or garden) in the past year and 63% visited 'every few months.' 60% spent time outdoors daily (excluding shopping trips/chores or time spent in their garden) with middle-aged people spending more time outdoors than younger people.
- Herefordshire fares relatively well in terms of access to green space but access to woodland is lower than nationally, and there are some variations in terms of access to the recommended equivalent of two football pitches within 10 minutes' walk.
- In 2021, 8% of people said parks and open spaces are the aspect of their local areas that most needed improving (the fourth highest proportion but nowhere near the 46% that cited roads and pavements) and only 2% (the joint lowest) say access to nature.
- Generally relatively low levels of air pollution but still two air quality management areas where levels of nitrogen oxide are higher than government standards (a section of the A49(T) corridor in Hereford and the A44/B4361 around Bargates, Leominster).

But these positives are being undermined by multiple risk factors:

- Climate change will mean more extreme weather events with consequent threat to lives and livelihoods.
- Here as elsewhere, intensive agriculture and development has over many decades degraded or destroyed habitats and led to a loss of biodiversity.
- Phosphate pollution currently poses a severe threat to the county's river ecosystems and is delaying much-needed development. However, innovative wetland solutions are being developed to try to alleviate this problem.
- Fly-tipping increased during the pandemic and has yet to fall to pre-COVID levels. Ever-increasing plastic pollution threatens water quality and wildlife.

Infrastructure

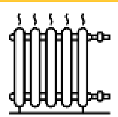
Herefordshire is one of England's most sparsely populated counties, **road infrastructure** mainly comprises minor roads with only the south-east directly connected to the motorway network.



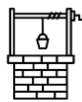
Limited **public transport** options – large areas no longer served by the rail network and bus travel does not offer a viable alternative to private cars in isolated rural areas. Bus usage took a big hit during COVID and has yet to recover. Majority of residents who travel to get to work do so by driving themselves in a car or a van (70%).

Unsurprisingly, transport is the biggest source of **carbon emissions** in the county accounting for 36% of total emissions.

The **state of the roads** is consistently the thing residents are least satisfied with (46% of people rated it most in need of improvement in the Community Well-being Survey 2021, and frequently cited in Budget consultations).

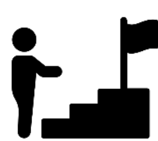


A lower proportion of houses in Herefordshire are connected to **main gas** than nationally (69% compared to 87%), with implications for heating costs, cold homes and fuel poverty (see Housing).



Over 2.000 households with **private water supplies** and not connected to mains sewers.

Historically access to **high-speed broadband** has been an issue but this is improving with coverage now over 90%. There is no dataset on mobile data coverage.



These challenges have implications in terms of living costs, access to services, education and employment. Low-income households living in isolated rural areas are disproportionately affected: almost two thirds of all Herefordshire LSOAs are among the 25% most deprived in England in respect to geographical barriers to services. They act as a constraint to both social mobility and business investment (with consequent implications for productivity and growth). Reducing carbon emissions from transport has additional challenges in rural areas.

Economy

Higher proportion **self-employed** than nationally (17% vs 10%*). 98% of enterprises comprise **micro** (0-9 employees) and **small businesses** (10-49 employees)

Lower proportion of workforce **qualified to NVQ4** and above than nationally (43% vs 50%*). Consistently high demand for nursing skills and some evidence of **hard-to-fill vacancies** in personal care services and some skilled manual occupations where it may reflect a **skills gap**.

Lower **unemployment rate** than nationally (3.5% vs 4.9%*). The claimant count for out-of-work benefits more than doubled during the first COVID-19 wave but has since fallen though remains 55% above pre-pandemic levels (October 2021). Broadly, areas that had the highest numbers pre-pandemic saw the largest increases.

Much higher proportion of **employments** in agriculture, forestry & fishing (12% vs 1%^) and manufacturing (13% vs 8%^) and lower proportion in professional, scientific & technical (5% vs 9%^) than nationally

Lowest **median earnings** of all 14 West Midlands authorities and the fifth lowest median earnings of all local authorities in the country

Second lowest **productivity** (GVA per hours worked measure) of any NUTS 3** sub-region of Great Britain

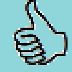
National evidence suggests **older workers** furloughed or unemployed for 6 months or more finding it hardest to re-enter the labour market.

* Great Britain ^ England **The NUTS classification (Nomenclature of territorial units for statistics) is a hierarchical system for dividing up the economic territory of the EU and the UK

Community

Living in a strong, diverse and cohesive community can provide a sense of identity, purpose and belonging. Strong local support networks can help prolong independent living. Conversely, areas with little sense of community, a lack of integration between different groups, or high levels of crime and anti-social behaviour, present significant risks to health and wellbeing.

Satisfaction with local area

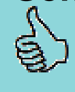


9 in 10 people are satisfied with their local area as a place to live.

Satisfaction is significantly lower among -

- people living in the most deprived areas
- younger people
- those who have lived in the county for less than 10 years

Sense of belonging



9 in 10 people say they belong to their local area strongly and there has been a marked positive improvement in attitudes since 2012.

Sense of belonging is lower in Hereford City among deprived households and among those who have lived in Herefordshire for less than 10 years.

Community support

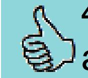
4 in 5 people felt that their community had supported each other during the last year (in the period covering the February 2020 floods and the first twelve months of the COVID pandemic).

4 in 5 people also agree that if they needed help during the pandemic, there would be people in their community who would be there for them.

Diversity

9 in 10 people believe that their local area is a place where people of different backgrounds get on well together (much higher than the 69% who did in 2012).

Community safety - Herefordshire is a relatively safe place to live and people generally feel safe living here.



4 in 5 people say they feel safe outside in their local area after dark, a significant improvement since 2012.

Feelings of safety are markedly lower among -

- people who live in the most deprived areas
- people who live in areas defined as ‘City and Town’
- younger people
- females
- those who rent their property
- those who do not feel a strong sense of belonging to their area

Connecting with others

Social isolation and loneliness

Involuntary social isolation and loneliness have a range of negative impacts on well-being. Older people in particular are often linked to living alone. Mental ill-health is a risk factor for loneliness and is more likely to affect people who are lonely.

10% people who say they feel lonely always or often

Highest levels of loneliness:

- *People living in most deprived areas (22%)*
- *housing association renters (20%)*
- *non-White British (19%)*
- *in poor current health (21%)*

- **16,600 (14%) of households were occupied by a single person aged 65 or over** in 2017 (compared with 12% & 13% in England and the W. Mids respectively). Numbers are expected to increase to 24,300 by 2035.
- **28% of people talk to family and friends less than before the COVID-19 pandemic.** Reduced contact much more likely for people living in the most deprived areas (45%) or in social rented accommodation (41%); with a disability (33%); with low mental wellbeing levels (54%); who have felt lonely often/sometimes in the last year (40%).
- **27% of people talk to neighbours less than before the COVID -19 pandemic.**

Digital divide

Having access to, and being confident using, the internet is increasingly important for accessing services, education and employment. Being digitally excluded is a risk factor for mental wellbeing.

11% 17,000 adults (age 16+) who don't use the internet

Main reasons for adults not using the internet: don't feel they need to use it or lack the necessary skills. Latter is highest among people:

- *aged 65+ (33%)*
- *living in most deprived areas (71%)*
- *with a disability or long-term health condition (40%)*

In 2019, 52% of Telecare service users didn't use the internet and 37% of them do not want to use it.

- **COVID has accelerated the pre-existing trend toward greater reliance upon digital communication and services** and locally the majority (69%) of people had made greater use of the internet during the past 12 months.
- **A significant minority of 22% feel concerned about the fact that more things are being provided online.** Concern is higher among respondents who do not regularly access the internet (38%), among those 65+ (28%), among the economically inactive (26%), and among the retired (28%).
- **Around 300 children in Herefordshire live in households where no home broadband above 2mbps is available at the premises and around 1,800 where there is no internet above 10mbps.**

Caring for vulnerable adults

2,200 adults are supported by Adult Social Care (ASC) services*

** Average number of adults aged 18 & over accessing long-term support from ASC at any one time during 2020-21.*

- Herefordshire Council supports around 750 people to meet their assessed eligible social care needs in a care home. This is around a third of the total Herefordshire care home capacity; the remaining placements are used by self-funders, the NHS, other local authorities, or are vacant.
- The need for care home beds for those aged 65 and over is projected to increase by around 70% over the next 20-years *(in the absence of changes to eligibility criteria or other policies that would affect future trends).*

- Herefordshire Council currently commissions just under 10,000 hours of home care per week from providers to support around 700 customers at any one time. This is around 60% of the total market in Herefordshire.
- The need for home care provision for those aged 65 and over is projected to increase by around 70% over the next 20-years *(in the absence of changes to eligibility criteria or other policies that would affect future trends).*

Find out more: Herefordshire Market Position Statement 2020-2025

Social care workforce

6,300 jobs
in adult social care

Herefordshire experiences workforce issues in relation to recruitment & retention, particularly in the home care service.

Unpaid carers

21,000 people (11%)
providing at least an hour of unpaid care a week *(Census 2011)*

In the more recent 2021 Community Wellbeing Survey, 23% of people indicated they provide unpaid care.

Armed forces community

- Herefordshire's Armed Forces community make an outstanding contribution to society with the majority of service personnel settled with their families, or as veterans having adapted well to civilian life.
- A minority of veterans have issues with mental health, housing, employment and training, and interactions with the criminal justice system.
- A great deal of work has been done by the Armed Forces Covenant and local authorities to ensure those who serve or who have served in the Armed Forces, and their families, are treated fairly.

Find out more: Armed forces community needs assessment 2019

Safeguarding the most vulnerable

- Throughout the JSNA, we highlight the interconnections between many of the risks to both physical and mental well-being: generational, adverse childhood experiences (ACEs), substance misuse, exploitation, crime, financial insecurity. These multiple complex vulnerabilities (MCVs) increase the risk of leading chaotic lifestyles and dying prematurely.
- Although few in number, people with MCVs consume a disproportionately high amount of resources across multiple services. At the start of the pandemic around 150 individuals with MCVs were identified by strategic partners, many of whom will have had at least one adverse childhood experience.
- Rough sleepers are one of the groups most likely to have MCVs, and have a shorter life expectancy. They were an early focus for Project BRAVE, which was initially set up to meet the government requirement of 'Everyone In' at the start of the first lockdown, when 200 people were provided with emergency accommodation at fifteen sites across Herefordshire. Its strategic ambition has since expanded to ''to make rough sleeping rare, infrequent and non-reoccurring''.
- Referrals to Herefordshire Adult Safeguarding are currently 25% higher than they were a year ago, believed to be partly due to increasing need due to COVID-19 and partly to increased awareness.
- A Complex Adult Referrals Matrix approach can contribute to positive outcomes for adults and greatly aids meaningful communication between services; over the last six months there has been a clear uptake in the use of CARMS by services.
- There is scope for further intelligence sharing across agencies to provide a more holistic understanding of the key vulnerabilities that lead to these complex cases.

Domestic abuse

7.3% of women and 3.6% of men aged 16-74 estimated victims

- An estimated 4,900 women and 2,400 men aged 16-74 were victims of domestic abuse (DA) in Herefordshire during the year to March 2020.
- Domestic abuse offences have been increasing steadily over the last 3 years, and in 2020/21 there were almost 2,200 offences recorded in Herefordshire by the police.
- Victims of DA are more likely to be younger and that prevalence rates largely decreases through the age groups.
- The majority of DA is between partners, with 4% of adults having experienced this type of abuse, and 1.9% of adults experiencing abuse from family members. Women are also most likely to be victims of all types of DA, although the difference in prevalence between men and women suffering family abuse is much smaller than the difference in prevalence between men and women suffering partner abuse.
- There were reports in national media that COVID-19 restrictions led to a large increase in domestic abuse, but local data does not suggest this has been the case in Herefordshire.

Housing in Herefordshire

Stock

High proportion of detached houses (40%) compared to England (23%)

Many (39% vs 8% nationally) were built pre-1900

Mains gas 69% of properties compared to 87% nationally

Housing delivery had not reached Core Strategy targets over the three years prior to 2020, with the delivery of just 80% of the target. However, last year saw an improved delivery rate of 106%

During 2020, around 1,100 households were eligible for prevention from homelessness or homeless relief

Affordability

Average house price rose by 15% in year to Sept 2021, to £279,500.

Consistently one of the worst areas of the West Midlands for housing affordability (2nd worst in 2020)

Fuel poverty

17% (14,000) of households in 2019 (higher than England's 13%) on 2021's new 'low income, low energy efficiency' measure.

Under the old 'low income, high cost' measure the last estimate was 13% (10,700) in 2018, compared to England's 10%. Lower than the 17% in 2015, although estimates fluctuated since 2011.

Condition

High proportion of dwellings perform worse for excess cold hazards: 17% compared to 3% in England, 2019)

27% of properties in the owner occupied and 25% in the private rented sector were rated (2019) as having a serious hazard, largely due to excess cold and presence of fall hazards.

Similarly, 24% of owner occupied dwellings and 21% of private rented dwellings have an EPC (Energy Performance Certificate) rating below band E. Under legislation which came in to force in April 2020, landlords can no longer continue to let such domestic properties, unless they have a valid exemption in place.

Financial security

Nationally the gap between the most and least well-off households has widened and there is widespread concern about combined impact of the end of the Universal Credit uplift, rising inflation (especially in energy, food and fuel prices), and the end of the ban on bailiff-enforced evictions on struggling families, especially those where no one is in work.

The local picture

- Herefordshire has historically had a low-wage economy with an above average proportion of elementary occupations.
- Pre-COVID (2019), around 18,500 people living in income deprivation across Herefordshire (10% of the population). More than half (57%) of these in urban areas of the country.
- Historically, Herefordshire has had relatively low levels of both absolute and relative poverty [see next slide] compared to nationally but there is an increasing trend (in line with the national picture) for numbers living in relative poverty.
- In the first quarter of 2021 14% of households in Herefordshire said they were finding it difficult to pay for their basic living needs (CWS, 2021).
- At the same time, 5% of people said they always or often cut back on the use of their heating and 4% always or often skipped meals or ate less (CWS, 2021).
- Anecdotal evidence from local foodbanks is that more people were supported during 2020; Hereford Food Bank saw a marked spike in food distribution in April and May of 2020, falling away during the summer before rising again the autumn.

Find out more: Economic impact of coronavirus bulletins produced monthly during 2020 and 2021

What does poverty look like in Herefordshire?

Being in relative poverty is officially defined as having an income of less than 60% of the average (median) household income. Absolute poverty is where someone lives in a household with an income that is below a level that was the relative low-income threshold in 2010/11 adjusted for inflation. However, the Joseph Rowntree Foundation and others are campaigning for a Minimum Income Standard that would raise many low-income households out of poverty and mean they could afford to buy more necessities.

There are many individual indicators of financial insecurity in Herefordshire, but it's not currently possible to determine how they relate to each other – which means we don't have a clear picture of those people who are 'just about managing'

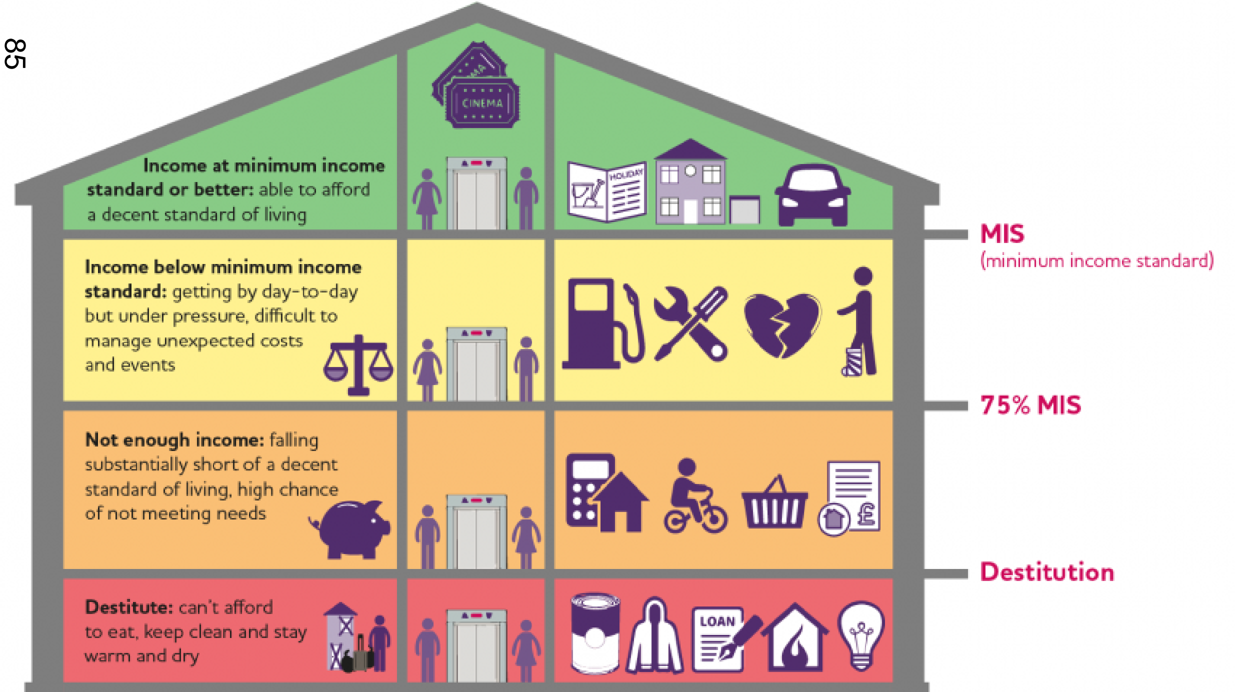
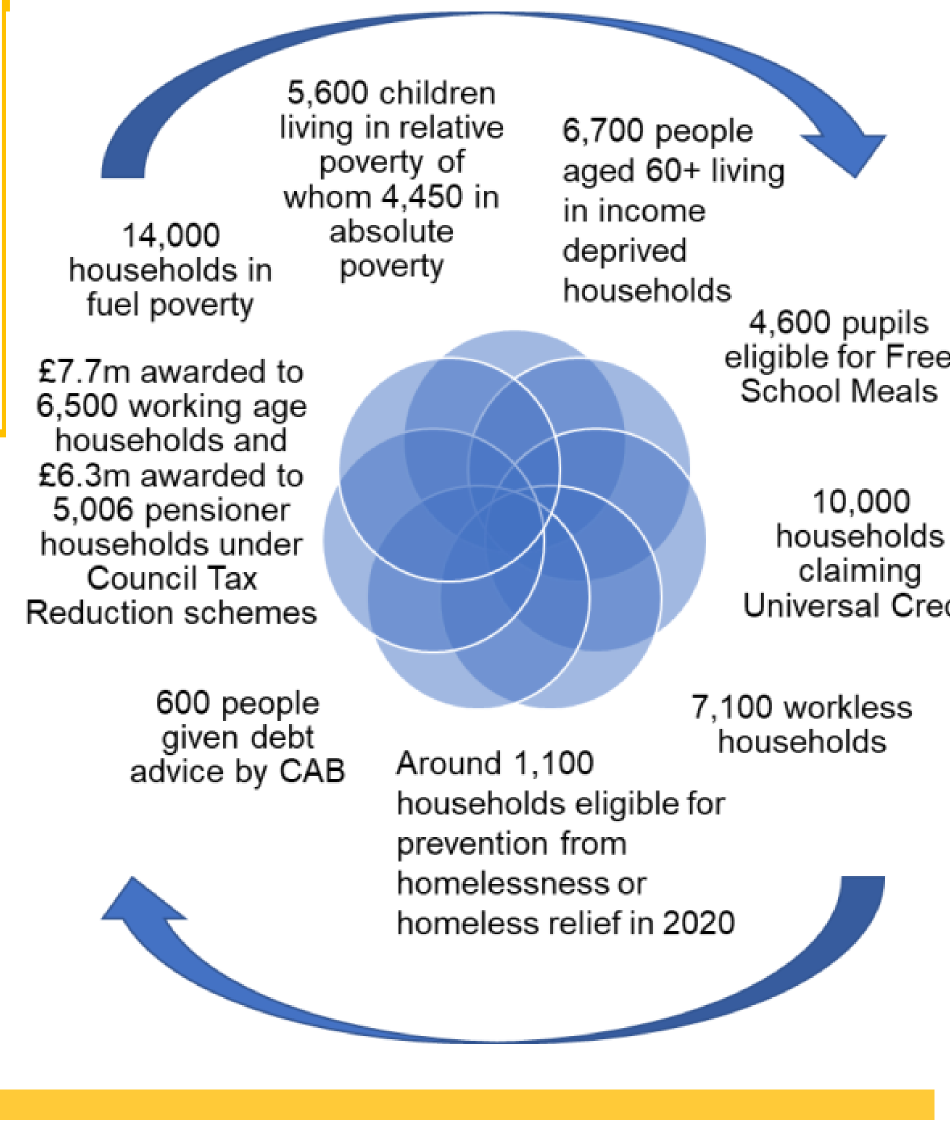


Image credit: [the three levels of poverty](), Joseph Rowntree Foundation



Getting a good start: children and young people in 2021

Health and well-being

- Few underweight babies, increasing rates of breastfeeding at 6-8 weeks, and falling teenage pregnancies. But smoking at delivery is high, falling vaccinations of 2 year-olds and rising A&E attendances for <5s.
- Obesity doubles between ages 4-5 (10%) and 10-11 (20%), and one in three 5 year-olds have dental decay (see *Healthy lifestyles*).
- Healthy eating: only a fifth had 5+ portions of fruit and veg 'yesterday'; falls with age although older pupils less likely to eat crisps, sweets and chocolate 'most days'.
- By the last year of primary, boys are more likely to be physically active than girls.
- Smoking and drinking amongst secondary pupils has fallen since 2007.
- Correlation between risky behaviours: drinking, smoking, drugs and sexual relationships. Those with no trusted adult more likely to drink or smoke.
- Although most are happy with life, only a quarter of teenagers say that their lives aren't affected much by worry and anxiety. Most common worries are the future, the way they look, and their mental health. (see *Mental Health*)

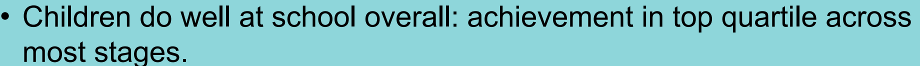
Safe environments (physical, online, safeguarding)

- Majority of pupils (2/3) feel safe in their local area during the day, but 1/3 of primary and ¼ of secondary never feel safe going out after dark.
- 1/3 are sometimes afraid of going to school because of bullying, and 1/5 have been bullied in the last year. Fewer than 1/10 feel unsafe online, and cyber-bullying doesn't feature very highly on the list of what they worry about.
- 5,500 children live in households with any of the so called 'toxic trio' of domestic abuse, parental mental ill-health or substance misuse; 300 of them with all three. Rates are amongst the lowest in England. These children are most at risk of harm or neglect.
- 'Children in Need' of support from social services have increased in last 18 months; the rate is now above comparators. Within this, the proportion of children in care (LAC) remains significantly higher than would be expected. Although the number of children with protection plans (CPPs) has increased since early 2020, the rate remains lower than average.
- Majority of CPPs are due to emotional abuse (1/2) or neglect (1/3), and ¼ of children with a plan in 2021 had one previously.

Relatively low child poverty, and no change in absolute poverty in last 5 years (14%) whilst national rate has risen (to 16%)

But still means that **4,450 <16s were living in absolute poverty** in 2019/20

Highest levels of deprivation in parts of Hereford, Leominster and Ross (> 25%)



Education and moving into adulthood

- Children do well at school overall: achievement in top quartile across most stages.
- But persistent inequalities: disadvantaged children (incl. eligible for free school meals) do less well than peers, with indications that the gap was already widening pre-covid.
- Full impact of pandemic not yet known, but national studies indicate these children have fallen further behind. At schools who shared GCSE results in 2020, attainment rates for disadvantaged pupils and those with EHCPs were amongst lowest in England.
- Proportions of young people not in education, employment or training (NEET) remain high – although we have fewer 'unknowns' than nationally. We don't know the status of many care leavers.
- All contribute (with local low wages) to county being a social mobility 'cold spot': one of the 20% worst areas in terms of the chances that disadvantaged children will do well at school and get a good job and secure housing.
- Only 1/4 teenagers feel they have enough guidance about options after leaving school – although this almost doubles amongst non white British and disadvantaged pupils.
- Following a review of local approaches, the rate of first time entrants to the Youth Justice System had fallen to average levels by 2019.

Be part of the community

- Overall majority feel strong sense of belonging (to school, neighbourhood, county and Britain), although dips amongst secondary pupils
- Mixed picture on 'having your say', with the majority having chances to give their views but around half say it makes no difference (*Feeling of belonging*)
- Majority make use of parks / open spaces, and around half of all school-age boys and girls take part in sports clubs or classes (the most common leisure activity for all).
- Over half said that nothing stops them doing the activities that they want to do; for those who do face barriers, the main reasons are being too busy doing other things or having nothing that they wanted to do.

Healthy lifestyles

Lifestyles and associated health issues are generally better than nationally, but there is significant variation, often linked to areas of multiple deprivation

Oral health: not good

- Remains significantly worse than across England: a third of 5 year-olds showing visible signs of decay in 2018/19. Little change over last 10 years and compares unfavourably even with other unflouridated areas.
- Access to dentists has historically been an issue in Herefordshire and national reports suggest that the pandemic has exacerbated this problem. In summer 2021 around half of children and young people said they had seen a dentist in the 2020/21 academic year.
- Poor oral health and oral diseases disproportionally affect people who are disadvantaged, vulnerable or socially excluded. In Herefordshire primary school children living with one parent are less likely to brush their teeth twice a day, or to have seen a dentist than those living with both parents.

Find out more: *Oral Health Needs Assessment, 2019*

Smoking: positive news

- Remains less common than nationally, and has fallen by a third in recent years (to 2019/20). Numbers accessing Stop Smoking support increased during the pandemic - with early indications that quit rates have improved.
- Smoking-related mortality has also fallen and is lower than nationally, although hospital admissions have remained stable.
- Encouragingly high rates of children and young people have 'never smoked'.
- **However…**there are still almost 20,000 smokers across the county, with those in the most deprived areas twice as likely to smoke and to die from smoking related conditions than those in the least deprived. In 2019/20 significantly more mothers are known to be smokers at time of delivery: 14% compared to 10% for England

Food, activity and weight: mixed picture

- As nationally, rates of excess weight continue to rise, and increase with age: in 2019/20 26% of Reception children, 34% of Year 6, and 61% of adults were overweight. Some link with deprivation, but importantly, there are no areas of the county where fewer than 12% of 11 year-olds are obese.
- 1 in 2 children and young people and 2 in 3 adults routinely eat the recommended '5 a day' fruit and vegetables: little change in recent years, higher than across England. Secondary pupils who are eligible for free school meals are less likely to eat vegetables most days (36% vs. 52%).
- Physical activity rates are higher than nationally, although close to 20% are considered to be physically inactive. A substantial minority of adults (42%, early 2021) said their levels of activity had fallen during the pandemic - social renters and disabled people the most likely to say this.

Alcohol & substance misuse: difficult to tell

- Little known about current levels of alcohol consumption amongst adults in Herefordshire, although previously similar to the national picture. Indications are that nationally overall levels of consumption increased during lockdowns.
- Following the national trend, alcohol-specific hospital admissions continue to rise, with 600 seen in 2019/20.
- People from the most deprived areas remain twice as likely be admitted to hospital and 50% more likely to die prematurely due to alcohol than those in the least deprived.
- Nationally, problematic use of drugs such as heroin and crack cocaine more common in otherwise disadvantaged communities. Furthermore, those drug users living in more deprived areas less likely to get care and treatment. Opiate and crack cocaine use appears less prevalent here than nationally, although the age profile of users is older than in neighbouring authorities.

Find out more: *Alcohol Needs Assessment, 2019*

Inequalities in healthy lifestyles

IMD 2019 in local context
(Herefordshire quintiles)
Darker = more deprived

88

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People and places

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Those living in the most deprived areas are more likely to overweight than those living in the least deprived areas. In Herefordshire:

23%

ADULTS

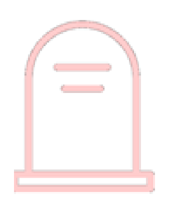
in most deprived areas are 23% more likely to be overweight compared to those in

2X

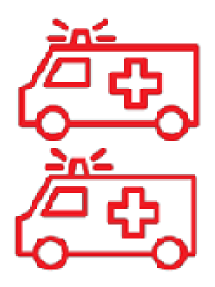
CHILDREN

in most deprived areas children are twice as likely to be obese compared to those in least deprived

People living in the most deprives area of Herefordshire are twice as likely to smoke compared to those in the least deprived.



Those living in the most deprived areas are twice as likely to die prematurely than those living in the least deprived areas



Adults living in the most deprived areas of Herefordshire are twice as likely to be admitted to hospital for alcohol specific conditions

Mental health

Nationally, Covid-19 increased many of the pre-existing risk factors for mental health, as well as generating anxiety around contracting the virus, raising demand for services.

At the same time, the supply of specialist mental health services has fallen with a sharp drop in adults in contact with MH services in April 2020 and which is still no where near pre-pandemic levels.

(Institute for Fiscal Studies, Nov 2021)

Recap of mental health risk factors in Herefordshire

- 10% of adults say they feel lonely always or often.
- 5% of adults always or often cut back on the use of their heating and 4% always or often skipped meals or ate less during the COVID-19 pandemic.
- Over 7,000 workless households.
- 7% of women and 4% of men aged 16-74 were victims of domestic abuse in the year to March ‘20.
- Alcohol-specific hospital admissions continue to rise, with 600 seen in 2019/20 but opiate and crack cocaine use appears less prevalent here than nationally.
- During 2020, around 1,100 households were eligible for prevention from homelessness or homeless relief.

Mental wellbeing outcomes

- 10% of adults have a poor wellbeing score (on the Warwickshire Edinburgh Mental Wellbeing scale)
- 28% of Herefordshire adults rate their anxiety levels as 6-10 (where 10 is completely anxious). Covid-19 increased anxiety for 45% of adults and 40% of school-children locally. More likely amongst women, housing association renters and disabled people.
- 25% of primary and 48% of secondary/FE age pupils had low/medium-low mental well-being scores in summer 2021. Emotional well-being and resilience is lowest amongst teenage girls.
- Around 4,900 young people are living with a parent with severe mental health issues.
- 65% of those affected by flooding in 2019/20 said it had affected their mental health, and 85% were worried about being flooded again in the future.
- The number of Herefordshire patients diagnosed with depression increased by 13% (to 19,850) between March 2020 and November 2021.
- The volume of Harm Assessment Unit referrals from the police to Adult Safeguarding has substantially increased over the last 24 months; currently over 100 each month. On average 50% of the referrals received from police each month are mental health related.

What does this mean for access to Mental Health Services

Uncertainty about current and future demand and how this will impact in terms of access to services

Health services and prevention – the bigger picture

Health inequalities are unfair and avoidable differences in health across the population. These are related to age, the conditions in which we are born, grow, live and work, all factors which influence opportunities for good health, and how we think, feel and act which in turn shapes our mental health, physical health and wellbeing. These factors have all been influenced by Covid-19, resulting in many cases, in the widening of inequalities compared to before the pandemic.

Inequalities in health care and treatment

An assessment across four care pathways (COPD, heart failure, hip arthritis and cataracts) for each ICS in the Midlands in 2021 found:

- The likelihood of emergency hospital admission increases with level of deprivation, particularly aged 55+
- Whilst, as seen across the region, patients living in the most deprived areas are more likely to be identified by GPs and placed on a heart failure register there does not appear to be significant inequality across the rest of the pathway.
- Inequalities exist across deprivation levels in hospital admissions for respiratory diseases, mental and behavioural disorders and disorders of blood and immune system.
- Although local BAME populations are small there are indications that considerable inequalities exist across a range of conditions for people from non-white ethnicities.
- In particular, it appears that people from the most deprived areas, or who are not 'white' are several times more likely to be discharged without a firm diagnosis. Further investigation as to why was recommended.

For reasons both of fairness and of overall outcomes improvement, the NHS Long Term Plan is taking a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care.

Trends in prevention and protection: pre-Covid (up to 2019/20)

- Overall cancer screening rates were higher than in England, although for some county GP practices they were lower. While generally similar to, or better than nationally, rates of breast and cervical cancer screening amongst older women were falling, while those for bowel cancer and cervical amongst younger women had been rising.
- Screening uptake is lower in the most deprived areas while mortality rates from cancers were higher compared to least deprived areas.
- Prevalence of diagnosed diabetes was increasing steadily in line with the national pattern, although it is estimated that over a third of cases remain undiagnosed.
- Mixed picture for school age vaccinations: proportion of 5 year olds receiving two doses of the MMR vaccine remains steady and higher than England, but the uptake of the HPV vaccine in 12-13 year old girls had fallen to below the national figure.
- As observed across the country the proportion of those aged 65+ who have had a flu vaccine increased during the pandemic and is now higher than nationally (83% in 2021, compared to 81% for England)

Health care towards the end of life

- Despite the ageing population, the proportion of people aged 65+ diagnosed with dementia has not changed since 2017: 3.4% in 2020 (1,600). At just over 50% of estimated cases, the diagnosis rate is one of the worst in England (nationally 62%).
- A system-wide approach to falls prevention has been a priority in 2020/21. An estimated 8,000 patients are at high risk of a fall, 2,000 of them severe. A 2020 Healthwatch consultation found that, although a number of services are available to help prevent falls, many aren't known to the public until they experience one.
- Emergency admissions related to falls in those aged 65+ are lower than for England, although the numbers are rising. Numbers of hip fractures amongst older people is similar to nationally.
- Place of death: it's widely recognised that most people would prefer not to die in hospital. Since March 2020, 36% of Herefordshire deaths occurred in hospital – lower than the 41% average for 2015 to 2019, although it's difficult to unpick the impact of the pandemic.

Health services and prevention – impact of Covid-19

The Covid-19 pandemic has disrupted all aspects of healthcare, and the focus now is on recovery and restoration.

- NHS waiting times have increased with concern about missed/delayed diagnoses. Particularly cancer, but also other long term conditions.
- Delayed treatment can reduce chance of survival, but also has implications for quality of life of both patients and their carers whilst they are waiting: for example reduced mobility can increase isolation. Also widening existing inequalities.

Primary care

- Nationally GP appointments fell during the first lockdown but have since recovered to 2019 levels, although referral rate below 2019 level.
- In 2021, 87% of H&W patients reported overall experience of their GP practice as ‘good’, similar to 2020 and slightly higher than England (83%). During pandemic, 41% of patients who felt they had needed an appointment had avoided making one – main concerns were the burden on the NHS (21%) and the risk of catching covid-19 (17%).
- Impact of long COVID unclear: An estimated 700 people are likely to suffer severe post-acute COVID-19 and require support from services between Jan ‘20 and Dec ’21. By Oct ’21, 150 GP patients had been recorded as having ‘post-covid syndrome’, 25% of which have been referred for further assessment.

Impacts of covid-19 on some preventative services locally included:

- NHS Healthchecks suspended by GPs from March 2020; numbers have been increasing slowly since spring 2021 but remain at ~10% pre-pandemic levels
- Suspension of routine cancer screenings during the first wave in 2020
- Alcohol and drug support moved to a telephone only service; numbers in receipt of services haven’t changed
- Sexual health services stayed open throughout

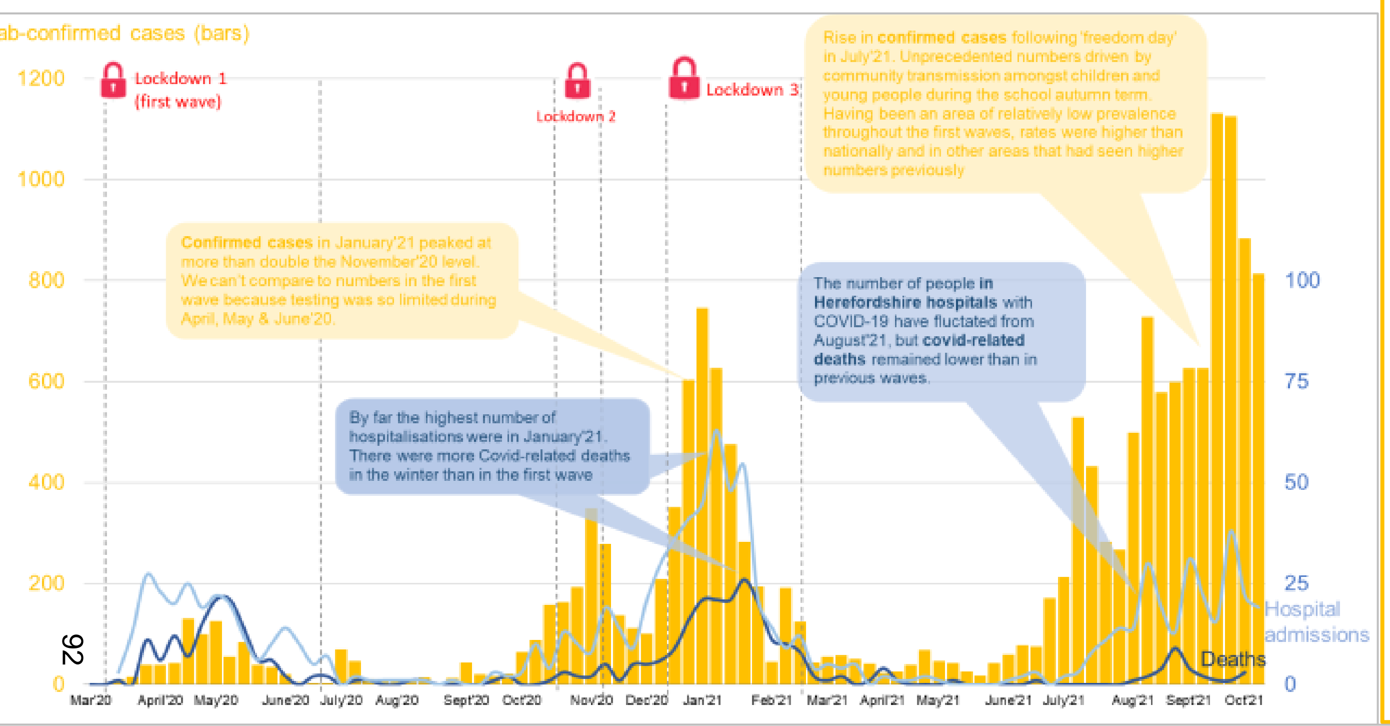
Impacts on hospital patient access

- Emergency visits to A&E at Hereford hospital halved from average of 5,400 a month at the onset of the pandemic, but returned to pre-Covid levels during summer 2020 and have remained there (except during the winter lockdown).
- In March 2020, elective (planned) admissions at Wye Valley Trust fell by 90% from the 2019/20 average of 1,700 a month. Recovery of services across elective, cancer and diagnostics is challenging. Overall waiting lists and times have increased, as expected in the early phase of recovery.

Challenges of recovery

- Scale of recovery: British Medical Association (BMA) estimates that if elective activity increased to 110% of 2019 levels, the waiting list would take up to five years to come back down to pre-pandemic levels, and up to a decade to return to more manageable levels
- Implications of recovery for an already tired and vulnerable workforce: in 2021, 59% of doctors and health care workers reported higher than normal levels of exhaustion or fatigue in the BMA’s COVID-19 Tracker Survey.

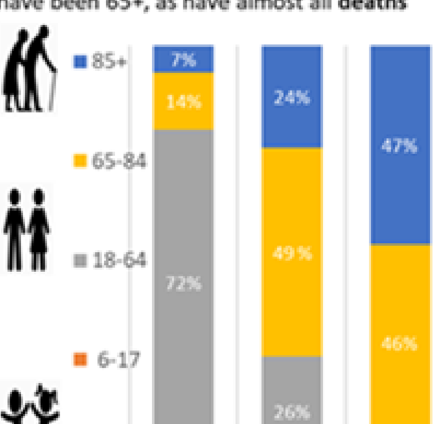
Covid-19: story of the pandemic in Herefordshire

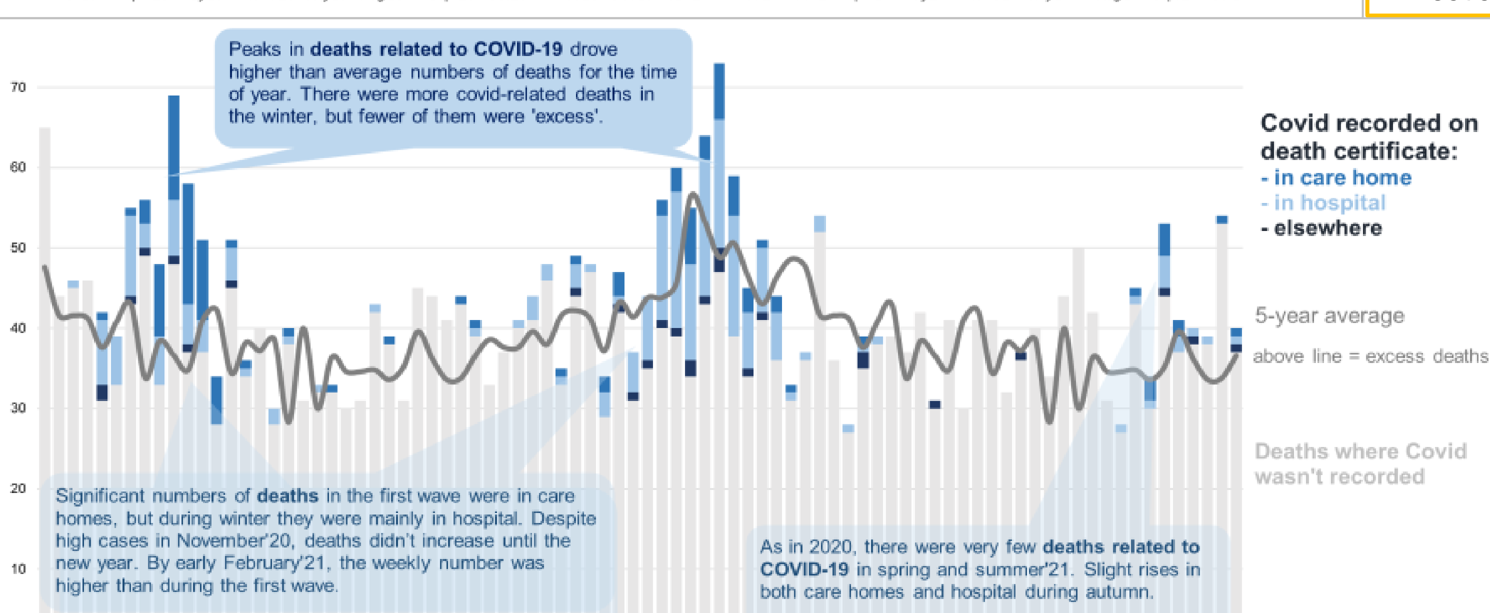


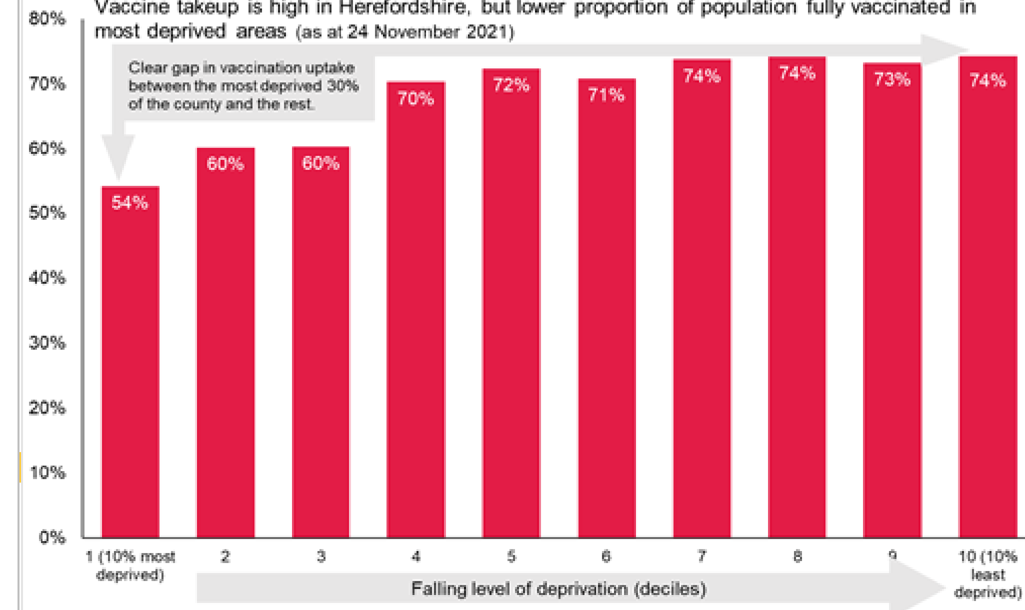
Case rates were generally below national levels until late summer 2021, when – as in other areas of low prevalence – infections spread amongst children and young people particularly.

As of November 2021, in Herefordshire:

- Throughout the pandemic there have been 328 excess deaths (compared to the average for the five years preceding the pandemic).
- Since April'20 COVID-19 has been mentioned in a higher proportion of deaths than any other single condition* (9%), although not necessarily the underlying cause of death
- Vaccine uptake is high overall: 80% of those aged 12+ fully vaccinated, but is notably lower amongst most deprived 30% of county.
- 3,700 people are estimated to have some post -COVID symptoms between Jan'20 and Dec'21. One fifth of these are likely to suffer severe post-acute Covid-19.







Premature mortality

Understanding Herefordshire
People and places

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their age, circumstances and environment. Factors such as where we live, the state of our environment, genetics, our income and education level can all have considerable impacts on health.

Premature mortality (i.e. before age 75) in Herefordshire is lower than nationally. However, there are local pockets where mortality is higher compared to the overall picture with these inequalities being clearly linked to deprivation – residents in the most deprived areas of the county are almost twice as likely to die prematurely than those in the least deprived areas.

As nationally, the most common causes of premature death in Herefordshire are cancer, heart disease, stroke and lung disease, between them accounting for on average 3,800 years of life lost annually. Recent trends and comparisons to the national picture are in the table below.

In the five years prior to the pandemic 28% of mortality was premature - a similar proportion has been seen during the pandemic (in 2008-12 the proportion was one third)

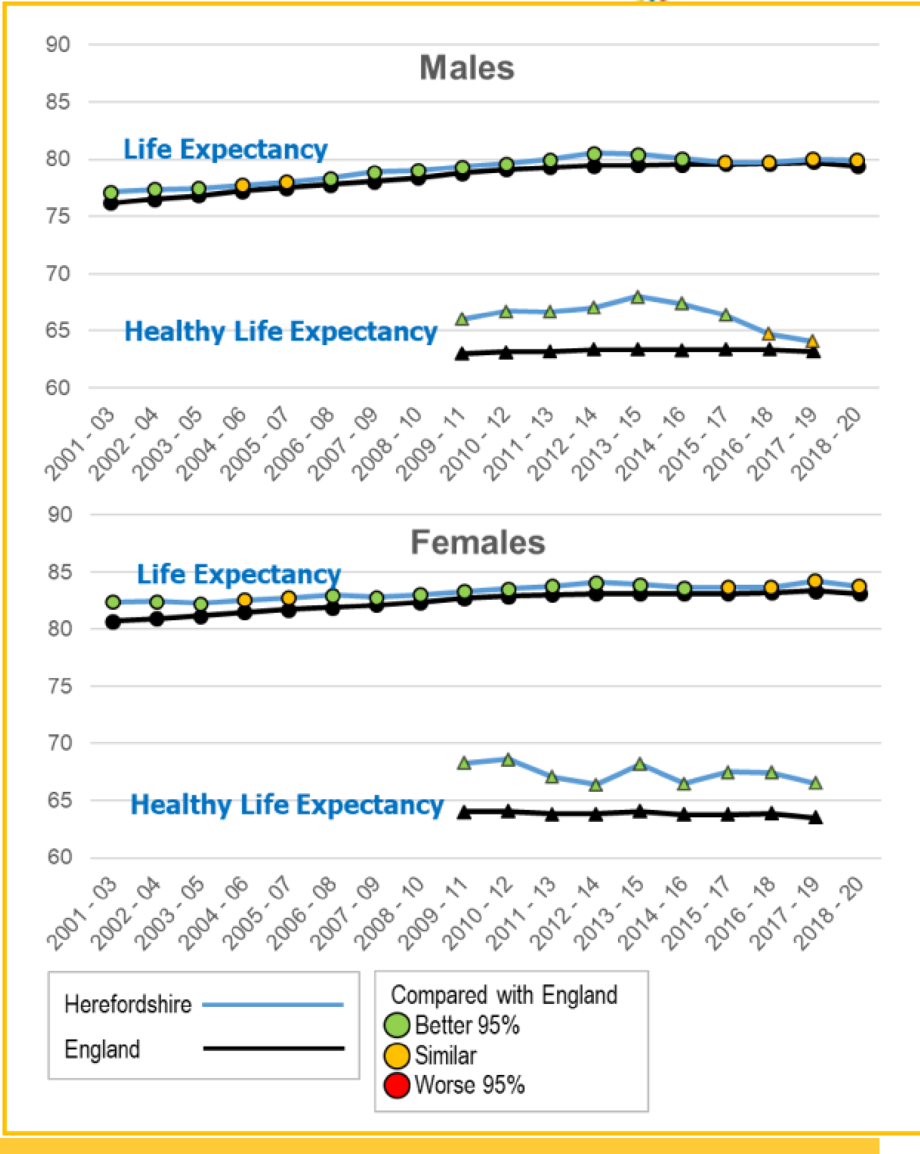
Cause of premature mortality	Prevalence of key risks	Disease prevalence and trend (nb. not age adjusted)	Premature mortality	Inequalities: difference between most and least deprived areas
Cancer	Smoking: falling and lower than nationally (12.5% compared to 13.9% in 2019)	Consistently higher, rising in line with England for last decade 2019/20 was 4.1% compared to 3.1% for England	Fell between 2017 and 2019 to below national level, but a small rise in 2020 brought it back in line with national rate: 113 per 100,000 in 2019/20 In line with England but no clear pattern	1.5 x more likely to die of cancer
COPD / respiratory	Asthma: stable since 2005/06, similar to England 6.9% in 2019/20 compared to 6.5% nationally	COPD higher: 2.5% in 2019/20 compared to 1.9% for England Increasing steadily since 2005/06, whilst national has been stable	Respiratory mortality increased between 2009 and 2017 but subsequently fallen. Consistently below England: 26 per 100,000 in 2017-19 Better than England	2.5 x more likely to die of respiratory disease
Heart disease (CHD) / heart failure	Smoking: falling and lower than nationally (12.5% compared to 13.9% in 2019)	CHD and heart failure are consistently higher: 3.6% in Hfds had CHD in 2019/20 compared to 3.1% for England Stable for last decade while national rate falling	Consistently in line with national; almost halved since 2003-05 34.9 per 100,000 in 2017-19 Stable, in line with England	2 x more likely to die of heart disease
Stroke	High blood pressure (the single biggest risk factor for stroke) has been rising steadily in Herefordshire and in 2019//20 local prevalence was 16.7% compared to14.1% nationally	Stroke prevalence consistently higher than England: 2.5% in 2019/20 compared to 1.8% nationally. Rising slowly locally since 2014/15, in line with national	Fallen in recent years, to below national rate 9.2 per 100,000 in 2017-19 Falling, and better than England	2 x more likely to die of cerebrovascular disease, including stroke

Life expectancy

Life expectancy is the ultimate health outcome. Measures are broken down into total, healthy and disability-free years at birth and at age 65.

- COVID-19 resulted in a small fall in total life expectancy nationally (2018-20), but no significant changes locally. Levelled off in last decade, but remain higher than in 2007-09.
- On most measures, females in Herefordshire fare better than nationally. But the gap has closed for males: most measures are no longer significantly different to England.
- Proportion of life lived without a disability appears to be falling locally (stable nationally): 4 years lower for men in 2017-19 than 2015-17.
- Inequalities in life expectancy between people born in the most and least deprived areas of Herefordshire remain lower than nationally, with no change over the last decade. Gap is currently (2017-19) 9.5 years for men; 7.3 for women.
- The most common causes of death in Herefordshire are dementia and Alzheimer's combined (accounting for 12% of deaths a year).

Indicator	Period	Herefs	W.Mid	Eng	Worst	England Range	Best
Healthy life expectancy at birth (Male)	2017 - 19	64.1	61.5	63.2	53.7		71.5
Healthy life expectancy at birth (Female)	2017 - 19	66.5	62.6	63.5	55.3		71.4
Life expectancy at birth (Male)New data	2018 - 20	79.9	78.5	79.4	74.1		84.7
Life expectancy at birth (Female)New data	2018 - 20	83.8	82.5	83.1	79		87.9
Disability-free life expectancy at birth (Male)	2017 - 19	62.2	61.6	62.7	53.4		69.6
Disability-free life expectancy at birth (Female)	2017 - 19	62.8	60.6	61.2	49.9		70.3
Inequality in life expectancy at birth (Male)	2017 - 19	6.3	9.5	9.4	14.8		2.9
Inequality in life expectancy at birth (Female)	2017 - 19	4	7.3	7.6	13.3		1.5
Healthy life expectancy at 65 (Male)	2017 - 19	11	10	10.6	6.1		16
Healthy life expectancy at 65 (Female)	2017 - 19	13.6	10.4	11.1	5.2		16.7
Life expectancy at 65 (Male)New data	2018 - 20	19.5	18.3	18.7	16		23.1
Life expectancy at 65 (Female)New data	2018 - 20	21.7	20.8	21.1	18.6		25.4
Disability-free life expectancy at 65 (Male)	2017 - 19	9.4	9.4	9.9	7		15.1
Disability-free life expectancy at 65 (Female)	2017 - 19	11.4	9.1	9.7	6		13.5
Inequality in life expectancy at 65 (Male)	2017 - 19	2.9	5.1	4.9	10.5		2
Inequality in life expectancy at 65 (Female)	2017 - 19	2.8	4.6	4.7	8.6		-0.6



Find out more: Understanding Herefordshire website

https://understanding.herefordshire.gov.uk/

Understanding Herefordshire
People and places

Ageing well | Community | Economy & place | Growing up | Health | Inequalities | Lifestyles | Population

Home > Latest news

Latest news

Herefordshire Economic Summary

Tuesday 14 September 2021 3.41pm

The latest (September 2021) Herefordshire Economic Summary (formerly the Economic Impacts of COVID-19 Summary) has just been published on the 'Economic impact of coronavirus' page of the Understanding Herefordshire website. The summary contains th... read more

New population estimates published

Thursday 9 September 2021 11.10am

ONS have published new population estimates which show Herefordshire's population has increased to 193,600 in mid-2020. Data is now available to download from the Population pages.

Economic impact of coronavirus (COVID-

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7. Appendix

Some of the detail behind the key findings

Work that's informed the 2021 JSNA

Round-up of what we've learnt since the 2018 summary, with a particular emphasis on inequalities and understanding the impacts of Covid-19

Existing work pre-2021	New research / analysis in 2021
Economic impacts of coronavirus (monthly)	**Talk Community well-being survey** ** Published July **
Armed forces community assessment	**CYP Quality of Life Survey** ** Published November **
Rural inequalities	Domestic abuse needs assessment (draft)
Housing stock condition	Profile of mental well-being (draft)
Children's integrated needs assessment	Health and social care needs of older opiate users (in progress)
Needs assessments on oral health, alcohol, vulnerable persons' housing needs, and the evidence base for physical activity strategy	Understanding wider impacts of Covid-19 to inform recovery
	Health and well-being needs of SEND (in progress)
	Cardiovascular disease (CVD) needs analysis

2021 engagement

Understanding Herefordshire
People and places

Meeting	Date
All Member Public Health briefing	29/4/21
Supplementary portfolio holders briefing (Public Health)	13/5/21
UH Forum (officers)	26/5/21
WVT Board	1/7/21
CPF Forum	27/7/21
Management Board: plans & process	17/8/21
Informal portfolio holders' session	27/9/21
*1-2-1 engagement with key subject matter experts throughout September and October**	
Community Leaders' meeting	7/10/21
Business Board	4/10/21
CCG QPR Committee	6/10/21
HWBB workshop	1/11/21
Community Partnership workshop	10/11/21
Management Board: pre sign-off	*Nov*
HWBB sign off	**6/12/21**
Followed by further opportunities for awareness-raising	

Acknowledgements for input from colleagues across the council and partners, including:

- All age commissioning
- CCG information & finance
- Environmental & environmental health services
- Education performance & school admissions
- Housing
- Public health
- Strategic planning

Proportion of the population aged 65+ by sub-locality - 2001

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People and places

19%	Herefordshire
16%	England

% aged 65 and over by sub-locality
- over 30%
- 26% to 30%
- 21% to 25%
- under 21%

Mortimer
Leominster rural
Leominster town
Kington rural
Kington town
Weobley
Bromyard town
Bromyard rural
North Hereford
Ledbury rural
Ledbury town
Rural Hereford
South Hereford
Golden Valley
Ross rural
Ross town

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kilometres

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Proportion of the population aged 65+ by sub-locality - 2011

21%	Herefordshire
16%	England

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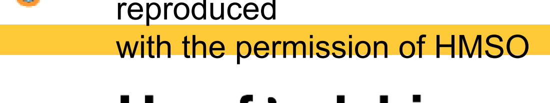

Proportion of the population aged 65+ by sub-locality - 2018

Understanding Herefordshire
People and places

24%	Herefordshire
18%	England

% aged 65 and over by sub-locality
- over 30%
- 26% to 30%
- 21% to 25%
- under 21%

Mortimer
Leominster rural
Kington rural
Leominster town
Kington town
Bromyard town
Weobley
Bromyard rural
North Hereford
Ledbury rural
Rural Hereford
Ledbury town
South Hereford
Golden Valley
Ross rural
Ross town

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Proportion of the population aged 65+ by sub-locality - 2028

28%	Herefordshire
21%	England

% aged 65 and over by sub-locality

- over 30%
- 26% to 30%
- 21% to 25%
- under 21%

Mortimer
Leominster rural
Kington rural
Kington town
Leominster town
Bromyard town
Weobley
Bromyard rural
North Hereford
Ledbury rural
Rural Hereford
Ledbury town
South Hereford
Golden Valley
Ross rural
Ross town

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Understanding Herefordshire
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Proportion of the population aged 65+ by sub-locality - 2038

32%	Herefordshire
24%	England

% aged 65 and over by sub-locality

- over 30%
- 26% to 30%
- 21% to 25%
- under 21%

Mortimer
Leominster rural
Kington rural
Leominster town
Kington town
Bromyard town
Weobley
Bromyard rural
North Hereford
Ledbury rural
Rural Hereford
Ledbury town
South Hereford
Golden Valley
Ross rural
Ross town

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Economic impact of COVID

The Covid-19 pandemic delivered the greatest shock to the British economy for over 300 years:

- 30% of Herefordshire employments furloughed by June 2020 (down to 4% by July 2021).
- 32,400 claims made by 10,300 individuals under the Self-employment Income Support Scheme with a total value of £87,900,000 (and many were not eligible!).
- Almost £209 million government-backed loans offered to Herefordshire businesses.
- Around £111 million in local authority administered grants paid to Herefordshire businesses.
- £1.7 million claimed under the "Eat Out To Help Out" scheme.
- Herefordshire Council investing in a £6 million economic and wellbeing recovery plan, funded by Government Covid-19 outbreak management funds, to support the county to recover from the impact of Covid-19.

Wards with highest unemployment

Key points:

- Generally, those wards with the highest claimant count rates before the pandemic still have the highest rates in August 2021
- These include Leominster East , Hinton & Hunderton, and Newton Farm, which also have the highest numbers of claimants (160, 185 & 175 respectively). Followed by Widemarsh (145) and Red Hill (140).
- Ross North, and Widemarsh Wards have seen the largest increases in claimant count rate from March 2020.
- The claimant count rate for the county as a whole in August was 3.3%.
- Note that due to the small population sizes a relatively small change in the number of claimants can have a significant impact on the rate.

Data source: ONS/NOMIS
Date last updated: 14 Sept. 2021
Frequency of update: monthly
HC data lead: Intelligence Unit

Claimant count as a proportion of all residents aged 16 to 64

Leominster East
Hinton & Hunderton
Newton Farm
Widemarsh
Red Hill
Leominster South
Kington
Central
Bromyard West
Ross West
Ross North
Greyfriars
Bromyard Bringsty
Ledbury North
Ross East
Leominster West
Bishops Frome & Cradley
Ledbury South
College
Weobley
Herefordshire
Wormside
Saxon Gate
Mortimer
Hope End
Kings Acre
Bobblestock
Leominster North & Rural
Three Crosses
Penyard
Queenswood
Whitecross
Arrow
Kerne Bridge
Castle
Hampton
Belmont Rural
Eign Hill
Ledbury West
Aylestone Hill
Hagley
Old Gore
Credenhill
Sutton Walls
Stoney Street
Backbury
Golden Valley South
Holmer
Llangarron
Dinedor Hill
Tupsley
Bircher
Golden Valley North
Birch

0 1 2 3 4 5 6 7 8 9

March 2020 | Increase March 2020 to August 2021

Need to know: The claimant count rate should not be confused with the official unemployment rate which is based on different data and is not available at Ward level. All data are rounded to the nearest 5

Talk Community Well-being Survey 2021

Telephone based survey of 1,100 household residents across Herefordshire Primary Care Network localities

Community wellbeing survey: themes

Road & pavement repairs continue to be the aspect that most needs improving across Herefordshire (mentioned by 46% of respondents).

89% agree that their local area is a place where people from different backgrounds get on well – 69% in 2012/ 67% in 2018

82% feel that people in their community have supported each other during the last year, while just 5% do not

People living in urban areas, and in more deprived locations, are the least likely to hold positive views of their local community.

DIGITAL INCLUSION

89% regularly access the internet

69% have increased their use since the start of the pandemic

22% are concerned about more services being moved online (e.g. banking, shopping, public service information)

http://www.

Plenty of positives; in general:

- High levels of satisfaction with / belonging to local area
- People get on well together & have supported each other through pandemic
- Most have daily contact with others
- Most trust their neighbours & feel safe out after dark
- Two-thirds didn't see their income fall
- Comparatively good mental health

But some important minorities:

- 3% struggling to cope financially
- 4% / 5% have had to cut back on heating / food
- 10% feel lonely always or often
- 10% don't use the internet

And significant differences:

- Less of a sense of community in Hereford
- Some groups highlighted throughout the survey: most deprived, social renters, lower socio-economic, younger people, disabled people, newer residents

Differences between areas (and groups)

EAST

Those in the East hold very positive views of their local area and community.

99% are satisfied with their local area as a place to live.

92% believe people in their local community have supported each other during the last year – significantly higher than all other PCNs.

A third (34%) have provided unpaid support to group(s), club(s) or organisation(s) on a monthly basis in the last year.

NORTH & WEST

Those living in the North & West PCN are significantly more likely to want to see public transport improved in their area (21%).

14% do not access the internet on a regular basis, and 28% are concerned about more services moving online (e.g., banking, shopping etc).

A third (34%) are dissatisfied with the way the council runs things.

HEREFORD CITY

People living in Hereford City are significantly more likely to want traffic congestion to be improved in their local area (11%).

77% believe people in their community have supported each other in the last year, and only 38% feel able to influence local decisions.

A third (33%) are dissatisfied with the way the council runs things, and 28% are in fair/poor health (significantly higher than other PCNs).

SOUTH & WEST

Fewer people in South & West believe that people of different backgrounds get on well together (85%).

During the Covid-19 pandemic, 34% spoke less to family/friends, and 30% spoke less to neighbours – a higher proportion than other PCNs.

They are more likely than in other PCNs to want to see health services improved (6%).

CYP Quality of Life Survey 2021

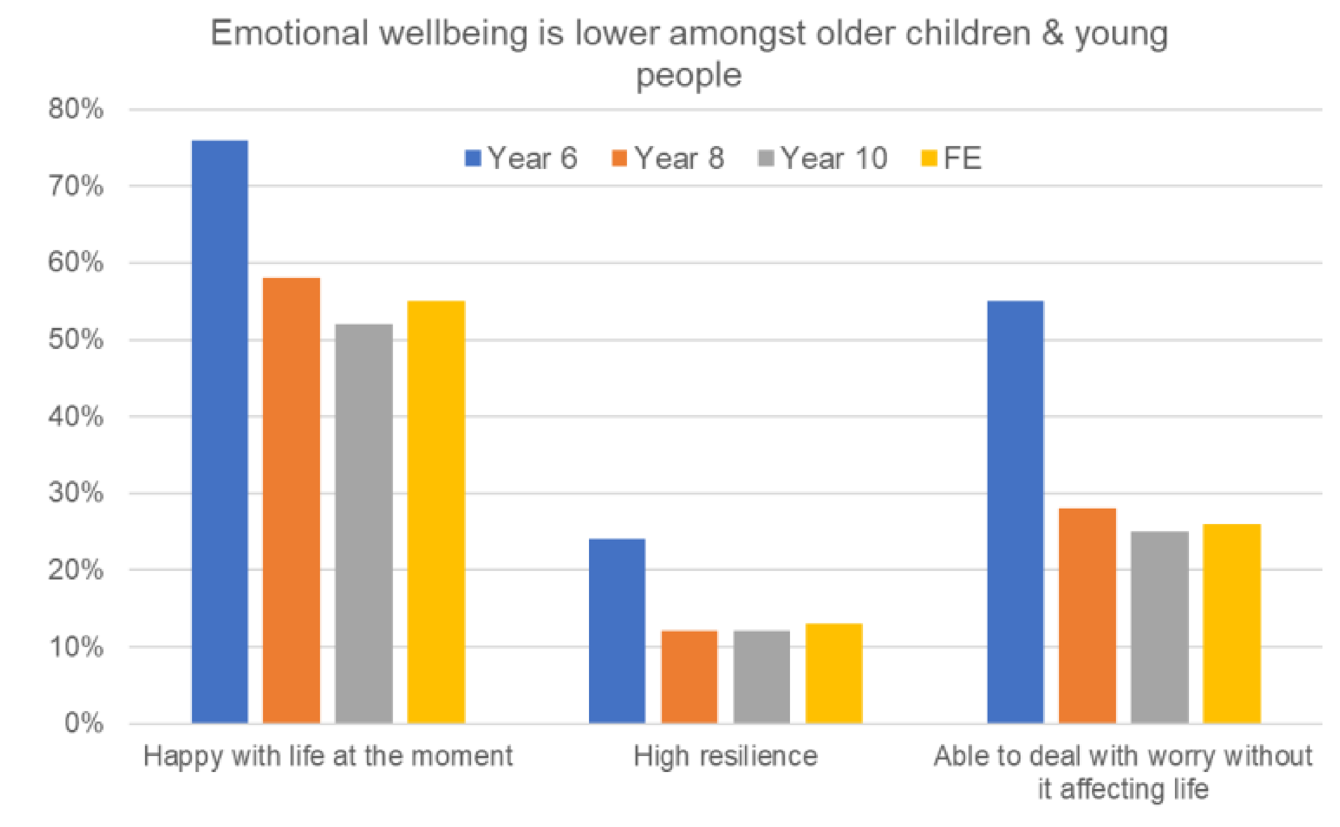
School-based survey of 4,700 pupils in 25 primary, 11 secondary, 2 FEs and 1 special school.

Note: the following slides are based on interim results so may change slightly; they are also only a selection of key findings based on work to date

Headlines: emotional health & wellbeing (1)

- Majority are ‘happy with life at the moment’
  - Highest amongst primary age:
    - 42% boys / 34% girls **very** happy
  - Notably lower amongst older girls:
    - 28% Y7+ girls **not** happy
    - 10-13% of boys of all ages

- Emotional wellbeing and resilience was lower amongst older pupils
- Large minority said feelings of worry or anxiety have got worse since Covid-19
    - 37% of primary, 36% FE
    - 40% of secondary



Common worries

- Biggest worries vary by age/sex
  - Primary pupils: Covid-19 (38%)
  - Secondary girls: the way they look (59%)
  - Secondary boys: their future, e.g. home, job (39%)
  - FE: their future (61%), looks (49%), mental health (44%)

- Other key points
  - 'Environment & climate change' and 'Being safe on the road': less likely to worry secondary pupils
  - 'Physical or mental health of a family member: almost one third of all ages
  - Even at primary age, 28% of boys worry about the future and 34% of girls worry about the way they look
  - Note awareness of own mental health at all ages

Worry 'quite a lot' or 'a lot'	Primary	Secondary	FE
Covid-19	**38%**	17%	17%
Environment & climate change	30%	19%	23%
Being safe on the road	29%	16%	23%
Health of family member	29%	28%	31%
Future, eg home, job	28% (b)	**39% (boys)**	**61% (all)**
The way they look	34% (g)	**59% (girls)**	**49% (all)**
Own mental health	20%	**34%**	**44%**
Sexual harassment		27% (g)	**36% (g)**

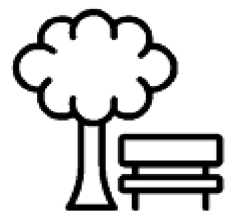
Headlines: emotional health & wellbeing (2)

- One in three primary & secondary pupils afraid to go to school at least 'sometimes' because of bullying
  - 20% had been bullied at or near school in last year
  - Lower for FE students: 12% afraid; 5% had been bullied
  - Most common reasons: the way they look or size / weight
  - Fear / experience of bullying higher amongst:
    - Y4-6 who live with one parent (42% afraid to go to school vs 32% of those who live with two)
    - Secondary pupils with SEND (48% afraid to go to school vs 29% of those without SEND)
    - Secondary pupils eligible for free school meals (27% have been bullied in last year vs 18%)

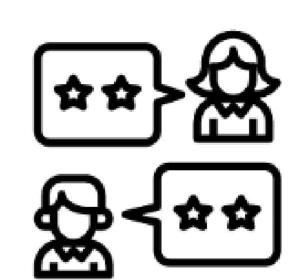
- The most common way of dealing with a problem was to talk to someone about it
  - Majority of Year 6 (63%) and FE (57%) pupils
  - Secondary pupils less likely to (45%)

Connecting with local area

- Majority make use of parks or open spaces in their free time
    - Almost three out of four primary (72%) / secondary pupils (73%), and
    - Two out of three FE students (67%) had been to park/open space in the last 4 weeks

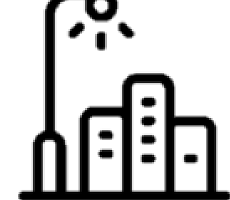


- Mixed picture on 'having your say':



- Majority (two-thirds) have chances to give their views about their **community and environment**, although not all use them and engagement falls with age
    - 40% of Y6, 28% of secondary, 17% of FE have chances and use them
- Two-thirds of all age groups say they've had chances to give their views about **leisure opportunities**, but around half say it makes no difference to what happens
    - 51% of Y6, 53% of secondary, 45% of FE

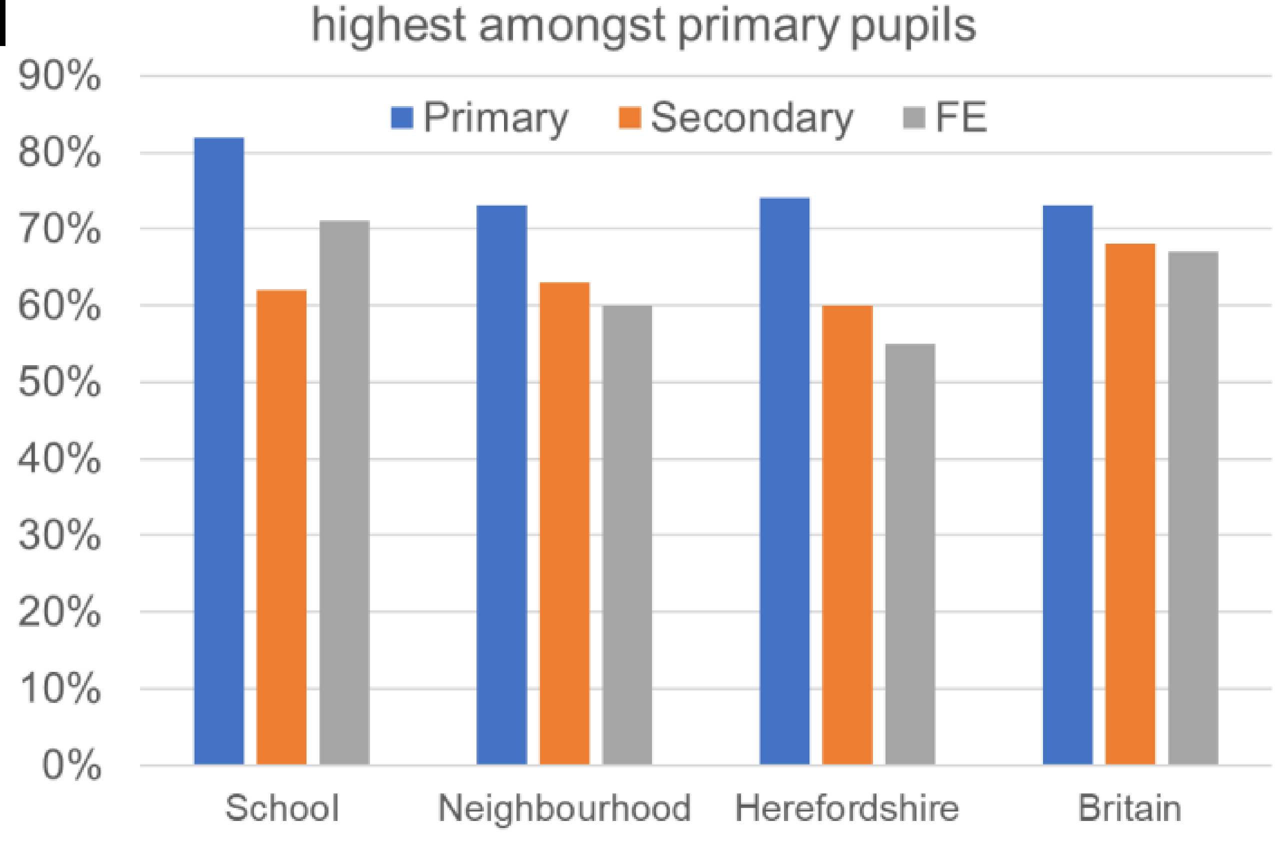
- High levels of feeling safe at home (>90%), and at school / college (~80%), but a large minority 'never' feel safe going out after dark
    - 34% of primary, 25% of older



Feelings of belonging to community

- Primary pupils are most likely to 'strongly' feel they belong to their school

- Relatively low levels of 'strongly' belonging to a local community* amongst older CYP (60 -70%)
    - Primary: 75-85%
    - Community well-being survey of adults: 88% 'strongly' belong to local area



* school, neighbourhood or community, rather than Britain

Title of report: Herefordshire and Worcestershire Integrated Care System (ICS) Mental Health Strategy

Meeting: Health and Wellbeing Board

Meeting date: Monday 6 December 2021

Report by: Senior Commissioning Officer - Communities

Classification

Open

Decision type

This is not an executive decision

Wards affected

All wards

Purpose

To review and endorse the draft Herefordshire and Worcestershire Mental Health Strategy.

Recommendation(s)

That: The Health and Wellbeing Board

a) **Endorse the draft Herefordshire and Worcestershire Mental Health Strategy, and determine any recommendations it wishes to make to the council or relevant health bodies to improve the provision of mental health services for Herefordshire.**

Alternative options

1. There are no alternative options. The strategy has been developed by statutory NHS bodies with involvement from stakeholders and partner agencies including Herefordshire Council. There is an expectation within national policy and the NHS Long Term Plan that each Integrated Care System (ICS) area will have a Mental Health Strategy in place.

2. Members may wish to consider whether the Council develops its own mental health strategy. However, as the provision of mental health services is a responsibility of the NHS and Clinical Commissioning Groups, this would not be a recommended option.

Key considerations

3. The strategy has been developed by Herefordshire and Worcestershire Clinical Commissioning Group and overseen by the Integrated Care System (ICS) Mental Health Collaborative Committee (formerly the STP Mental Health Programme Board).

Further information on the subject of this report is available from
John Burgess, 01432 260885, email: john.burgess3@herefordshire.gov.uk

4. The strategy for Herefordshire and Worcestershire sets out how local services will support and treat people with mental health issues over the next five years. The NHS Long Term Plan sets out the strategic direction for mental health services nationally. The Herefordshire and Worcestershire Mental Health Strategy develops the national expectations into a local delivery plan in a way that works for our area, as well as identifying local priorities to meet specific needs based on feedback from stakeholders.

5. The strategy is intended to give effect to various priorities and factors emerging in relation to mental health:

    i. From 1 April 2020, Herefordshire mental health services transferred from 2Gether NHS Foundation Trust to Herefordshire and Worcestershire Health and Care NHS Trust.
    ii. The Herefordshire and Worcestershire Integrated Care System (ICS) for Mental Health is focused upon ensuring equitable access to mental health services across the ICS area.
    iii. Herefordshire and Worcestershire was an early implementer for the transformation of community mental health services for adults, bringing significant resources. Implementation of the transformation locally began in October 2020 in Herefordshire and parts of Worcestershire, with roll out to the rest of the ICS from October 2021.

6. The Herefordshire and Worcestershire Mental Health Strategy sets out ambitions to support and treat people with mental health issues over the next five years, while delivering the national strategy in a way that works for the ICS area, as well as identifying local priorities to meet specific needs based on engagement with stakeholders.

7. In developing the strategy there was a great deal of stakeholder engagement and evidence gathering sessions in the latter part of 2019 and the beginning of 2020. There was a survey and a series of listening events with local stakeholders in autumn 2019, followed by engagement/co-production events in early 2020. Reports detailing this engagement are appended to this report at Appendix 3 & 4.

8. The strategy seeks to articulate a vision for mental health and wellbeing captured within five key areas: Accessible Services; Integrated Services; Community Empowerment; Person-Centred Services; Early Intervention.

9. The impact of the COVID 19 pandemic on all aspects of life during 2020 and into 2021, especially on the NHS, has led to a delay in the strategy being brought forward for consideration by members of the Health and Wellbeing Board.

10. The mental health strategy develops aspects of the Joint Strategic Needs Assessment (JSNA) which states that; ‘ a key message to local commissioning groups is that individual treatment and pathways developed by traditional health and social care services have to adapt to increasing complexity of need. There is rising demand for management of co-morbidity of physical and mental disorders rather than of single diseases’.

11. There are very clear connections between the focus of the Talk Community strategic approach, and that of the mental health strategy. Talk Community has identified a number of community wellbeing issues that link to mental health, including the recognition of a need for the transformation of mental health services to meet the changing needs of the population, and be delivered closer to the community.

12. The transformation of mental health services commenced across Herefordshire as of 1 October 2020. Community Mental Health Teams have been divided into five new services based around each of the Primary Care Networks. GP surgeries will have direct access to the mental health

teams using an agreed appointment schedule, which should enable patients to be seen and assessed by mental health services much more promptly than was previously the case.

13. In order to provide support across the whole spectrum of mental health disorders from mild to serious, additional support has been commissioned by Herefordshire and Worcestershire Clinical Commissioning Group from voluntary and community services (VCS). ‘Link Workers’, provided by Herefordshire MIND, have been put in place who will provide support and guidance to people with mild mental health issues. The role of the ‘link workers’ is to help people to re-connect with their communities, perhaps through Talk Community Hubs, to help address underlying problems which could include unemployment, debt, isolation or loneliness.

14. The COVID-19 pandemic has had a significant impact on the way mental health services are delivered, and the strategy acknowledges this. Although the full extent of this impact is yet to be understood, in managing the earlier phase of the lockdown a number of changes took place in the way mental health services were delivered. These included video conferencing and some ward based staff being re-deployed to provide intensive community based treatment. Some of these changes will develop into more flexible approaches in the future delivery of mental health services.

15. From November 2021 the new Mental Health Support Teams in Schools, available to young people across all the secondary schools of Herefordshire, will become fully operational. The teams provide support to young people who may be self-harming or at risk of developing mental health problems.

16. One of the key areas the strategy is focussing on, is that of community empowerment. This links closely with Herefordshire’s Talk Community strategy which aims to achieve :

- More people participating in their local community
- More vulnerable people supported in their local community
- People able to use public services closer to where they live
- Increased self-declared wellbeing and independence
- Reduced prevalence and extent of loneliness
- Reduction in demand for domiciliary care
- Reduction in demand for primary care and community health services

Community impact

17. The proposed changes in addition to the extra funding for mental health services via the NHS suggest that there should be an overall positive impact on the Herefordshire community. Mental health services will be provided around each of the Primary Care Network areas, with GPs able to refer patients more quickly and with less bureaucracy, and there will be closer links with VCS organisations and community groups including Talk Community Hubs. A key aim is to continue to expand awareness of mental health and self-care, and promote community asset growth.

18. The Herefordshire County Plan 2020-2024, under the ‘Community’ heading states; ‘Our ambition is to make wellbeing inevitable here in Herefordshire by putting physical and mental health at the heart of everything we do. Talk Community is the key council initiative by which we aim to progress this objective’. The Mental Health Strategy identifies Talk Community as an important partner for helping to develop integrated services across statutory and voluntary organisations and to continue to expand awareness of mental health and self-care, and promote community asset growth.

19. There are no direct implications of this report for the Council's role as corporate parent. However, some of the changes to services identified in the Mental Health Strategy should go some way to resolving a number of challenges identified in the current Herefordshire Corporate Parenting Strategy under Priority 5 – 'All looked after children enjoy the best possible health'. For example the introduction of Mental Health Support Teams across all secondary schools to identify young people at risk of developing mental health problems, and reduce the level of self-harming behaviour.

20. There are no specific implications for the council relating to health and safety arising from this report. There may be health and safety implications for partner agencies during the transformation process of mental health services across Herefordshire

Environmental Impact

21. The development of the Mental Health Strategy and its aims and objectives are taking place with reference to the Herefordshire and Worcestershire Clinical Commissioning Group (CCG) 'Green Plan, 2021 – 2022'.

22. The NHS has a very large carbon footprint as a major buyer of goods and services from local, national and international economies and as such, has a significant opportunity to improve economic, environmental and social sustainability. Being sustainable will enable all NHS organisations to make the most of existing resources. Therefore, in practice this will require the CCG to ensure the following principles are mainstreamed into all decision making:

    a) Planning services which are efficient and effective
    b) Buying services which provide highest quality at best value and which have the least impact on the environment
    c) Avoiding duplication, inefficiency and waste
    d) Focus on preventative, proactive care
    e) Patients and public engagement and involvement in planning and design of services
    f) Building resilience and protecting and developing community assets and strengths
    g) Making best use of all the resources we have
    h) Minimising carbon emissions This approach should also help to reduce inappropriate demands, reduce waste and incentivise more effective use of service

23. Green Social Prescribing initiatives are being developed. They will provide local systems with the opportunity to work with partners to systematically embed green prescribing into local social prescribing schemes at an individual, community and whole system level and with a particular focus on supporting mental health issue.

Equality duty

24. Please state how does this decision / proposal pay due regards to our public sector equality duty as set out below [do not remove the wording in the note, from section 149, below]

    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.

25. The council and the NHS Herefordshire and Worcestershire Clinical Commissioning Groups (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

26. In the Equality Act a disability means a physical or a mental condition which has a substantial and long-term impact on your ability to do normal day to day activities

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

28. A copy of the Equality Impact Assessment is attached to this report (Appendix 2). The document identified no potential negative impacts but did indicate potential positive impacts for a number of equality groups including age, disability, race including travelling communities, as well as pregnancy and maternity

Resource implications

29. The strategy has the potential to influence the application of NHS resources to mental health services in Herefordshire, taking into account other changes within NHS services including the transfer of provision to Herefordshire and Worcestershire Health and Care Trust and the transformation of community mental health services.

30. The strategy has no direct resources implications for Herefordshire Council. However, the council will need to review the impact of the strategy regarding access to NHS services for local residents and the use of the council's own resources in meeting individual needs. There are no direct resource implications arising from the Mental Health Strategy, but the strategy will influence the commissioning of new and additional services, the cost of which will be met through NHS resources.

31. As one of 12 Early Implementer sites nationally to transform adult community mental health services in line with the new national framework, Herefordshire and Worcestershire have received a significant increase in NHS funding which will also enable the development of new services around eating disorders and Complex Needs.

Legal implications

32. There are no specific legal implications in the recommendation,

Risk management

33. There are a number of significant changes taking place to the delivery of mental health services in Herefordshire as a result of Herefordshire and Worcestershire Clinical Commissioning Groups amalgamating from April 2020. Similarly the NHS Long Term Plan has specific expectations around the delivery of mental health services. Not endorsing the strategy may lead to some delays with completing the strategy, however changes to the provision of mental health services across Herefordshire have already commenced as of 1 October 2020

Risk / opportunity	Mitigation
Within the new health structures of the Clinical Commissioning Groups and Health and Care Trust, there may be a risk that attention is focussed more on the needs and expectations of Worcestershire.	There are a number of groups in place (e.g. the Mental Health Advisory Group) across Herefordshire able to influence priorities. Herefordshire Mental Health Partnership Board has wide stakeholder membership including representatives from the CCG and Herefordshire and Worcestershire Health and Care NHS Trust. There is specific reference within the strategy to ensuring equitable services across the Integrated Care System footprint
The COVID-19 pandemic and subsequent lockdown caused delays to implementation planning during the early months of 2020 but the original timescales for implementation have not been adjusted accordingly	The CCG and H&W Health and Care Trust are working closely with Primary Care Networks, VCS and Talk Community to mitigate any initial problems with implementation and service delivery during these early stages. The strategy has been updated to address additional pressures put onto mental health and primary care services as a consequence of the COVID 19 pandemic.
There is an opportunity to improve access to a larger range of mental health services covering a wide spectrum of illnesses and disorders.	Herefordshire Council will seek to ensure that it and local partners continue to have input and influence on the development of mental health services so they align with the aims and ambitions as laid out in the current Corporate and County Plans.
There have been challenges in recruiting suitably qualified staff to undertake new roles and responsibilities as community mental health services have expanded.	There is a national issue with regard to recruiting and retaining staff across the health and social care sectors. Herefordshire and Worcestershire Health and Care Trust continue to run recruitment

This has slowed down the expected progress to date	drives and are confident that existing gaps in staffing will be filled.

Consultees

34. The Clinical Commissioning Group has undertaken a number of engagement events in Herefordshire and Worcestershire during the latter part of 2019 and the beginning of 2020. There was also a survey undertaken in 2019. The full report on the outcomes of the survey and engagement events can be found at Appendix 2.

35. There is now a Mental Health Advisory Group meeting on a monthly basis. The membership includes elected members and officers from Herefordshire Council, senior management of Herefordshire and Worcestershire Health and Care Trust and CCG, VCS representation, as well as individuals with lived experience of mental illness. The forum is used to keep stakeholders up to date with transformation changes and enable some level of scrutiny of progress.

36. Herefordshire Mental Health Partnership Board will continue to have updates on the progress mental health service developments and act as a ‘critical friend’. The chairperson of the MHPB is a general practitioner who will be able to observe first-hand how well the transformation programme is working for patients and his colleagues.

Appendices

Appendix 1 – Mental Health Strategy DRAFT v13

Appendix 2 – Mental Health Strategy Equality Impact Assessment 2019

Appendix 3 – Mental Health Strategy - Engagement Evaluation Report – Final

Appendix 4 – Mental Health Strategy – Engagement Report Summary

Background papers

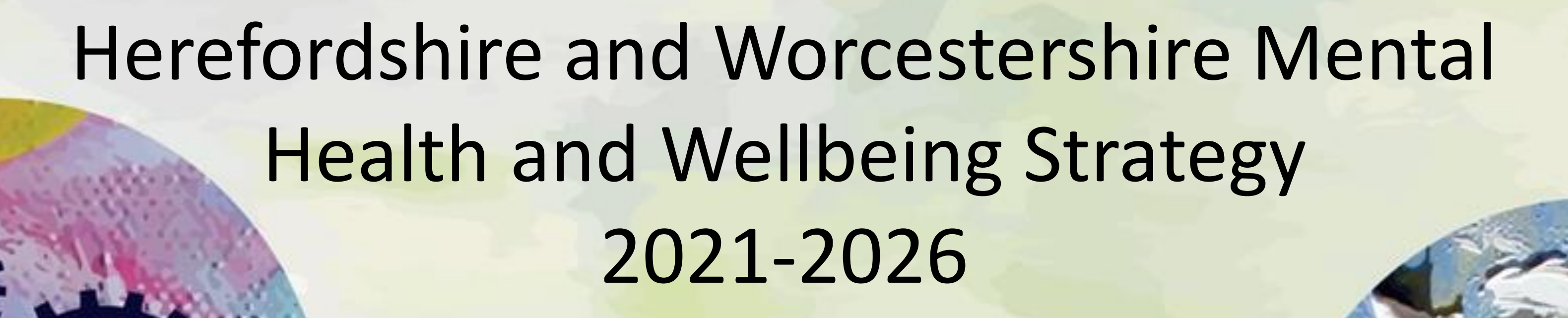
None identified

Report Reviewers Used for appraising this report:

Governance	Mathew Evans	Date 09/11/2021
Finance	Kim Wratten	Date 08/11/2021
Legal	Kate Coughtrie	Date 08/11/2021
Communications	Luenne Featherstone	Date 08/11/2021
Equality Duty	Carol Trachonitis	Date 08/11/2021
Procurement	Lee Robertson	Date 08/11/2021
Risk	Paul Harris	Date 08/11/2021

Approved by	Paul Smith	Date 23/11/2021

Appendix 1



Herefordshire and Worcestershire Mental Health and Wellbeing Strategy 2021-2026

DRAFT

Herefordshire and Worcestershire
Integrated Care System

Introduction

Awareness of mental health and wellbeing is growing in the public consciousness and is a major priority both in Herefordshire and Worcestershire, and nationally. This is reflected in the NHS Long Term Plan, which sets our the strategic direction for NHS mental health services nationally over the next 5-10 years.

Our strategy for Herefordshire and Worcestershire sets out our ambitions to support and treat people with mental health issues over the next 5 years, in terms of delivering the national strategy in a way that works for our area, as well as identifying local priorities to meet our specific needs based on feedback from stakeholders.

This Strategy is informed by what people have told us about their experiences either as a person who has experienced mental health illness, a carer of someone with a mental health illness, or a member of staff working with people experiencing mental health illness.

Executive Summary

We will work with local people and communities so that everyone can be mentally well, or access services quickly when they need them, and that those services will work together in an integrated fashion to provide the best possible care.

A key role of Integrated Care Systems (ICS) is to ensure that services are delivered in a way that works for each local area. 'Mental health' has a variety of meanings to different people, and mental health services span an equally wide range of needs. These include inpatient and community care delivered by NHS Trusts, social care support delivered by local authorities, liaison and diversion services funded by the Police and Crime Commissioner, acute hospital services and A&E supporting people in crisis or co-occurring physical health needs, police, ambulance and fire services responding to mental health related emergencies, mental health workers in GP practices, or a huge range of voluntary and community services supporting mental health and wellbeing.

The majority of national ambitions for mental health services stem from the NHS Long Term Plan, however broader ambitions such as from the National Police Chiefs' Council National Strategy on Policing and Mental Health must also be considered. Local ambitions are driven by the respective Health and Wellbeing Strategies for Herefordshire and Worcestershire County Councils, which both identify mental health and wellbeing as a key priority.

This strategy aims to set out a plan for how both local and national ambitions for mental health services can be achieved, through integrated working across a diverse range of partners. An essential element of this is ensuring that services are delivered to meet the needs of our local population and geography. This means achieving the same outcomes for service users, though this may be delivered in very different ways, for example services for residents in urban centres and rural communities. This balance is at the heart of how the ICS will work, with oversight from stakeholders at ICS, county and community-levels, through Health and Wellbeing Boards and partnership forums.

What this means for local communities is that services will be accountable at county and local level for delivery of services that work at place, with greater opportunity for local organisations to influence and mould the delivery of mental health services. For example Primary Care Networks are working with Neighbourhood Mental Health Teams to set out how community mental health services can work together to improve patient care. A key element of this strategy that supports this drive is to change how services are commissioned from voluntary sector organisations to provide a commissioning environment that is conducive to high quality services, collaborative working and sustainability, while also providing an increased voice into commissioning priorities.

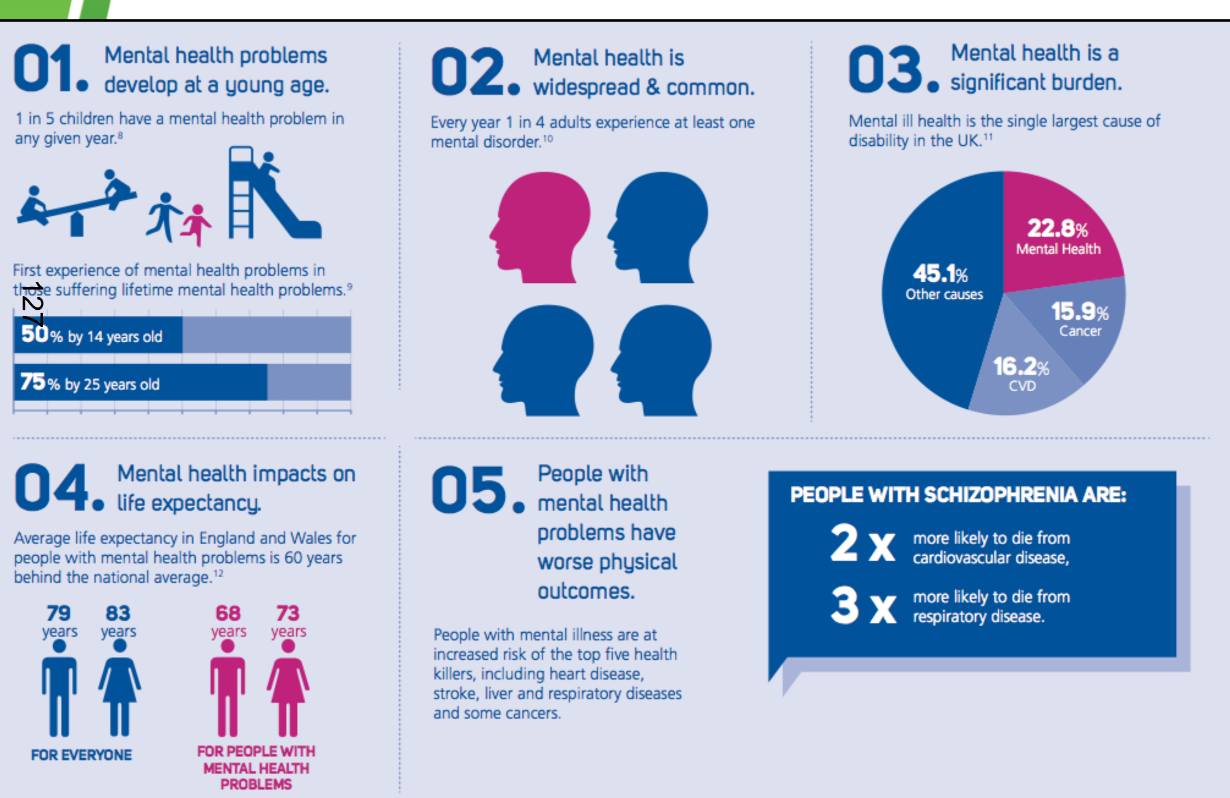
Though this strategy sets out a range of new initiatives to be delivered within the next 3 years, which will be refreshed in line with the next stage of the NHS Long Term Plan and the re-development of local Health and Wellbeing Strategies, these services cannot be delivered in isolation. The underlying principle is therefore one of joint working across partners to deliver local change, while achieving consistent, positive outcomes across both counties.

What is mental health and wellbeing?

‘In many ways, mental health is just like physical health; everybody has it and we need to take care of it. Good mental health means being generally able to think, feel and react in the ways that you need and want to live your life. But if you go through a period of poor mental health you might find the ways you're frequently thinking, feeling or reacting become difficult, or even impossible, to cope with. This can feel just as bad as a physical illness, or even worse.’ ‘Mental wellbeing describes your mental state - how you are feeling and how well you can cope with day-to-day life. Our mental wellbeing is dynamic. It can change from moment to moment, day to day, month to month or year to year.’	Mind
‘When our mental health is good, we feel positive about ourselves, enjoy being around others and feel able to deal with life’s challenges. We all go through times when we feel worried, confused or down. But when it starts to feel difficult to do everyday things like hanging out with friends, getting work done or doing the things we normally enjoy, this could mean we have a problem with our mental health.’	Young Minds
‘Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others.’	World Health Organisation
‘There’s a stigma attached to mental health problems. This means that people feel uncomfortable about them and don’t talk about them much. Many people don’t even feel comfortable talking about their feelings. But it’s healthy to know and say how you’re feeling.’	Mental Health Foundation
‘Mental health and mental illness have an impact on all of us, either directly or indirectly – whilst we can all benefit from having good mental health, 1 in 6 adults experienced a common mental health problem in the last week.’	Public Health England
‘One in four adults and one in 10 children experience mental illness, and many more of us know and care for people who do.’	NHS England
‘Mental wellbeing can be described as 'feeling good and functioning well.’	Herefordshire County Council
‘One in four people will experience and mental illness in their lifetime - it is not as uncommon as you think.’	Rethink Mental Illness

National Picture

Mental health illness is widespread and common, and is linked to wider determinants of health. It is also linked to a broad range of inequalities, both with mental health services and in daily life.



National Picture

Adverse Childhood Experiences (**ACEs**): 47% of people report at least 1 ACE, 9% report 4 ACEs or more

1 in 4 adults experience at least one diagnosable mental health problem in any given year

One in six school age children has a mental health problem

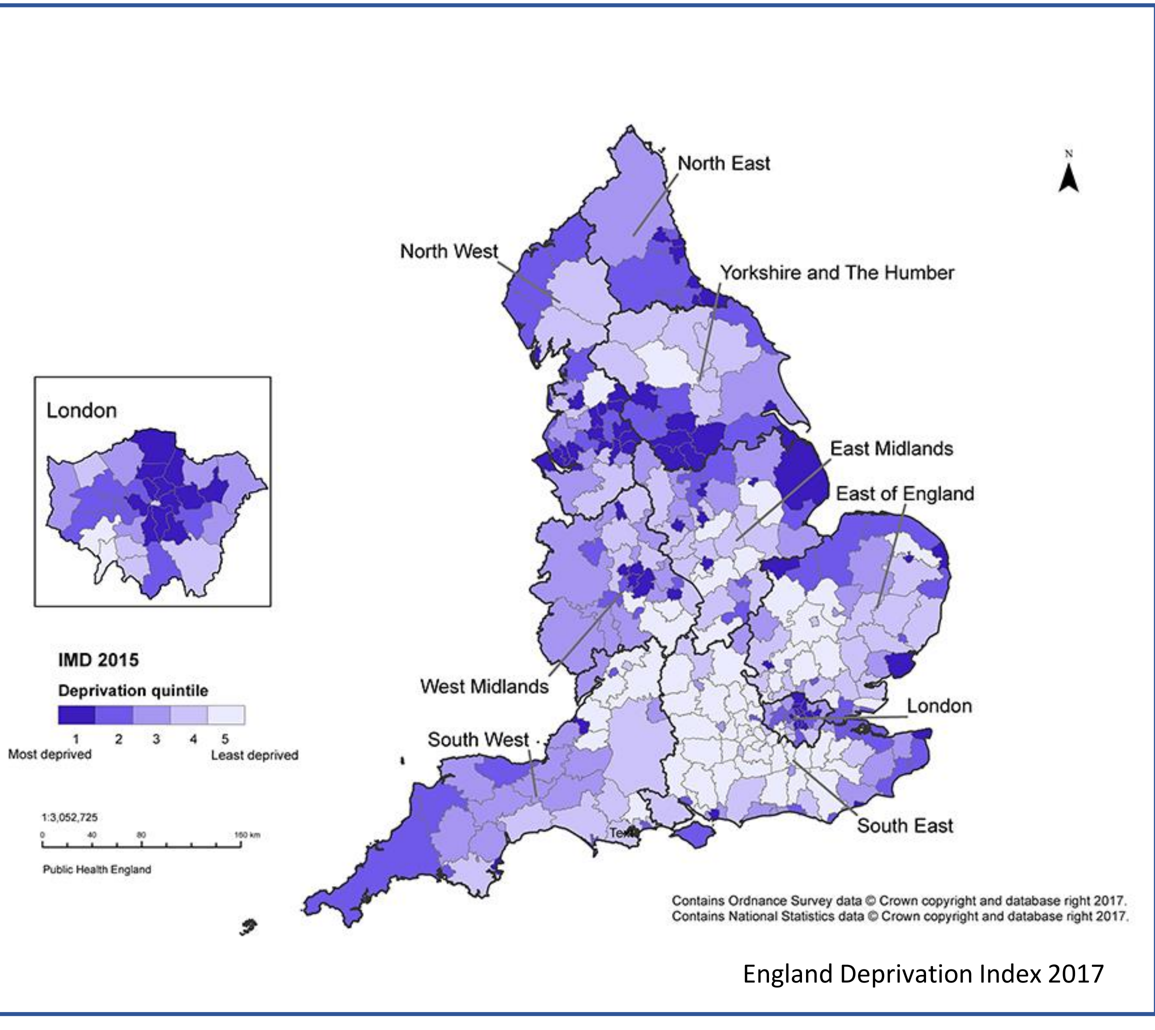
Suicide is the leading cause of death in 15-29 year olds and the second leading cause of maternal death

75% of adults with a diagnosable mental health problem experience the first symptoms by the age of 24

Severe Mental Illnesses affect around **500,000** people in England

1 in 5 older people are affected by depression

1 in 5 mothers suffer with depression, anxiety or psychosis in pregnancy or first year after children



England Deprivation Index 2017

National context and background

There are a number of national drivers that shape and influence the way mental health services are delivered in the UK

'Parity of esteem is the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2012.' ***Centre for Mental Health***

'The Mental Health Investment Standard (MHIS) is the requirement for CCGs to increase investment in Mental Health services in line with their overall increase in allocation each year.' ***NHS England***

A 'parity approach' enables NHS and local authority health and social care services to provide a holistic, 'whole-person' response to each individual in need of care and support, with their physical and mental health needs treated equally. The relationship between physical and mental health is such that poor mental health is linked with a higher risk of physical health problems, and poor physical health is linked with poor mental health. ***Mental Health Foundation***

The anticipated Health and Care Bill aims to remove barriers to integration, 'remove much of the transactional bureaucracy' and 'ensure a system that is more accountable and responsive to the people that work in it and the people that use it'. ***Government white paper setting out legislative proposals for a Health and Care Bill***

Legislation	Context
Care Act 2014	Five Year Forward View for Mental Health (2016)
Health and Social Care Act 2012	NHS Long Term Plan (2019)
Equalities Act 2010	NHS & Adult Social Care Outcomes Frameworks
Mental Health Act 1983	Advancing Mental Health Equality (2019)
Policing and Crime Act 2017	Prevention Concordat
Children's Act 2004	Crisis Care Concordat

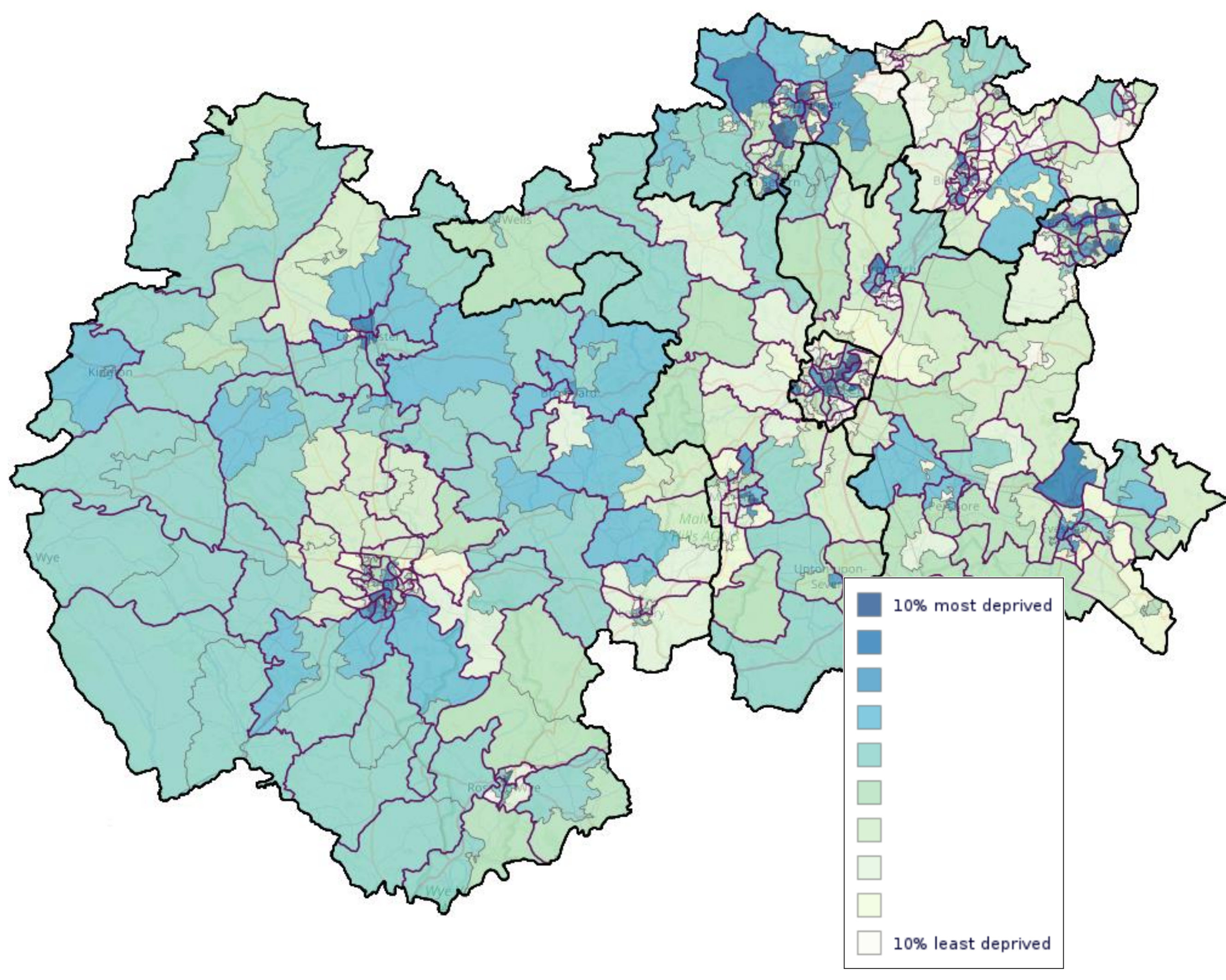
Local Picture

The determinants of mental health are not limited to an individual's attributes but include social, cultural, economic, political and environmental factors. Deprivation, generally described as a relative disadvantage in terms of material and social factors (including money, resources and access to life opportunities) increases the risk of poorer mental health.

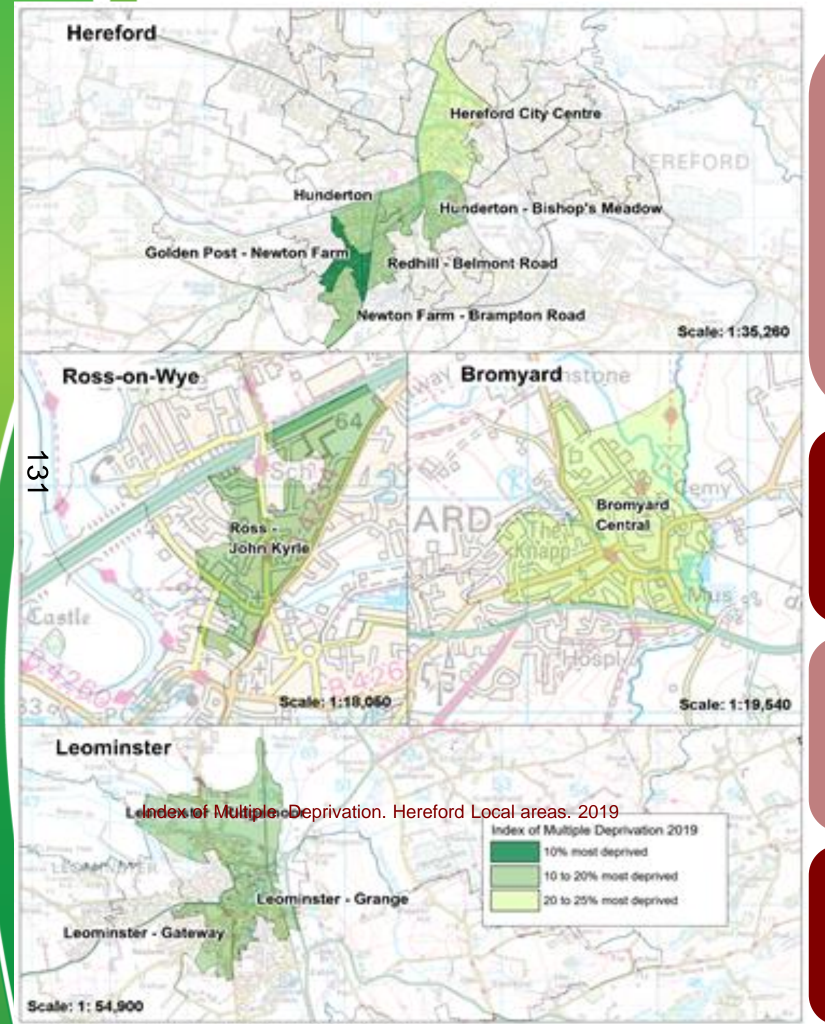
The Index of Multiple Deprivation (IMD) is a combined measure of deprivation reflecting 37 indicators across 7 domains and is used to compare relative deprivation across different geographical areas. Prevalence of psychotic disorders among the lowest fifth of household income is 9 times higher than in the highest and double the level of common mental health problems between the same groups. Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%.

Both Herefordshire and Worcestershire are predominantly rural counties with some urban areas, particularly in Worcestershire. The health of the rural population is on average better than that of urban areas though this is not clear cut, with evidence suggesting very diverse levels of affluence in rural areas also. This is in line with the variation in IMD seen across the two counties (right).

Mental health services need to recognise this variation wherever possible to reflect the diverse needs of different areas in order to deliver services most effectively.



Local Picture - Herefordshire



Index of Multiple Deprivation. Hereford Local areas. 2019

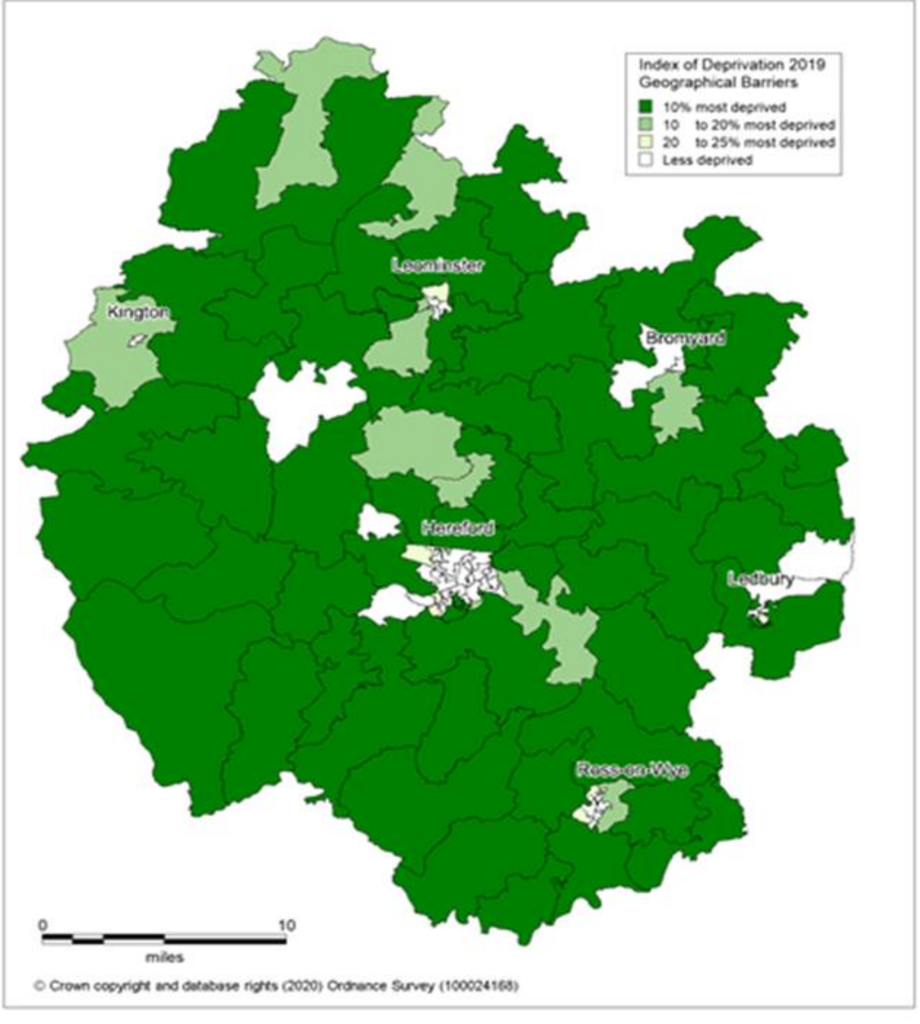
Rurality concerns : Almost half the county's areas are amongst the 10% most deprived in relation to physical distance from essential services and facilities including schools and the GP.

Less than 25% of adult carers receive as much social interaction as they would like.

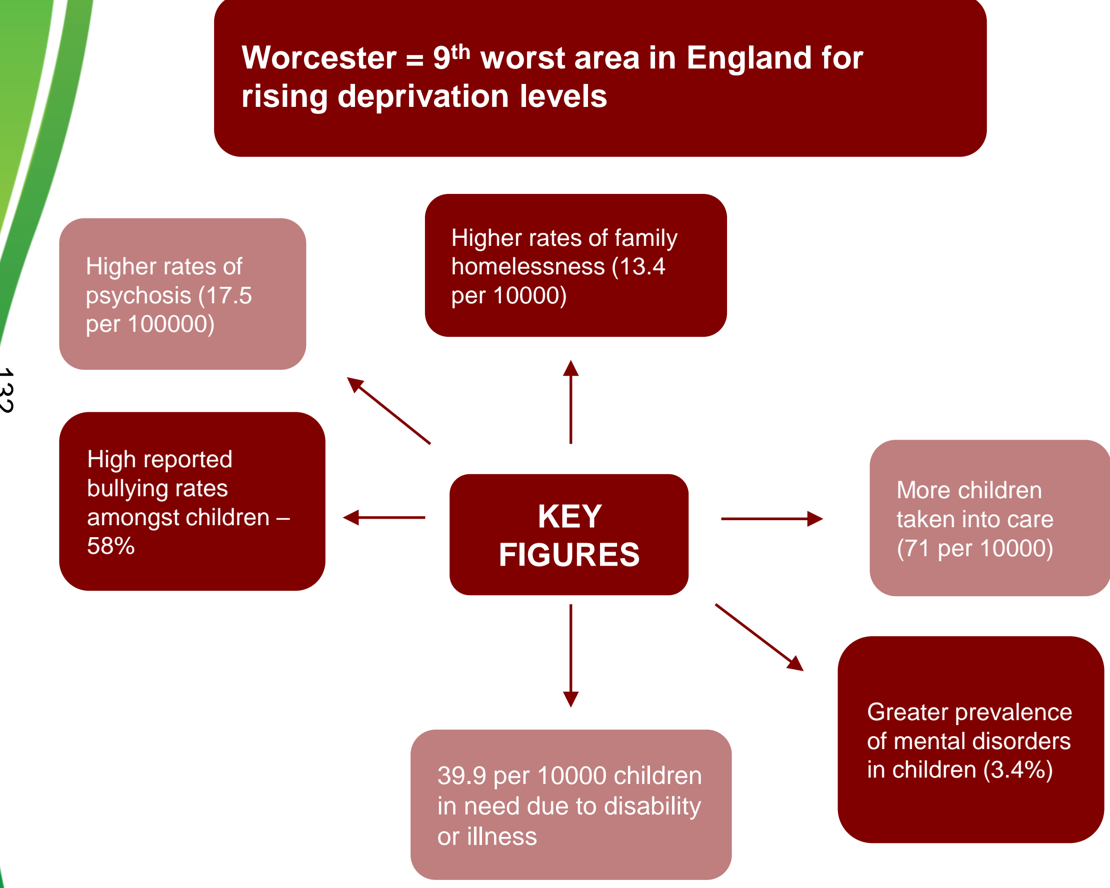
3% of children have social, emotional or mental health needs (above national benchmark)

69% of adults classed as overweight or obese (above national benchmark)

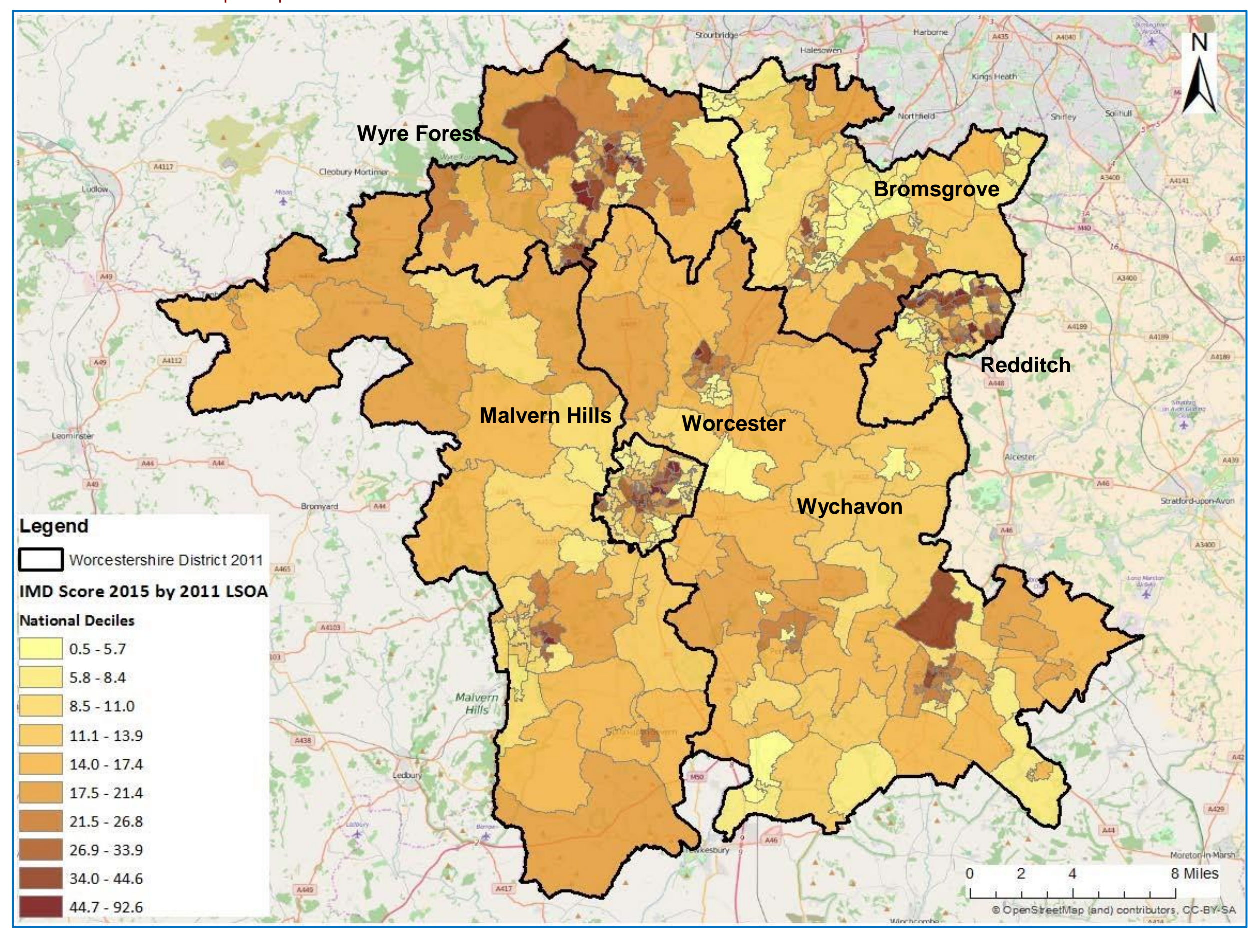
Index of Deprivation 2019 (Geographical Barriers)



Local Picture - Worcestershire



Source: Indices of Multiple Deprivation 2015



COVID-19

COVID-19 has had, and will continue to have, a major impact on peoples' mental health and wellbeing, and on the way mental health services are delivered. In the short term many mental health services saw a dramatic reduction in referrals, meaning fewer people are receiving the care that they require, though these have largely now returned to normal levels. Conversely there was also increased demand for some services, as a result of the increased stresses brought about by the pandemic and subsequent lockdown.

The scale of the longer term negative impacts of the pandemic on mental health and wellbeing, both direct and indirect, remains unclear. They are expected to be significant however, and we are now seeing a significant increase in mental illness, and exacerbation of existing ill health. Issues such as anxiety and depression are expected to become more prevalent, particularly as negative economic effects impact on employment; trauma caused directly by treatment for COVID in Intensive Care Units is also a risk, and it is also being reported that people presenting to services are experiencing a greater acuity of symptoms, suggesting that people are not accessing services as early as previously.

There have however been some positives that have come out of the pandemic, as coronavirus has also forced organisations to think differently about how services are delivered and triggered major rapid transformation of services.

While mental health services in Herefordshire and Worcestershire remained largely operational during the first wave of the pandemic, in contrast to many elective physical health services, many have begun to routinely utilise digital solutions such as appointments by phone or videoconference. An acute mental health ward that was closed to accommodate COVID-positive patients, with staff redeployed to deliver intensive community treatment instead, is proving a success. Estates strategies are being revisited off the back of a more flexible, mobile workforce than ever before, and public awareness of mental health and wellbeing continues to grow. Our local Voluntary, Community and Social Enterprise (VCSE) sector has provided wide-ranging and invaluable support, including closer integration with statutory services, and continues to buck the trend around workforce challenges.

While there remain challenging times to come as a result of COVID-19, it is important that we take advantage of and retain the major positive changes that have been made to how services are delivered wherever possible.

Inequalities

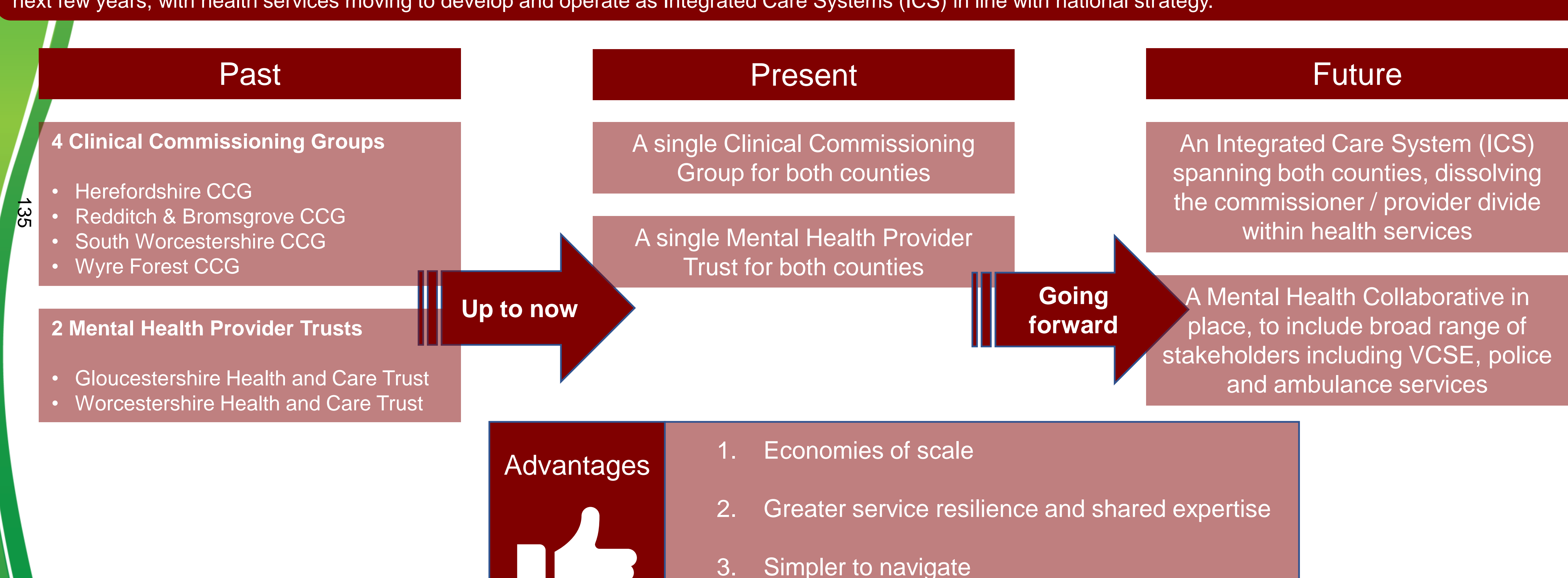
Many inequalities of access, experience and outcomes of services for people with mental health illness are longstanding, but are understood to have been exacerbated by the COVID-19 pandemic. National data shows:

Characteristic	Access	Experience	Outcomes
Age	Older people are a fifth as likely as younger age groups to have access to talking therapies but six times as likely to be on medication Children and young people from BAME communities are less likely to be able to access services which could intervene early to prevent mental health problems escalating	Older people with common mental health problems are more likely to be on drug therapies and less likely to be in receipt of talking therapies	Young people in prison are more likely to take their own lives than others of the same age Older people have better recovery outcomes in IAPT than working-age, but access is lower
Ethnicity	Many black-African and Caribbean people, particularly men, do not have access to psychological treatment at an early stage of their mental health problem People from black-African and Caribbean communities are 40% more likely than white-British people to come into contact with mental health services through the criminal justice system	BAME patients are less likely to rate their overall experience as 8 or above on a 10-point scale (44% vs 49% for white-British) Black adults are more likely than adults in other ethnic groups to have been detained under a section of the Mental Health Act	Though there have been gradual improvements, the IAPT recovery rate for BAME service users is below that of their white-British Counterparts
Gender	Men are less likely to be referred to IAPT services, and enter IAPT treatment, than women	Women are more likely to be restrained than men and girls are more likely to be restrained in a face down position than boys	Women, on average, have a longer length of stay in secure care
Sexual Orientation	LGB people still experience discrimination in healthcare settings and many avoid healthcare for fear of discrimination from staff	LGB patients are far less likely to feel they had been treated with dignity and respect by NHS mental health services (55% vs 73%)	LGB people experience poorer recovery outcomes in IAPT than their heterosexual counterparts
Disability	People with disabilities face unique barriers to accessing care with transportation and cost cited as significant barriers	A Mental Health Foundation survey found that those with a learning disability were not as satisfied with MH care provided	People with disabilities experience poorer recovery outcomes in IAPT than those without a disability
Deprivation	People in lower income households are more likely to have unmet mental health treatment requests compared with the highest	Evidence on differential patient and carer experiences of mental health in deprived localities is still emerging	IAPT recovery rates are generally poorer in the most deprived localities compared to the least deprived
Other	Many health inclusion groups face barriers to accessing healthcare services in the round, including those sleeping rough, sex workers, and migrants	Evidence on differential patient and carer experiences in mental health services is still emerging	People of the Muslim faith experience poorer recovery outcomes in IAPT services than any other faith group

A Herefordshire and Worcestershire Mental Health Inequalities Board has been established to review local intelligence and put in place action plans to address inequalities identified locally.

Local context and background

Mental health services in Herefordshire and Worcestershire have recently undergone a period of significant change, with the move to both a single NHS mental health provider trust and a single NHS Clinical Commissioning Group expected to have a beneficial impact on services across both counties. Further change is expected over the next few years, with health services moving to develop and operate as Integrated Care Systems (ICS) in line with national strategy.



Local context and background

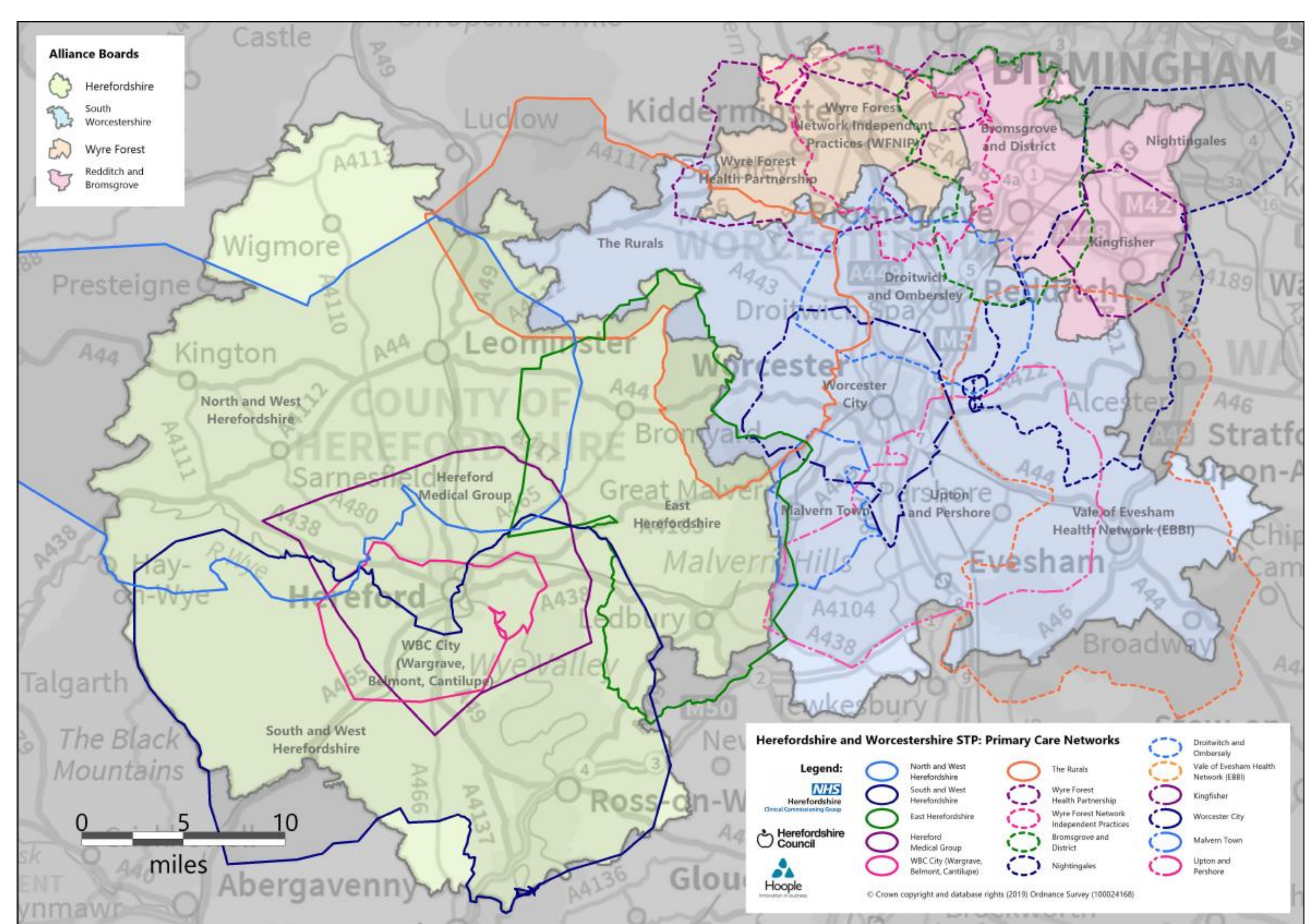
Although Herefordshire and Worcestershire now have a single mental health provider and a single CCG as health commissioner, services that address local needs are essential.

The following statutory commissioning and provider bodies support and ensure localised delivery of services across the ICS:

- 2 County Councils (including Public Health teams)
- 6 District Councils in Worcestershire
- 3 Acute Hospitals
- 8 Community Hospitals
- 16 Primary Care Networks (PCN)
- 85 GP Practices

While some services are best delivered at an ICS-level, such as more specialised services, many are better delivered at different levels such as county, district or PCN-level.

At whatever geography services are delivered, the purpose is to improve health and wellbeing outcomes for all and to reduce the gap between those with the best and worst outcomes by working as equal partners to drive collaboration. This is delivered through the triumvirate of place leadership, provider collaboratives and system leadership, underpinned by the principle of subsidiarity.



Local context and background

How services are commissioned and delivered

Level	Description
Regional	The most specialist services are commissioned and delivered at a regional level, notably Children and Adolescent Mental Health inpatient wards. Other services commissioned and/or delivered at regional or sub-regional level who have regular contact with mental health patients include ambulance and police services.
ICS	Many NHS mental health services are commissioned at, and have management structures at, an ICS level covering both counties, such as acute inpatient units, perinatal mental health services or IAPT (Healthy Minds) services. The majority of these services retain local delivery teams for each place however.
County / Place	The majority of mental health services, including NHS, local authority and VCSE-provided, are delivered at place. This includes social work teams, CAMHS, Early Intervention in Psychosis, Crisis Resolution and Home Treatment, and Safe Haven services, amongst others. Commissioning and management arrangements vary, but county-based services make up the bulk of services from both a health and social care perspective, recognising the importance of place.
District / PCN / Local Delivery	A major aim of both the NHS Long Term Plan and this strategy is to shift the delivery of services to a more local level, with flexibility of delivery depending on local need, while still delivering the same outcomes for individuals. A major driver for this within adult services is the Community Mental Health Transformation, which created Neighbourhood Mental Health Teams operating at a more local level linked to identified Primary Care Networks (PCN). Broader wellbeing support and lower level interventions in particular are often best delivered by local, often smaller organisations who are a part of the community. It is through locally-devised solutions that equality of mental health services will be improved, through agencies working together to ensure equitable access, outcomes and experience for all people requiring mental health support.

Local context and background

Mental health and wellbeing affect people in all walks of life, but has particular links to a number of other issues. This strategy does not seek to replace but to link to these strategies, including those below.

Strategies

- Herefordshire Learning Disability Strategy
- Worcestershire Learning Disability Strategy
- Herefordshire Autism Strategy
- Worcestershire All-Age Autism Strategy
- Herefordshire & Worcestershire CYMPH Transformation Plan
- Herefordshire & Worcestershire Dementia Strategy
- Herefordshire Homelessness Prevention and Rough Sleeping Strategy
- Worcestershire Homelessness and Rough Sleeping Strategy
- Herefordshire Health and Wellbeing Strategy
- Worcestershire Joint Health and Wellbeing Strategy
- Herefordshire Joint Carers Strategy
- Worcestershire Carers Strategy
- Herefordshire Interim Housing Strategy
- Worcestershire Strategy for CYP and SEND
- Herefordshire & Worcestershire Sustainability and Transformation Plan

Local context and background

Below is just some of the work already underway locally that this strategy seeks to support includes:

Worcestershire All-Age Autism Strategy:

Links adult services with services for children and young people for support

Ensure that people with autism spectrum conditions are supported as they progress to more independent living. Enables children, young people and adults with autism spectrum conditions to have access to all universal and health and social care services

Herefordshire and Worcestershire Children and Young People Mental Health and Emotional Wellbeing Transformation Plan:

Plans on improved crisis care and early identification of children in need to prevent escalation or further risks and continued support in recovery

Worcestershire Joint Health and Wellbeing Strategy:

Prioritise building resilience to improving mental wellbeing and dementia. (A higher proportion of adults in Worcestershire are diagnosed with dementia (7.8%) than the national average (5.8%)

Worcestershire homelessness & rough sleeping strategy:

Poor mental health outcomes of homeless people are twice as high compared with the general population

Plans to develop, review and promote local housing and support pathways for groups vulnerable to becoming homeless as a result of mental health problems

Herefordshire Suicide Prevention Strategy:

Focus on suicide prevention through identifying key areas for development, improving support for those already at risk

Herefordshire Joint Carers Strategy:

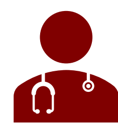
Provide support to enable fulfilled lives as 82% carers struggle with their health

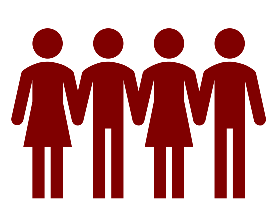
Challenges

The profile of mental health has risen in recent years, and with it has come greater focus as well as increased funding. While this is welcomed, there remain significant challenges to delivering high quality mental health services to our communities.

Workforce

With a shortage of 40,000 nurses and 10,000 Consultants nationally, finding sufficient workforce is challenging, particularly in rural areas. We need to think differently about our workforce in Herefordshire and Worcestershire to ensure we are able to provide safe, quality services.



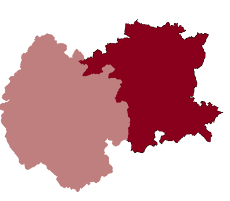


Increasing demand

Demand for mental health services is increasing, by as much as a third nationally over the last five years. Our services need to meet the rising and changing profile of demand in across the ICS, while addressing gaps and maintaining quality within existing provision.

Bringing together two counties

Mental health provision looks different depending on whether you live in Herefordshire or Worcestershire. We want to bring both areas closer together so that there is a consistent service offer no matter where you are in our ICS.



Ambitious national agenda

The NHS Long Term Plan is ambitious in what it has set out to achieve over the next 5 and 10 years, with all areas expected to improve and expand mental health services at pace. While this is very welcome, it also poses a challenge to local systems to deliver.

System Financial Recovery

Local authorities and the NHS are under significant financial pressure and Herefordshire and Worcestershire ICS is currently in a financial deficit position. Mental health services need to do their part to drive efficiency and ensure services across the system are sustainable.

Responding to local need

Herefordshire and Worcestershire is a mixed area geographically with both urban and rural areas that pose different questions, and require different solutions. Getting the right services for each local population while also gaining the benefits of ICS-wide services will be key.

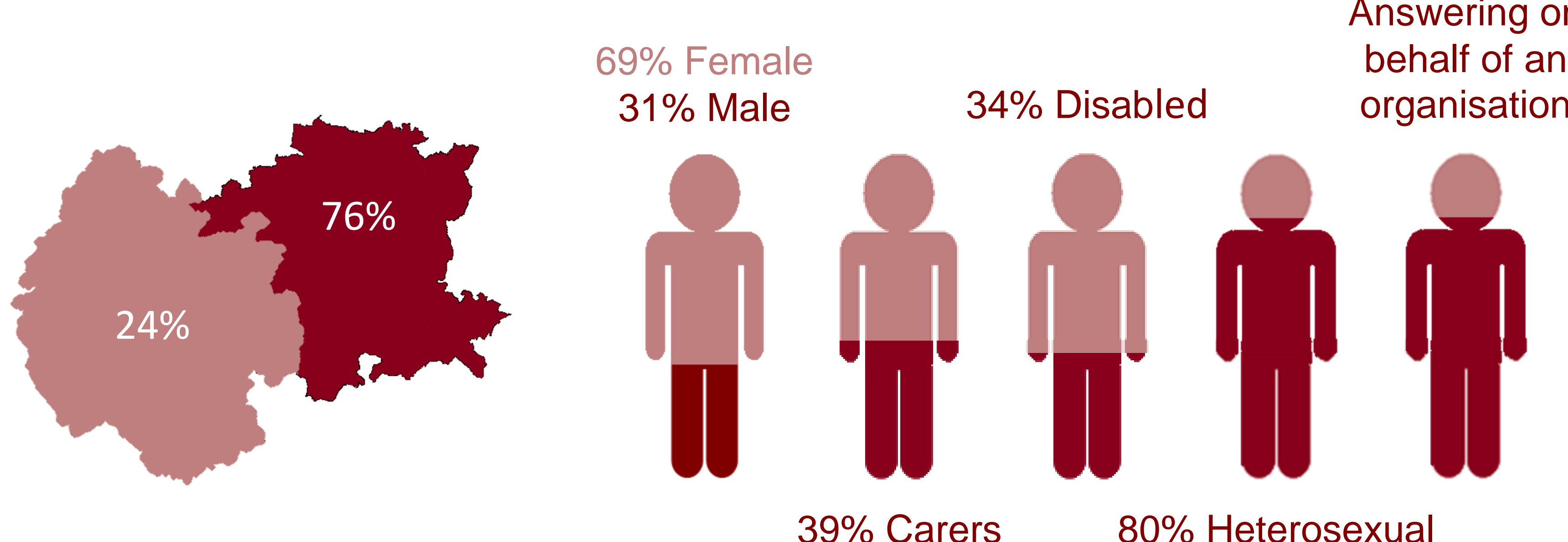
Who we spoke to

Between 1 October 2019 until 12 November 2019 the Engagement Manager on behalf of the Herefordshire and Worcestershire Integrated Care System ran a survey and a series listening events to engage with the Herefordshire and Worcestershire populations, with the purpose of gaining their views on a new ICS Mental Health Strategy. The full Engagement Report is available at http://www.redditchandbromsgroveccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=198401 .

192 people responded to the survey and 47 people attended a Listening Event. Respondents were asked to comment on the following three questions:

1. What do you think works well for people with a mental health condition in the area where you live?
2. What doesn't work well?
3. What do you think the mental health strategy should focus on?

239 Respondents



Who we spoke to

Mental health and wellbeing is a broad area covering many issues affecting people in all walks and stages of life, and alongside a wide range of other issues. Though present everywhere, mental health difficulties are particularly prevalent alongside difficulties such as:

- Homelessness and housing issues
- Substance misuse
- Long term physical health conditions
- Autistic Spectrum Condition (ASC)
- Learning disabilities
- Being a Carer
- Bullying
- Unemployment or workplace stress
- Debt issues

Mental health is therefore a regular topic of conversation at a variety of different forums within health and social care. This strategy will impact on, and has therefore been discussed at or shared with, the groups and forums to the right:

- Herefordshire and Worcestershire CCG Clinical Commissioning Committee
- Herefordshire & Worcestershire ICS Mental Health Programme Board
- Herefordshire & Worcestershire CCG Clinical Commissioning Group
- Herefordshire CYP MH and Emotional Wellbeing Partnership Board
- Herefordshire County Council Cabinet Members and Scrutiny Chairs
- Herefordshire Health and Wellbeing Board
- Herefordshire County Council Departmental Leadership Teams
- Herefordshire Mental Health Partnership Board
- Herefordshire Suicide Prevention Sub-Group
- Hereford Autism Partnership
- Herefordshire Homeless Forum
- Worcestershire CCGs Patient Advisory Group
- Worcestershire Health & Care Trust Community Engagement Panel
- Worcestershire Health & Care Trust Youth Board
- Worcestershire County Council Youth Cabinet
- Worcestershire CYP MH and Emotional Wellbeing Partnership Board
- Worcestershire Integrated Commissioning Executive Officers Group
- Worcestershire Health and Wellbeing Board
- Worcestershire CCGs Clinical Innovation Group
- Worcestershire County Council Departmental Leadership Team
- Worcestershire Strategic Housing Partnership
- Worcestershire Suicide Prevention Steering Group
- Worcester Cares Vulnerable People and Homelessness Forum
- Worcestershire Autism Partnership Board

Engagement reports from public events are available here:

- http://www.wyreforestccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=198401
- https://www.herefordshireandworcestershireccg.nhs.uk/about-us/publications/engagement/additional-engagement-docs/274-mental-health-strategy-summary-engagement-report-final-july-2020/file

What people told us - what works well?

Question 1 – What do you think works well for people with a mental health condition in the area where you live? [this could be a service, a team, how to access information or help, or anything else that you think works well]

Key Theme 1 - Praise for a specific / individual mental health service
There were various individual services that respondents thought worked well for people with a mental health condition. These included a wide range of services across both counties.

Key Theme 2 - Ability to access the service
Numerous respondents thought that access to a service was good. Comments included praise for the following:

- Self-referral option
- Online and telephone support
- 24/7 availability of the Crisis Team
- Support available in the community

Key Theme 3 - The role or support of staff
The care and support received from staff, featured high in the comments of what people thought works well. Respondents praised various individual staff members and teams.

What people told us - what doesn't work well?

Question 2 – What doesn't work well? [this could be a gap / lack of service, a team, how to access information or help, or anything else that you think that needs improvement]

Key Theme 1 - Access
Many comments highlighted 'access' as being the area of highest concern. Nearly half of the comments received for Question 2 gave feedback about access. Waiting times and access for children and young people all gained the highest criticism.

Key Theme 2 - Shortages – staff and services
Respondents reported various aspects of service where they felt there was a shortage of either staff or services.

Key Theme 3 - Poor communication
Some respondents gave examples of how they felt communication had been poor. Access and lack of information came across as the key areas of concern.

Shortages identified through engagement process:

Staff

- Psychiatrists
- Psychologists
- Nurses
- Mental Health Liaison in A&E
- Mental Health staff across the health system

Service

- Children & Young People's Services
- Voluntary Community Sector
- Drop-in Service
- Bed Availability
- CAMHS Out of Hours
- Personality Disorder Service
- Complex Childhood Abuse Service
- Service for those at risk of offending
- Service for those with a 'medium' mental health need
- Outreach
- Out of hours
- Services for those with multiple diagnoses / health needs

What people told us - what should we focus on?

Question 3 – What do you think the Mental Health Strategy should focus on?

The top five themes that received the most comments were: Improved access, early intervention, children and young people, prevention, and patient-centred care.

"Improving long term care & targeting young children at an early age."

"Making support available, particularly for young people, much more quickly."

"The strategy should focus on mental health support for CYP in schools, colleges, universities. There needs to be support for parents and coping mechanisms so that the child can stay within the family unit."

"Younger children and support to parents."

"Easy quick access to the right support and enough of it."

"Easier and quicker access to services."

"Improving access to community-based mental health services and support, counselling, psychotherapy."

"Access in a reasonable timeframe to all services."

"Prevention to stop mental health moving into crisis."

"Prevention, education, self-help."

"Staying well, prevention."

"Prevention. Maintain good mental health alongside exercise healthy eating etc for all ages."

"Treating clients as individual human beings."

"Helping the individual & getting them settled."

"Individual needs. A good initial assessment and what the patient thinks they think would help and the opportunity to experience 1:1, support group, someone on the end of a phone, online community support etc.to see what they feels helps."

"Using the time they have to focus on a plan of recovery specifically for patients on a one to one basis, rather than the textbook regime."

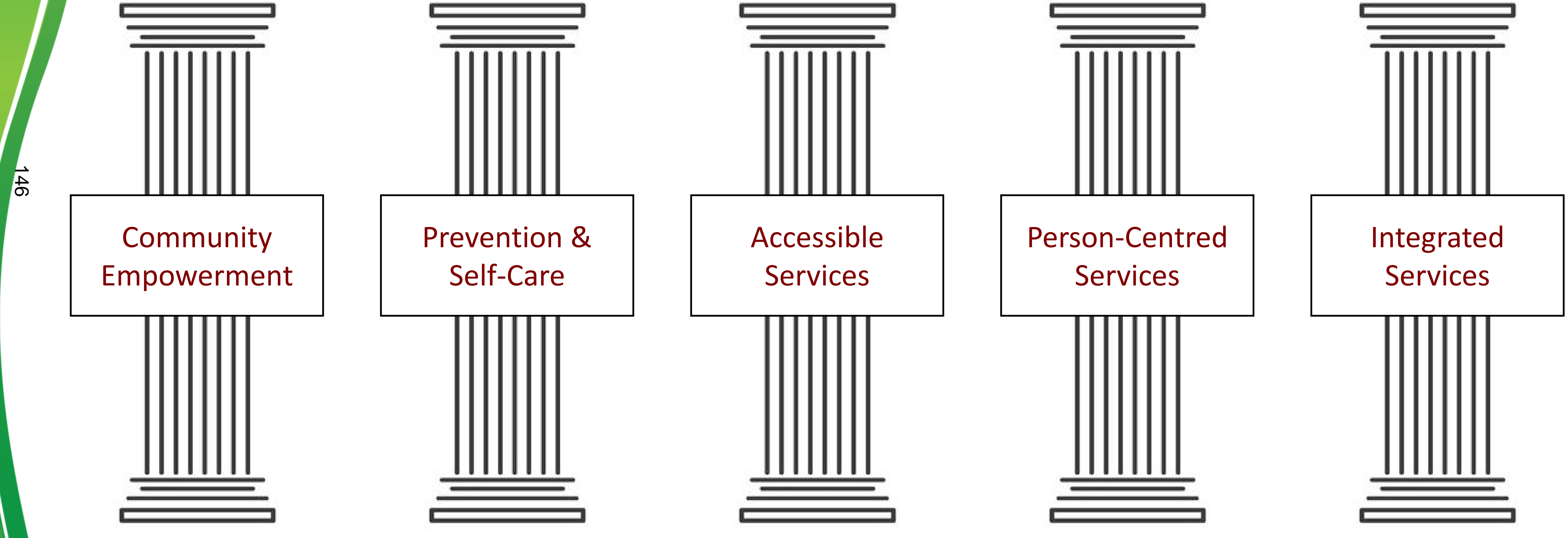
"Early intervention and enough staff to relieve police/A&E and others from responsibility except for reporting"

"Early intervention for any mental condition."

"Early Intervention in Primary and Secondary Schools."

"Early services. Catching people before they get too poorly. Early intervention as the public see it - take pre-emptive action."

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing



Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Community empowerment is having a mental health aware population. It is about the five ways to wellbeing and preventing mental illness. We want to build on the success of the 'Now We're Talking' campaign in Worcestershire and utilise the Talk Community approach in Herefordshire to continue to expand awareness of mental health and self-care, and promote community asset growth, across both counties.

Community empowerment is also about supporting and empowering our Voluntary, Community and Social Enterprise (VCSE) sector to do more, grow and flourish. There is currently very different infrastructure and capacity within our VCSE across both counties, but a shared goal of supporting the growth of the VCSE across health and local authority organisations in both counties. It will never be possible for commissioners to fund all the activities of the various community organisations across Herefordshire and Worcestershire, nor would this be desirable as it would risk stunting innovation. Development and growth of supportive communities and the VCSE in Herefordshire and Worcestershire would therefore mean support in a variety of areas, depending on the needs of the organisations in questions, but would focus as much on sustainability and infrastructure as much as direct service delivery. This could include:

- Creating an environment where organisations are encouraged and incentivised to work together
- Build social capital through community asset growth
- Information sharing and awareness raising
- Infrastructure support for small organisations such as standard policies, procedures etc.
- Clinical supervision support
- Sharing of accommodation
- Support to access other funding streams
- Economies of scale for back-office functions
- System-wide training (direct and 'train the trainer')
- Celebrating success

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Linked to all of the above, prevention and self-care for mental health illness in Herefordshire and Worcestershire can provide the best possible outcomes for patients, minimise escalation to acute mental health services, and relieve pressure on secondary services, allowing a faster response for those in urgent need. Though children and young peoples' mental health services are key, prevention and self-care are important across the life course.

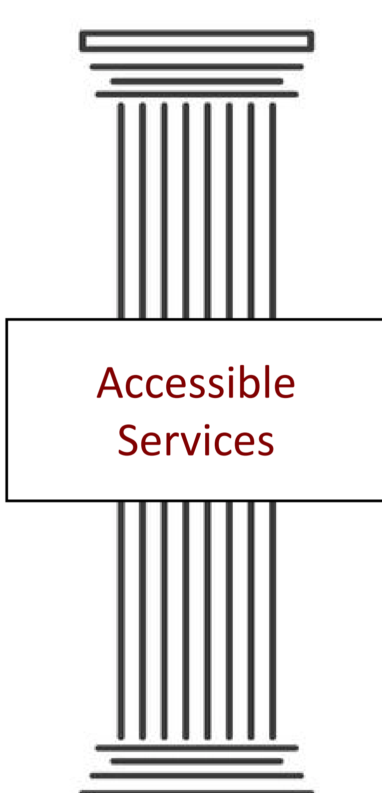
The principles of prevention and self care should apply at all levels, from mental health aware communities, to mental health literacy for frontline staff in areas such as housing, right through to self-care skills development and proactive crisis planning for people accessing acute and crisis mental health services.

We need to reconfigure funding and services where possible to provide greater focus on prevention, in local communities, to reduce pressure on secondary and acute services, as well as statutory partners. Investment in more preventative services will also help us as a system in terms or recruitment in a challenging environment, and support the growth of the VCSE, while investing in training for frontline staff across statutory and non-statutory partners will help us create mental health aware services more widely. There is a real groundswell of grass routes organisations supporting people with mental health issues, as well as statutory services, who would really benefit from links and training to support the people accessing their services. If we can develop a cohesive network to support these organisations and partners we hope to support and build the resilience of our communities.

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Accessibility of services was the most frequently talked about issue with mental health services, both positively where particular services are views as accessible and negatively where improvement is needed. Accessibility includes a variety of factors, such as:

- Early Intervention
- Waiting times for a first appointment or assessment
- Waiting times for the start of treatment
- Where a wait is unavoidable, communication from the service during this period
- Thresholds for accessing services
- Transitions from children and young peoples' services, either to wider community networks or to adult services where required
- Barriers to accessing services and reasonable adjustments
- Discharge from services requiring re-referral
- Identified gaps in provision of services



Our aspiration is for mental health services at all levels to be accessible for those who need them, in line with the national aim to move to a 4-week waiting time standard for secondary mental health services. Herefordshire and Worcestershire bid to become, and has been selected as, an Early Implementer site for the Community Mental Health (CMH) Transformation programme which is trialling this. The underlying principle of our proposal for this new model of service was that of inclusivity, seeking to remove barriers to services and based on an assumption of an appropriate offer for all.

Significant investment has been made into expanding mental health services nationally and locally through the NHS Long Term Plan and Mental Health Investment Standard. This expansion has been accelerated in response to COVID in order to meet growing demand, making it all the more important to ensure accessibility of services when they're needed, and for all.

A major focus is also on reducing inequalities within mental health services, demonstrated by the establishment of a H&W Mental Health Inequalities Board.

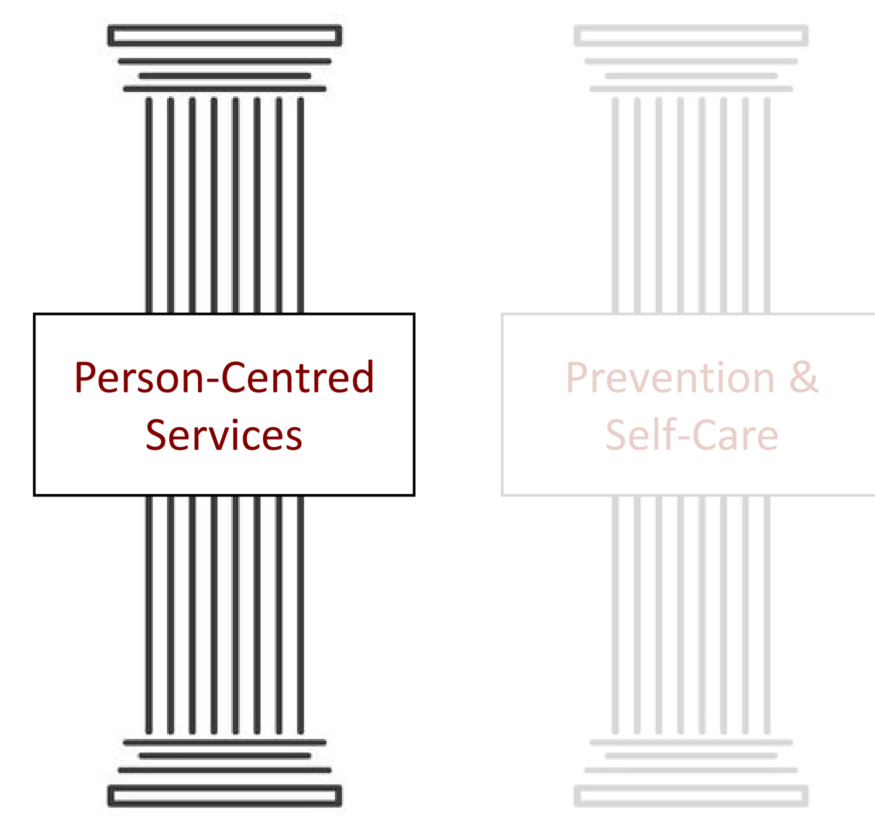
Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Another clear message from public and stakeholder engagement was the need for services to wrap around the individual and to prevent patients having to navigate between disparate services, often with no support, which can cause disengagement or deterioration. This extends to carers also, who too often hold the burden of supporting people who are mentally ill with limited support.

This priority links to both accessibility and collaboration above, but goes beyond this to patient choice on when, where and how they wish to receive treatment.

While there is a need to increase the treatment options available where possible, such as expanding the variety of talking therapies available or options available to people experiencing crisis, another important goal is to standardise the treatment offers available across Herefordshire and Worcestershire. To remove the 'postcode lottery' currently in place while continuing to reflect the distinct needs of different localities and communities will be a key challenge of working as an Integrated Care System.

An ambition of this strategy over the next 5 years is to minimise variation in treatment offers across Herefordshire and Worcestershire, continue to expand the treatment and support offers available, and to close the gaps between services through improved collaboration and shared outcomes.



Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

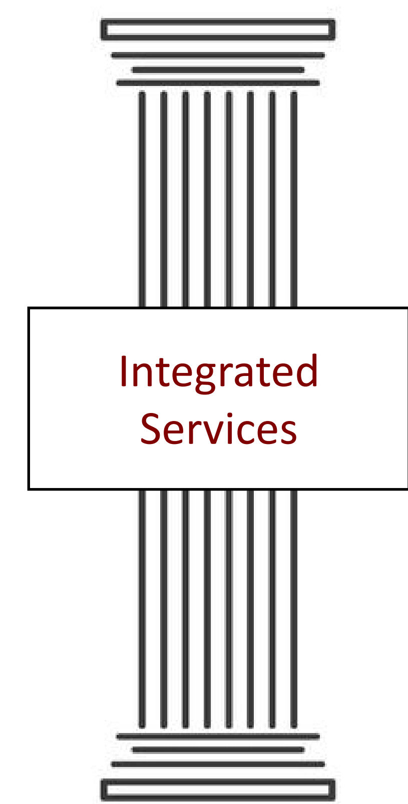
Another key message from public and stakeholder engagement was that many people are 'falling in the gaps' between services. Collaboration between different services is essential to close these gaps and links back to the principle of accessibility of services and removing barriers to services. This was particularly noted for individuals with multiple complex needs such as Autistic Spectrum Condition (ASC), learning disabilities, substance misuse issues and homelessness.

While the investment in mental health services in recent years is valuable and welcomed it is not and can not be the solution for everything, and so much more can be achieved through improved joint working across team and organisational boundaries.

Our ambition is to improve joint-working across organisations through a combination of enablers. These will include moving to an alliance-based model for mental health service provision, targeted investment where necessary for identified groups at risk of falling between services, and supporting the growth and development of the Voluntary, Community and Social Enterprise (VCSE) sector across both counties.

Integration across a range of geographical footprints will also be essential, with mental health and wellbeing services delivered at regional, ICS, county, PCN and community levels, supported by key programmes such as Talk Community.

The local desire for greater integration of services echoes the national strategy for the development of Integrated Care Systems, and Mental Health Provider Collaboratives, the focus of which is on improving joint working and decreasing duplication and bureaucracy by bringing funding and commissioning decision closer to frontline workers, with the ultimate aim of improving outcomes for individuals receiving services.

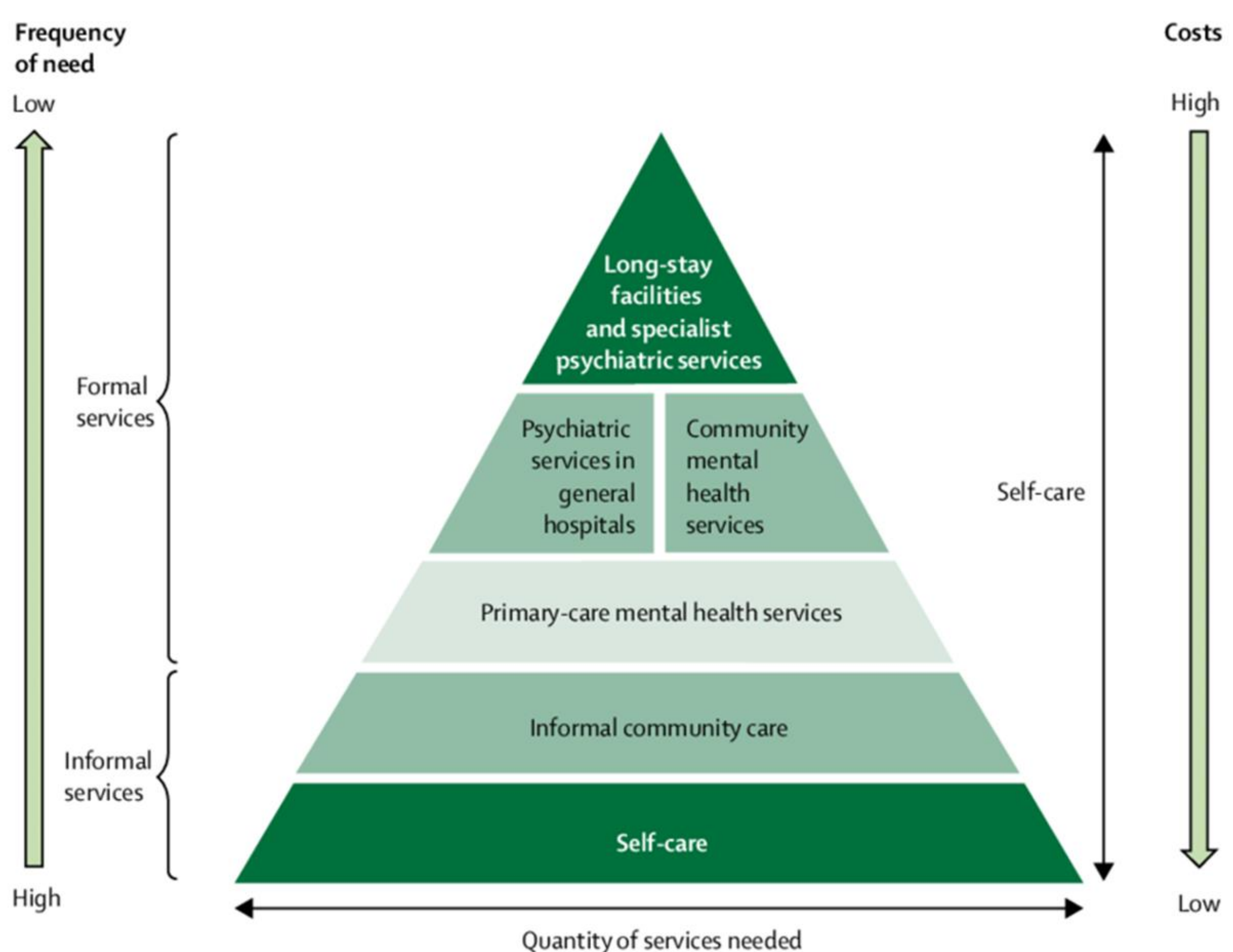


Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Historically, mental health services have focused more on those with the most acute needs, at the top of the pyramid where frequency of need is lower but costs higher. In recent years focus on the lower tiers of the pyramid of need has increased, but this has largely focused on primary-care mental health services and some inconsistent wellbeing provision across the ICS. To continue this move toward the bottom of the pyramid and preventing mental ill health, there remains much to be done.

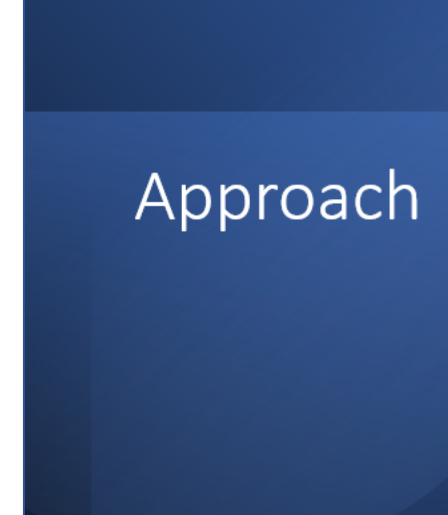
While the majority of the national priorities from the NHS Long Term Plan are rightly focused on increasing resources to and improving secondary care services where specific gaps have been identified, locally there is a real drive to increase wellbeing support, informal community care and self-care options. This has been clear from public engagement events and in some cases is already underway, including Talk Community and Integrated Wellbeing Offer for Worcestershire, as well as the Community Mental Health transformation programme. Mental health is a spectrum and it is important to remember that peoples' mental health can be good or bad, and that it will fluctuate, so self care and learning strategies to support this are essential in preventing mental health from deteriorating.

Transition of resources towards self care and more preventative services will be a gradual process, however this strategy represents a commitment to continue to move investment in this direction.



Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Mental health services must not be viewed in isolation, but alongside physical health needs and interventions. While national programmes such as comprehensive physical health checks for people with a severe mental illness rightly focus on the disparity in physical health and premature mortality, the reverse must also be considered. People with physical health illnesses, particularly long term conditions, are also more likely to experience poor mental health. A community wellbeing approach is being developed in Herefordshire to improve mental health support for people with long term conditions, ranging from self-care and community provision utilising the Community First model, to social prescribing and lifestyle advice, to clinical mental health services such as IAPT (Healthy Minds). This community wellbeing approach will utilise the principles below, with an emphases on consistent screening, understanding care pathways and education.



By using appropriate tools, clinicians across both secondary and primary care will be able to identify patients impacted by mental ill health due to their LTC

Using a strength based approach and understanding how activated a person is to take manage their own health, an appropriate intervention can be determined

Interventions will range from signposting to Talk Community for the most activated patients, a social prescribing referral for patients requiring more support, to lifestyle behaviour change or IAPT referral

Promoting 'I am' approach with clinicians

Each level of intervention will be able to 'refer' into community resources, groups and activities; utilising their skills and capacity to provide long term interventions for patients

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

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In order to expand provision and support for self-care and informal community care, we want to utilise a community-centred approach to enhance individual and community capabilities, and support the many community health assets already in place to grow and flourish.

This will mean working closely with community organisations to co-create resources and services that can support people before they become mentally ill, on the principle that prevention is always better than cure. Such an approach, aligned to the principles of 'anchor organisations', will require joint-working across statutory and non-statutory services, NHS and local authority, and utilises a 'family' of approaches including:

- Strengthening communities
- Volunteer and peer roles
- Collaborations and partnerships
- Access to community resources
- ABCD approach for community development projects

Who we spoke to

Following the successful engagement sessions in October 2019, two follow up engagement sessions were coordinated on the 27th Feb 2020 and 5th March 2020 to further discuss the ICS mental health strategy.

The purpose of these sessions were to give attendees an opportunity to voice their opinions on the first draft on the Mental Health strategy and how to develop it further.

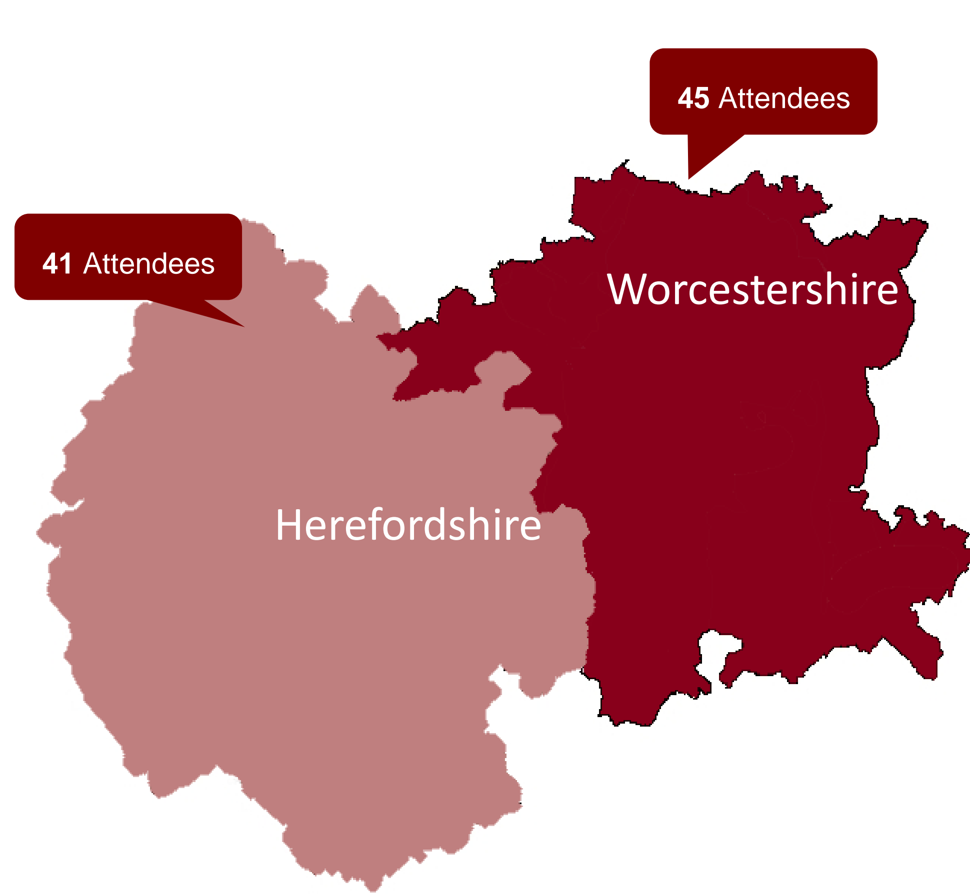
Attendees were asked to participate in the 2 following exercises:

Exercise 1 -
Focus on the 5 pillar themes and discuss:

- *What can be done in each area to move this forward*
- *What would enable these themes' success?*

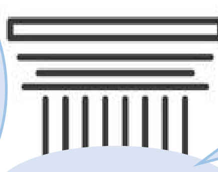
Exercise 2 -
Priorities and timeline plotting:

- *Choose top 3 priorities for each pillar*
- *Plot the priorities on a timeline, in order of what should be achieved in terms of urgency*



What you told us

Key themes identified for each area:



Better access for vulnerable groups and those with dual diagnoses

Specific services needed to enable accessibility e.g. Crisis Café Drop in Sessions

Accessible Services

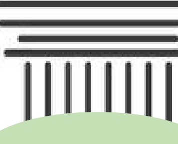
Important to have ability to self-refer, access services quicker and use a single point of access

Better access to shared information about service users

Important to value all services equally whether private or public

Integrated Services

Need to work together and possibility of colocation



Information needs to be accessible and clear. Consider usage of social media

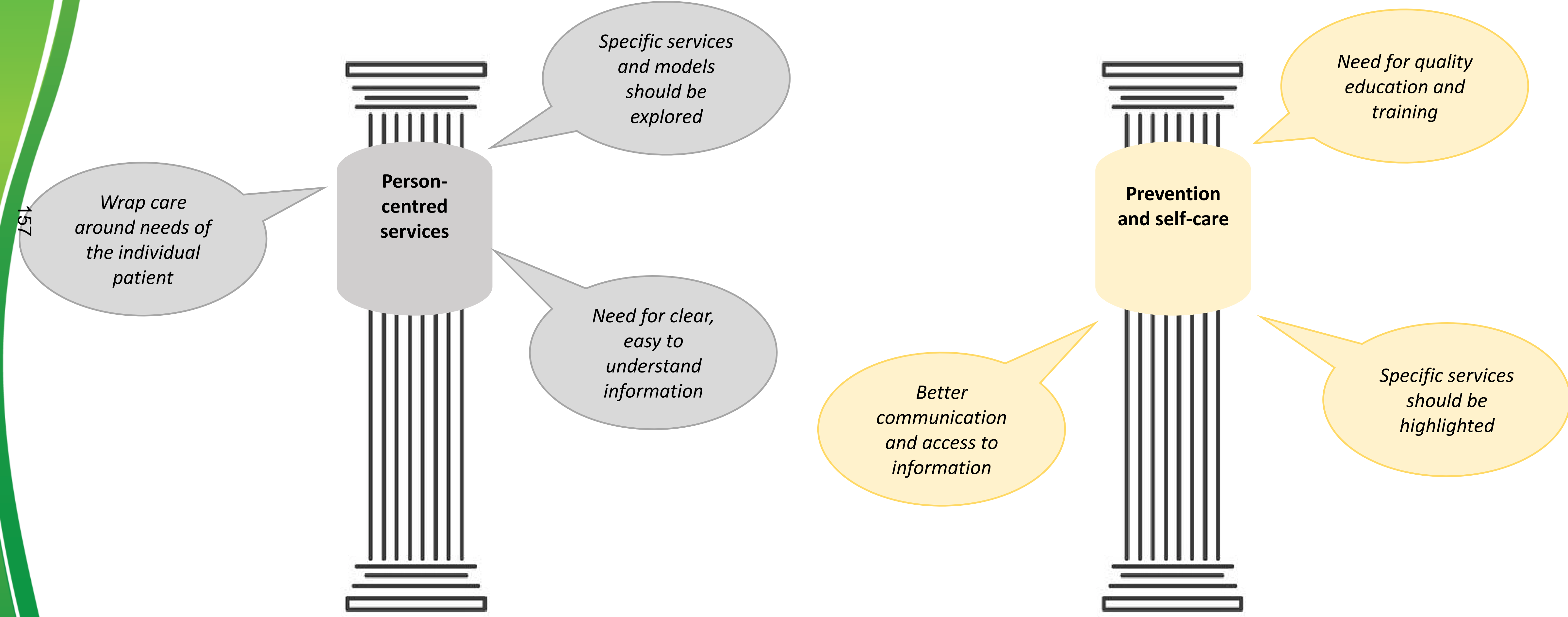
Consider specific services that may be helpful: Social prescribing Recovery College

Community Empowerment

Develop and maintain wellbeing, including staff

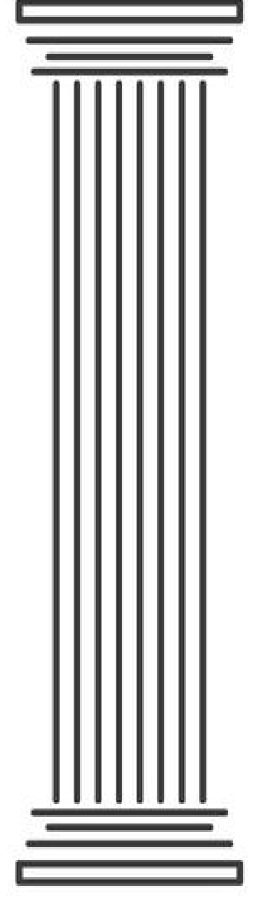
What you told us

Key themes identified for each area:

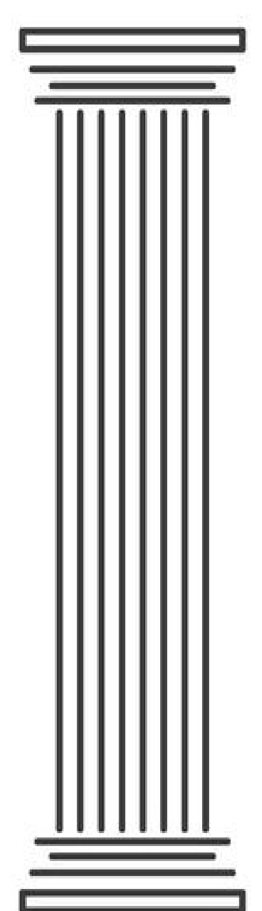


What you told us

Priorities identified:



Theme	Priorities
Accessible services	- Video consultations - Recovery college - Improved Information sharing - Increase of community based support i.e. drop-ins
Integrated services	- Co-locating services - Outcome framework - Shared discharge plans - Integrated dual diagnosis
Community empowerment	- Encouragement of joint working - Promotion of social prescribing - Outreach
Person-centred services	- Opportunity for face to face assessments - Create culture of greater compassion - Flexibility in interventions
Prevention and self-care	- Raise awareness of services to dispel stigma - Social media campaigns - Recovery and reablement approach



What you told us

Suggested timeline of priorities from co-production events:

ASAP

- Simple accessible patient communication
- Greater focus on wellbeing and resilience
- Broaden ways of working to develop support network
- Universal access to training opportunities
- Shift to focus on wellness not illness
- Multiagency care plan and equal partners
- Primary prevention
- Co-locating of services
- Accessible signposting

YEAR 1

- Integrated Commissioning
- Presence of mental health in community hubs
- Regular event forums promoted annually
- Shared plans on discharge
- Data sharing roadmap
- Capacity act
- Advocacy service
- Increase in social prescribing presence

YEAR 2

- Mobile wellbeing buses
- Interagency communication
- Integrated dual diagnosis
- Promote and improve awareness to social prescribing
- Encourage joint working
- Concept of operation recovery
- Break down barriers between primary and secondary care services

YEAR 3

- Primary prevention
- Greater focus on wellbeing and community development

Prevention, wellbeing and community development were themes throughout the prioritisation exercise, though may not have been put in the ASAP category as this was typically where specific issues with current provision were placed.

These suggestions will be taken forward through a variety of means, including existing transformation programmes, upcoming change projects such as the VCSE alliance approach work (see local plan for mental health and wellbeing below), and the Mental Health Inequalities Board.

The National Vision for Mental Health & Wellbeing

The NHS Long Term Plan has set out a range of ambitious deliverables for the five years from 2019-20 to 2023-24, including significant investment into CCG baselines of £21 million over the 5 years. This has been utilised to deliver transformation and increased access, with further developments outlined below. Where opportunities for shared funding with local authority partners are available these are also being actively pursued, increasing funding for mental health still further.

2021-22	2022-23	2023-24
24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions.	Improved therapeutic offer for inpatients to improve outcomes and experience, and deliver average length of stay of 32 days	Extended period of care, partner assessment and increased psychological therapies in place for perinatal patients
Establish Maternity Outreach Clinics / Maternal Mental Health Services (MMHS)	CYP MH plans aligned with those for learning disability, autism, SEND, children and young people's services, and health and justice	Support roll-out of national programme for health professionals working in ambulance control rooms
Establish 24/7 Mental Health Liaison across all acute hospitals	Comprehensive 0-25 support offer that reaches across mental health services for CYP and adults	24/7 crisis care to be in place for via NHS 111
24/7 crisis provision in place for children and young people		
Community Mental Health (CMH) Transformation Wave 2		
Early Intervention Service to achieve NCAP/CCQI Level 3 Standard		

The National Vision for Mental Health & Wellbeing

2021-22	2022-23	2023-24
Minimum of 733 women accessing community based perinatal mental health treatment	Minimum of 1,017 women accessing community based perinatal mental health treatment	Minimum of 1,301 women accessing community based perinatal mental health treatment
Minimum of 4,937 children and young people receiving treatment from an NHS-funded community mental health service	Minimum of 5,459 children and young people receiving treatment from an NHS-funded community mental health service	Minimum of 6,265 children and young people receiving treatment from an NHS-funded community mental health service
Minimum of 3,366 people with serious mental illness receiving physical health checks	Minimum of 3,856 people with serious mental illness receiving physical health checks	Minimum of 4,347 people with serious mental illness receiving physical health checks
Minimum of 19,089 people starting IAPT treatment	Minimum of 21,541 people starting IAPT treatment	Minimum of 23,658 people starting IAPT treatment
Minimum of 1,696 adults and older adults accessing integrated models of primary and community mental health care	Minimum of 3,464 adults and older adults accessing integrated models of primary and community mental health care	Minimum of 4,991 adults and older adults accessing integrated models of primary and community mental health care
Minimum of 429 adults accessing Individual Placement Support (IPS) services	Minimum of 592 adults accessing Individual Placement Support (IPS) services	Minimum of 742 adults accessing Individual Placement Support (IPS) services

Major programmes

Community mental health (CMH) transformation

In 2019 Herefordshire and Worcestershire was selected as one of 12 Early Implementer sites nationally to transform adult community mental health services in line with the new national framework. The transformation is taking place across approximately half the ICS, based on Primary Care Network footprints, with the new service set to expand to remaining PCNs in October 2021.

The vision for the new service model is to:

- Dissolve the barriers between primary and secondary care
- Be based on cross-sector collaboration, including increased VCSE resource
- Create and improve flexible, easy and clear means of access
- Maximise continuity of care
- Ensure there is no cliff-edge of lost care and support, moving away from current approaches based on referral and discharge
- Ensure timely access by testing 4-week waiting times from initial contact to appropriate care (and testing what appropriate care means)
- Adopt a principal of inclusivity as opposed to exclusions
- Increase access for people who currently fall through the gaps

PCNs trialling the new model for CMH

Herefordshire	Worcestershire
E Herefordshire	Wyre Forest HP
Hereford City	Wyre Forest NIP
Hereford Medical Group	The Rurals
N & W Herefordshire	Malvern Town
S&W Herefordshire	

In addition to the revised ‘core’ model above, further work is underway through the transformation to develop local Eating Disorders and Complex Needs services, to strengthen delivery in these areas.

Major programmes

Mental health support teams (MHST) in schools

In 2020 Herefordshire and Worcestershire successfully bid for national transformation funding to deliver mental health support teams in schools, a national initiative laid out in the NHS Long Term Plan. MHST in schools provide early intervention for mental health and emotional wellbeing issues, such as mild to moderate anxiety, as well as helping staff within a school or college setting to provide a 'whole school approach' to mental health and wellbeing. The teams act as a link with local children and young people's mental health services, supervised by NHS staff.

Four MHST have been established within the ICS, made up of senior clinicians and Education Mental Health Practitioners (EMHPs), and will:

- Work within the mental health supports that already exist, such as counselling, educational psychologisy, school nurses, pastoral care, educational welfare officers, VCSEs, local authority provision and NHS CYPMH services.
- Be responsible for a defined cluster or group of education settings, building a relationship with each, including the senior mental health lead.
- Work with each setting to scope out and co-design the support offer required.
- Work to ensure that the support offer reflects the needs of children and young people and education settings using clearly established expectations and ways of working that fit with the setting and the local system.

MHSTs will be expanded over the next 7 years to cover 100% of schools across the country. Two more MHSTs are due to commence in Herefordshire and Worcestershire by 2023-24, with the remainder to be implemented between 2024 and 2029.

Wyre Forest MHST
Primary and High Schools

Rural Worcestershire MHST
High Schools

Redditch MHST
Middle and High Schools, Special School and PRU

Herefordshire MHST
High Schools, Special Schools and PRUs

National Enablers

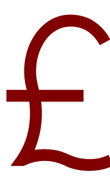
There are several projects underway or to be undertaken nationally that will act as key enablers to service change and improvement. These form part of the NHS Long Term Plan, and include:

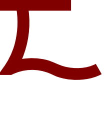
Data Quality
Under the NHS Long Term Plan, providers are required to be compliant with national data quality requirements including MHSDS, DQMI, SNOMED CT and patient-level costing. Having robust, high quality data aids decision-making and ultimately, better services.

Provider Collaboratives
The NHS Long Term Plan requires mental health providers to form collaboratives to take on budget and pathway management for specialist services. These include adult low and medium secure services, CYP inpatient services, and adult eating disorder specialised services, but are expected to expand to additional areas. These are distinct from the local Mental Health Collaborative within the Herefordshire and Worcestershire ICS, often covering a wider geography for more specialist services.

Digitisation
Another NHS Long Term Plan priority is the development of a wider range of self-management apps, consultations, digitally-enabled models of therapy, and digital clinical decision-making. With a Global Digital Exemplar as mental health provider within Herefordshire and Worcestershire, and an award-winning app for children and young people (BESTIE), we have a strong foundation to build on to further enhance our digital offer for people experiencing mental health difficulties.

Mental Health Investment Standard (MHIS)
The Mental Health Investment Standard, previously known as Parity of Esteem, is the requirement for NHS Clinical Commissioning Groups to increase investment in mental health services in line with their overall increase in allocation each year. Under the NHS Long Term Plan, all CCGs are required to achieve the MHIS for at least the next 5 years covered by this strategy.





Local Enablers

In addition to national projects, a variety of local programmes are already in place or being planned that can support the aims of mental health services across the ICS, and with which this strategy will seek to dovetail:

Integrated Wellbeing Offer

The Worcestershire IWO aims to bring together the many assets and services that offer “lower level” support for wellbeing and health to form a comprehensive, holistic pathway through services, where people can access and move between the services and support they need.

Having good health and wellbeing depends on a wide range of factors. We need to address all these factors that protect and create health and wellbeing, including those at community level, to achieve positive health outcomes for Worcestershire.

Building on the response to Covid19, we want to grow an integrated and enhanced health and well-being offer that promotes early intervention and prevention to best meet peoples’ needs, improve health and wellbeing, and reduce inequalities.

Now we’re talking is a mental health campaign, launched in 2018, to encourage communities to talk about and seek support when experiencing mental health difficulties.

The campaign aims to raise awareness of mental health issues, fight stigma, and support people to open up and talk about mental health while promoting self-care.

While originally focused on the Healthy Minds (IAPT) service, it has recently expanded to focus on parents’ mental health and children's mental health. Our ambition is to build on the strong foundations in place by continuing to expand this campaign, as a means to broaden awareness around mental health and self-care, to support the drive toward self-care, prevention and early intervention.

Talk Community

Talk Community is a system wide partnership approach focused on managing demand by linking three fundamental elements that promote and maximise independence and wellbeing within Herefordshire’s communities.

Talk Community therefore focuses on the strengths of people and communities; the place and space which those communities occupy; and the economy in which those communities work.

At the heart of Talk Community is a culture and ambition to make independence and wellbeing for Herefordshire citizens inevitable.

The Talk Community approach, and the philosophy it engenders, can be a major vehicle to support the expansion of mental health and wellbeing support, raise awareness, and support the empowerment of local communities to maximise prevention, self-care and independence.

The Plan for Mental Health & Wellbeing

2021-22	2022-23	2023-24
Worcestershire multiagency pathway and collaborative commissioning arrangements for assessment and diagnosis of children with Autism Spectrum Condition to be implemented in Herefordshire.	Review of existing and potential complimentary crisis care alternatives across the ICS, including for CYP.	Establish additional crisis alternative provision, based on local need and co-production approach.
Review and redevelopment of mental health VCSE provision across Herefordshire and Worcestershire.		→ Move to alliance-based model of provision for mental health services across the ICS.
Review care pathways for Looked After Children, children and young people subject to a child protection plan, and children with ADHD.	Establish system-wide approach to career development, support and training for Peer Support workforce.	Closer joint working regionally with police and criminal justice, including Liaison and Diversion and Crisis Alternatives, to ensure people reach the right services as early as possible while reducing the burden on police and other blue light services.
Commission Qwell online mental health support and advice portal across ICS, and Mental Wellbeing service in most deprived schools in Worcestershire (where MHST not in place)	Length of hospital stay and delayed transfers of care to be reduced for children and young people.	
Consistent service models to be established across Herefordshire and Worcestershire, following move to a single NHS provider.		
Establish ICS Mental Health Inequalities Board to address health inequalities across system, including those exacerbated by COVID	CAMHS waiting times to be reduced utilising Quality Improvement methodology and best practice across two counties and nationally.	
Needs assessments to be undertaken focusing on: • Mental Health • Employability among vulnerable groups • Sexual abuse and trauma	New Drugs and alcohol strategy to be developed for Worcestershire in line with Dame Carol Black review recommendations, including increased training and integration with mental health services.	
Patient Shared Care Record to be developed to provide up to date information for patients and clinicians across organisations	Develop a model of care that will provide rehabilitation, or reduce the need for admissions, for young people who require more intensive support.	
Service redesign for public health nursing, health visiting and school nursing to improve integration of services and strengthen the mental health offer for young families, pregnant women and school age children.		

Local Vision

We will work with local people and communities so that everyone can be mentally well, or access services quickly when they need them, and that those services will work together in an integrated fashion to provide the best possible care.

What good looks like

We will:

- **Provide more mental health services to more people, as per the NHS Long Term Plan**
- **Decrease waiting time for assessment of Autistic Spectrum Condition in children**
- **Offer more opportunities for work, and career development, for Peer Support Workers**
- **Increase mental health support to young families, pregnant women and school age children**
- **Decrease waiting time for children to access mental health support in CAMHS**
- **Reduce how long children and young people stay as inpatients in acute wards**
- **Increase equality of access, outcomes and experience for all of our population**
- **Provide alternative services to people experiencing crisis**

COVID response for Mental Health & Wellbeing

Almost all mental health services in Herefordshire and Worcestershire were maintained throughout the pandemic, with only limited redeployments to support key services such as the 24/7 crisis line. As the impact of the pandemic on peoples' mental health became clear, recovery and restoration planning focused on expanding capacity of services wherever possible. As many of the mental health priorities within the NHS Long Term Plan are focused on expanding provision, many of these ambitions have subsequently been brought forward from 2022-23 to 2021-22 to support with increased demand.

Phase 1: Response

- 24/7 mental health crisis line established
- Systems put in place to segregate COVID positive inpatients. Closure of one older adult mental health ward and set up of hospital at home provision
- Proactive contact and support approach adopted to ensure patients on caseload were supported through first national lockdown
- Single Points of Access established for each county for help and support

Phase 2: Recovery

- Preparation for longer term increase in demand for mental health services, including actively recruiting in line with NHS Long Term Plan
- Establishment of enhanced psychological support for health and social care staff, including process to ensure BAME staff were considered and protected
- Ensuring 24/7 mental health crisis line is made permanent and sustainable
- Review of interagency suicide prevention plans for each county

Phase 3: Restoration

- Re-establishment of transformation programmes including crisis alternative services, mental health support teams in schools, 24/7 psychiatric liaison and phase 2 of the community mental health transformation.
- Early implementation of NHS Long Term Plan ambitions including CYP crisis resolution and home treatment services and increasing access to psychological therapies.
- Recovery trajectories in place for services impacted by COVID (e.g. physical health checks for people with severe mental illness

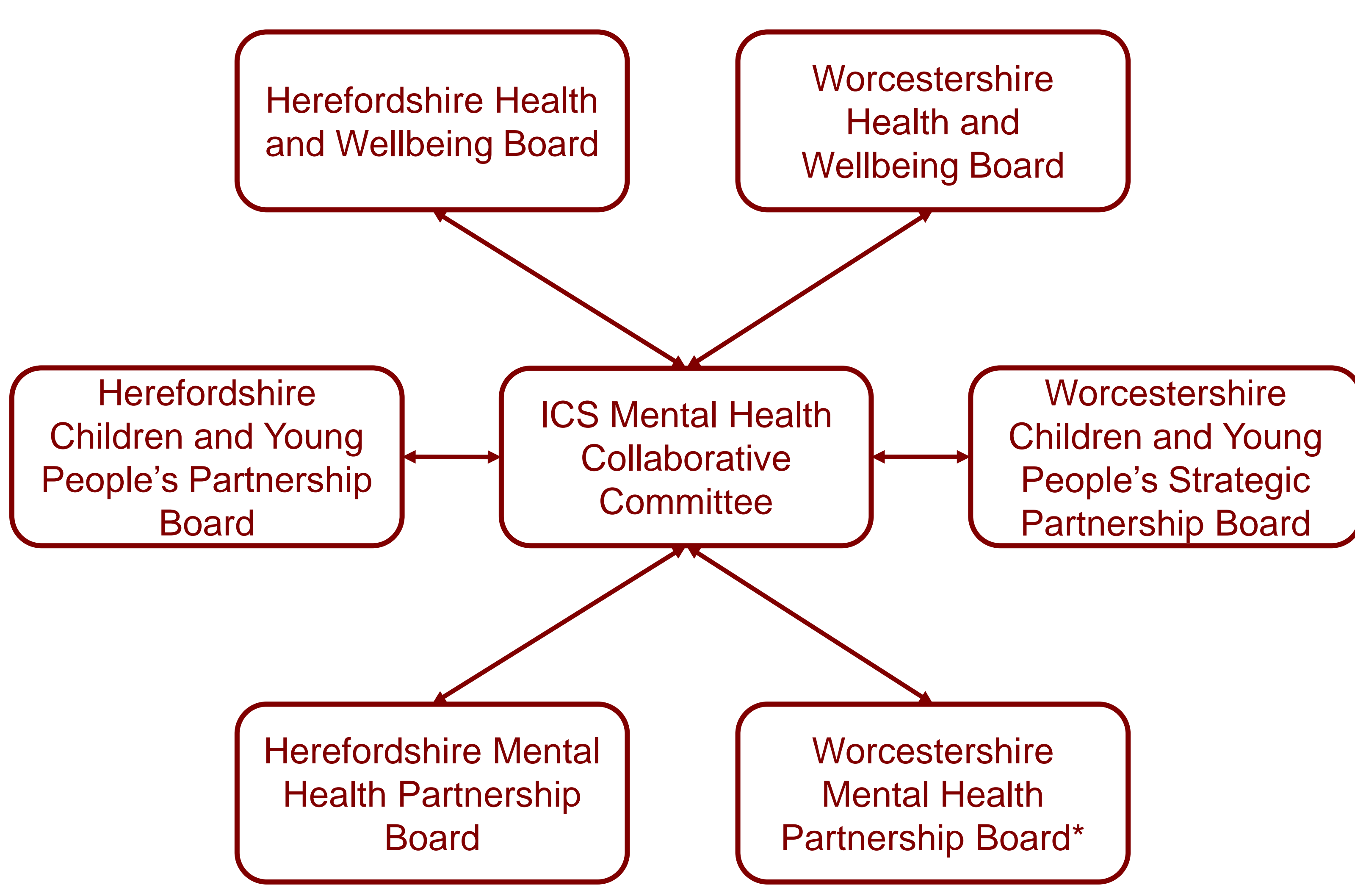
Delivery and accountability

From October 2021 the ICS Mental Health Programme Board will take on the broader remit of the ICS Mental Health Collaborative Committee. This committee will oversee delivery of the strategic aims within this strategy. The Mental Health Collaborative Committee will work closely with the Health and Wellbeing Boards in both counties, to ensure strong links between mental health and broader wellbeing services are maintained and built upon.

In Herefordshire there is an established Mental Health Partnership Board, comprising broad system partners and Experts by Experience, which will continue to be utilised to drive collaboration on key workstreams. In Worcestershire a similar county-level Mental Health Partnership Board will be established to fulfil the same role, ensuring a local voice for partners and Experts by Experience.*

In addition, the Mental health Collaborative Committee will also work closely with the Children and Young People's Partnership Boards in both counties to ensure collaboration at Executive, Strategic and operational levels.

This structure reflects the need for consistency of service offer and outcomes at an ICS level, but to be delivered at a more local level whether county, district or PCN, under the principle of proportionate universalism.



Delivery and accountability

Herefordshire and Worcestershire ICS Mental Health Collaborative Executive

The Mental Health Collaborative Executive will be a multi-organisational forum for the consideration of all matters regarding the transformation, commissioning and contracting of in scope mental health services are duly considered. The Executive will ensure that the requirements of an effective provider collaborative are complied with and the outcomes are delivered, and will act as a sub-group to the Herefordshire and Worcestershire Health and Care Trust Mental Health Collaborative Committee, a sub-committee of the Trust board.

Management and proposal development will be the core responsibilities of the Mental Health Collaborative Executive, addressing service transformation and performance, quality performance and improvement, financial control and risk management.

The Mental Health Collaborative Executive will have powers of decision making and to make recommendations to the Collaborative Committee. The views of partners will form an essential element of this within an open and transparent culture.

The Executive will sponsor and operate to the principles that underpin the Provider Collaborative model:

- Collaboration between Providers and across local systems, aligning priorities across the Partnership, and respecting sovereignty and risk and gain share
- Experts by Experience and clinicians leading improvements in care pathways
- People and patients come first – delivering parity of esteem and outcomes
- Managing resources and ensuring value for money across the collaborative to invest in community alternatives and reduce inappropriate admissions/care away from home
- Delivering a clinically and financially sustainable health and care system
- Working with local stakeholders
- Improvements in quality, patient experience and outcomes driving change
- Built upon innovation, international evidence, and proven best practice.
- Advancing equality for the local population

Membership

The ICS Mental Health Collaborative Executive will comprise membership from the following organisations:

- Herefordshire and Worcestershire Health and Care NHS Trust
- Herefordshire and Worcestershire Integrated Care Board (functions currently held by Herefordshire and Worcestershire Clinical Commissioning Group)
- Worcestershire County Council
- Herefordshire County Council
- Primary Care Network representation
- Place-based clinical leadership
- Service User representation
- Carer representation
- Housing
- West Mercia Police
- West Midlands Ambulance Service
- VCSE representation

Herefordshire & Worcestershire CCGs

STP Mental Health Strategy

Engagement Evaluation Report

November 2019

On behalf of:
NHS Herefordshire CCG, NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG

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Executive Summary

Between 1 October 2019 until 12 November 2019 the Engagement Manager on behalf of the Herefordshire and Worcestershire Sustainability Transformation Partnership (STP), ran a survey and a series listening events to engage with the Herefordshire and Worcestershire populations, with the purpose of gaining their views on a new STP Mental Health Strategy.

192 people responded to the survey and 47 people attended a Listening Event. Respondents were asked to comment on the following three questions:

1. What do you think works well for people with a mental health condition in the area where you live?
2. What doesn't work well?
3. What do you think the mental health strategy should focus on?

The top three themes raised through the survey were:

Works well

- Praise for a specific / individual mental health service
- Ability to access the service
- The role or support of staff

Doesn't work well

- Access
- Shortages – staff and services
- Poor communication

Focus of the mental health strategy

- Improved access
- Early intervention
- Children and young people

Survey Demographics

The demographics of the survey respondents was varied. The majority (76%) of respondents who completed the survey were from Worcestershire. This figure correlates with the demographic spread of residents in each county. The youngest respondent was aged between 16 – 25 and the oldest was aged 85 and over. Of those who participated, 32.6% reported to be limited in their day to day activities due to health problems or disability. Over a third of respondents (34.4%) said that they had a disability. Respondents were mainly female (68.9%). There were no respondents who reported to be pregnant or were an expected parent. Only one (0.53%) person reported to be post-natal, having given birth in the last 26 weeks. The majority (80.2%) of those who completed the survey reported to be heterosexual. Most respondents stated that they not served in the armed forced, compared to 4.81% who stated that they had. 38.5% of people considered themselves to be a carer.

Listening Events

47 people (19 patients / carers and 28 staff / partners) attended one of four listening events. Sessions were held in Hereford and Worcester city centres between 23rd – 25th October 2019. Attendees were asked the same three questions, as those in the survey. Key themes raised in each session varied. Access, children and young people and thresholds were common themes.

Engagement Overview

Between 1 October 2019 until 12 November 2019 the Engagement Manager on behalf of the Herefordshire and Worcestershire Sustainability Transformation Partnership (STP), ran a survey and a series listening events to engage with the Herefordshire and Worcestershire populations, with the purpose of gaining their views on a new STP Mental Health Strategy. The purpose of this engagement report is to present the key findings from this engagement exercise.

Background

Mental health services have become a high-profile topic in recent years, with increased investment welcomed, but with it increased scrutiny. While there are national NHS strategies for the delivery of improved mental health services (we are currently in both the penultimate year of the Five Year Forward View for Mental Health and the first year of the newly published NHS Mental Health Implementation Plan 2019/20 – 2023/24), there is no current local Mental Health Strategy in place in either Worcestershire or Herefordshire.

It is therefore proposed to develop a local Herefordshire and Worcestershire STP Mental Health Strategy, to engage patients and stakeholders and provide a roadmap for how local service will be developed and improve over the next five years. This will lay out the plan for delivery of national strategy, while ensuring that local needs and variation within the two counties are considered in the delivery of these ambitions.

Context

Across Herefordshire and Worcestershire all local health and care organisations are committed to providing the best mental health care possible. We want mental health and wellbeing to be high on our local agenda, to ensure members of our communities are aware of mental health and to recognise issues in individuals, and to be able to support or signpost appropriately. When things get harder or more serious, we want our specialist services to be equipped to provide support as early as possible, with a focus and commitment to recovery.

Organisations across our two counties are working together in partnership to provide services which are safe, effective and sustainable. We think it is important for people to be able to get help and support as early as possible and to live healthy and independently for as long as they can. When more support is needed, we want people to be able to access services quickly, in the right place at the right time.

The Clinical Commissioning Groups (CCGs) in Herefordshire and Worcestershire are working on behalf of the Herefordshire and Worcestershire Sustainability Transformation Partnership (STP) to set out a Herefordshire and Worcestershire Mental Health Strategy. We are interested to speak with local people, staff and partners to better understand their views on mental health, so that we can ensure the new strategy meets the needs of local people. We are hoping to gain a greater understanding of what people think works well and where we need to make improvements.

The views received will build upon previous engagement work that has been carried out but will provide us with an opportunity to work with patients, stakeholders and the wider community to understand what more we need to consider. This is an opportunity to work together to shape our mental health strategy over the next few years, to ensure mental health awareness is embedded across our communities, and to develop new and existing services so that people can get the help they need to support them in their recovery. We plan to undertake more specific engagement exercises soon, allowing us to work together to coproduce solutions.

Survey Exercise Summary

Active Period	1 October – 12 November 2019
Reach	Appendix 1
Extended Reach	Those contacted were asked to share the survey link with their respective networks/contacts. The CCG disseminated the survey via social media and on their organisational websites. Hard copies were also available, for anyone requesting them.
No. of Respondents	192
Results Key	**Qualitative Questions** • Key themes have been established and listed. • Example verbatim comments are listed within the text. **Quantitative Questions** • The most prevalent answer has been highlighted in blue. The survey questions can be found in Appendix 2.
Interpretation of Results	The results have been reviewed and analysed by the Engagement Manager. It is acknowledged that this method is subjective and open to interpretation. The CCG Delivery Programme Manager has been supplied with all the result data and verbatim comments.

Survey Results

Question 1 – What do you think works well for people with a mental health condition in the area where you live? [this could be a service, a team, how to access information or help, or anything else that you think works well]

There were 181 responses to Question 1. The comments were varied and centred around nine key themes. The themes are listed below and are ranked in order of most mentioned within the comments (1 = most mentioned and 9 = least mentioned):

1. Praise for a specific / individual mental health service
2. Ability to access the service
3. The role or support of staff
4. Advice and support from the GP practice or Primary Care
5. Information given to the patient
6. Good communication practice
7. Support from the voluntary and community sector
8. Low level mental health services
9. Receiving the right support / care

The top three themes have been explored further below:

Key Theme 1 - Praise for a specific / individual mental health service

There were various individual services that respondents thought worked well for people with a mental health condition. These included services such as:

- Lets Talk
- Healthy Minds
- Primary Care
- Mental Health Liaison
- Complex Needs
- Wellbeing Hub
- Oughton Project
- Cart Shed
- Primary Mental Health Service (PMHS),
- 'CAHT'
- GP
- Individual Placement and Support
- Employment Retention
- Child and Adolescent Mental Health Services (CAMHS)
- The Fold Care Farm
- Perinatal Mental Health Team
- Peer Support Groups
- Talking Groups
- Outdoor Therapy
- Day Care Stonebow Unit
- Crisis Intervention
- Community Wellbeing Café
- Local Authority Approved Mental Health Professionals (AMHP)
- Local Authority Deprivation of Liberty Safeguards (DoLs)
- Garage Art Group
- CBT Intervention
- Psychology Service
- Reach 4 Wellbeing
- Redditch Adult Mental Health Team
- Dementia Early Intervention Team.

`Examples of verbatim feedback received:

"The Cart Shed offers an effective service in Herefordshire, in the community. The team not only support individuals with their mental health but also all aspects/issues that may impact on it like housing, and benefits."

"I think the wellbeing hub is a great place for information and help."

"Our experience of CAHMS is of a caring and helpful service if only it wasn't so stretched."

"The Healthy Minds service works well if people know about it but even then the funding it gets given mean services it offers are limited."

Key Theme 2 - Ability to access the service

Numerous respondents thought that access to a service was good. Comments included praise for the following:

- Self-referral option
- Online and telephone support available
- Access to services via the Wellbeing Hub
- Quick response to referral
- Support available in the community
- 24/7 availability of the Crisis Team
- Prompt access to medication, when needed
- Quick access to information

Examples of verbatim feedback received:

"A quick response and a clear written assessment with recommendations."

"Access to healthy minds online."

"Quick access to gp services. Prompt action by the mental health team."

"I am currently utilising the Lets Talk service and the ability to self refer was hugely beneficial and the sessions so far have been really good in terms of my needs."

Key Theme 3 - The role or support of staff

The care and support received from staff, featured high in the comments of what people thought works well. Respondents praised various individual staff members and teams.

Examples of verbatim feedback received:

> ***"Support from the Recovery team works well."***
>
> *"The crisis team are amazing at the stonebow unit. They're really helpful and actually listen to you."*
>
> ***"The memory nurse service attached to Weobley Surgery."***
>
> *"The psychologist staff who provide the online Healthy Minds Service, seem patient and empathetic."*

Question 2 – What doesn't work well? [this could be a gap / lack of service, a team, how to access information or help, or anything else that you think that needs improvement]

There were 189 responses to Question 2. Comments centred around eight key themes. The themes are listed below and are ranked in order of most mentioned (1 = most mentioned and 8 = least mentioned):

1. Access
2. Shortages – staff and services
3. Poor communication
4. Poor information
5. Specific service dissatisfaction
6. Patients 'falling between the gaps'
7. Duel diagnosis
8. Joined up care

The top three themes have been explored further below:

Key Theme 1 - Access

Many comments highlighted 'access' as being the area of highest concern. Nearly half of the comments received for Question 2 gave feedback about access. Waiting times and access for children and young people all gained the highest criticism.

Examples of verbatim feedback received:

Waiting times

"Difficult to access support in a quick and easy way, via GP takes for ever. Lack of available support. People who are struggling find it difficult to navigate process and procedure."

> *"The time it takes to get help after initial contact. Having to wait eight weeks to see a G.P. to get initial signposting."*

"Huge wait for psychological therapies and impossible to get patients seen by a psychiatrist."

Children and young people

> *"Long waiting times for young people 16-18 often falling between services due to their age and referrals into CAMHS /AMHS"*

"Thresholds for CAMHS intervention are ridiculously high, meaning children in great distress are turned away."

> *"Long waits for assessment especially with children."*

Key Theme 2 - Shortages – staff and services

Respondents reported various aspects of service where they felt there was a shortage of either staff or services. The following shortages were highlighted by respondents:

Staff

- Psychiatrists
- Psychologists
- Nurses
- Mental Health Liaison in A&E
- Mental health staff across the health system
- Secondary care service staff
- Consultants

Service

- Children and young people's services
- Voluntary and community sector
- Drop-in service
- Bed availability
- CAMHS out of hours
- Service for those with a personality disorder
- Complex childhood abuse service
- Service for those with a risk of sexual offending
- Early intervention service
- Services for those with a 'medium' mental health need (those who do not been low level support or crisis level care)
- Out of hours
- Outreach
- Recovery services
- Personality disorder support
- Services for those with a multiple diagnosis
- Services for those with multiple health needs

Examples of feedback:

"Lack of Mental Health Liaison in A&E departments overnight. Long waiting list for psychology. Long waiting list for CARS and Psychiatrist appointments Lack of bed availability when inpatient stay required Lack of CAMHS out of hours Lack of OAMH out of hours

"Staff retention within the Mental Health teams is a challenge."

"Insufficient bed space. Insufficient out of hours provision. No real outreach work."

"Secondary care services, understaffed and lots of staff turnover in community roles resulting in lack of continuity of care."

Key Theme 3 - Poor communication

Some respondents gave examples of how they felt communication had been poor. Access and lack of information came across as the key areas of concern.

Examples of feedback:

"Access to information. No signposting. being passed from one organisation to another."

"Poor access to information. Lack of information on self help and dealing with the cause."

"I suffer from a lack of information on what is available."

"Lack of information. Could do with a weekly drop in for people with mental health issues."

Question 3 – What do you think the Mental Health Strategy should focus on?

There were 189 responses to Question 3. Respondents wanted the new strategy to focus on multiple areas. These are listed below.

Key Themes	
Access to talking therapies	Outreach
Appropriate services	Patient centred care
Assessible services	Patient empowerment
Back to basics caring	Peer support
Better reporting and monitoring of services	Prevention
Building resilience - staff	Primary Care
Building resilience - patients	Provide long term support
CAMHS service	Quicker diagnosis
Children and young people	Relapse - support and care for patients
Clear and understandable service pathways	Rapid response teams
Communication	Reducing stigma
Complex needs	Reducing gaps in care
Continuity of care	Reducing loneliness and isolation
Crisis - prevention	Reducing the reliance of the police service
Crisis - care	Retention and recruitment of staff
Dementia services	Secondary care
Early intervention	Seldom heard
Information for patients and carers	Self-care
Education	Self help
Employee health	Service development
Employment services	Service mapping in the community
Face to face appointments	Services for all ages
Faster waiting times	Services for people before crisis point
Following care plans	Services for people with autism
Funding opportunities	Services for those with multiple and / or complex needs
Getting the 'basics' right	Services in the community
Quality care	Severe mental health
Holistic care for the patient	Signposting
Homeless	Single point of assessment
Housing	Social prescribing
Improving Access to Psychological Therapies (IAPT)	Staff shortages
Assessment process - for patient	Staff wellbeing
Improved access to services	Staying well
Increase inpatient beds	Substance abuse
Increase number of staff	Suicide
Increase services in Herefordshire	Support for families
Increase treatment options	Support for GPs and Primary Care staff
Information - for patients and carers	Support for people returning to work

Joined up working	Support in the community
Listening to patients	Supporting and developing mental health practitioners
Local support	Supporting and developing staff
Medium level mental health support	Supporting people back into employment
Mental health promotion	Training for patients and carers
Multiple diagnosis	Transitions
Multiple health needs	Triage
Older people	Veterans
Ongoing support	Wellbeing
Out of hours	Wider range of therapies offered
Outdoor therapies	

Top five themes

The top five themes that received the most comments were:

1. Improved access
2. Early intervention
3. Children and young people
4. Prevention
5. Patient centred care

Examples of feedback:

Improved Access

"Easy quick access to the right support and enough of it."

"Easier and quicker access to services."

"Improving access to community-based mental health services and support, counselling, psychotherapy."

"Access in a reasonable timeframe to all services."

Early intervention

"Early intervention and enough staff to relieve police/a&e and others from responsibility except for reporting"

"Early intervention for any mental condition."

"Early Intervention in Primary and Secondary Schools."

"Early services. Catching people before they get too poorly. Early intervention as the public see it - take pre-emptive action."

Children and young people

"Improving long term care & targeting young children at an early age."

"Making support available, particularly for young people, much more quickly."

"The strategy should focus on mental health support for CYP in schools, colleges, universities. There needs to be support for parents and coping mechanisms so that the child can stay within the family unit."

"Younger children and support to parents."

Prevention

"Prevention to stop mental health moving into crisis."

"Prevention, education, self-help."

"Staying well, prevention."

"Prevention. Maintain good mental health alongside exercise healthy eating etc for all ages."

Patient Centred Care

"Treating clients as individual human beings."

"Helping the individual & getting them settled."

"Individual needs. A good initial assessment and what the patient thinks they think would help and the opportunity to experience 1:1, support group, someone on the end of a phone, online community support etc.to see what they feels helps."

"Using the time they have to focus on a plan of recovery specifically for patients on a one to one basis, rather than the textbook regime."

Survey – Demographics

The demographic details of the 192 survey respondents were very varied. A summary of the respondents' demographics can be found in Appendix 3.

Listening Events Exercise Summary

Active Period	Wednesday 23 October 2019 – Warndon Hub, Worcester Thursday 24 October 2019 – Perdiswell Young People's Leisure Club Friday 25 October 2019 AM – Hereford Town Hall Friday 25 October 2019 PM – Hereford Town Hall
Reach	Appendix 1
Extended Reach	Those contacted were asked to share the survey link with their respective networks/contacts. The CCG disseminated details about the Listening Events via social media and on their organisational websites. The Delivery Programme Manager disseminated details to their staff and partner organization networks.
No. of attendees	47 (19 patients / carers and 28 staff / partners)
Interpretation of Results	The results have been reviewed and analysed by the Engagement Manager. It is acknowledged that this method is subjective and open to interpretation. The Delivery Programmed manager has been supplied with all the raw result data and verbatim comments.

Listening Event Feedback

The key themes from each listening session are listed below.

Key themes – Session 23/10/2019 Worcester – Staff and Partners

- Access – waiting times, thresholds
- Partners working together
- Voluntary sector – supporting them to be part of the system (e.g. longer contracts)
- Navigating the system / directory of service
- Person focused service (not just prescriptions and limited support)
- Added difficulty to get support if the person has a substance misuse issues, multiple diagnosis or is vulnerable (e.g. homeless)

Key themes – Session 24/10/2019 Worcester – Patients and Carers

- Access
- Carers support and training
- Services for children and young people
- Transitions

Key themes – Session 25/10/2019 AM Hereford – Staff and Partners

- Link between mental and physical health
- Different commissioning relationships with providers and partners
- VCS links and access and funding
- Thresholds for services and different levels of support (e.g. transitions and crisis)
- Rurality and farming communities

Key themes – Session 25/10/2019 PM Hereford – Patients and Public

- Access – thresholds and criteria
- Knowing about and finding the right service
- Transitions
- People focused Holistic approach (mental, physical health, addition, accommodation etc)
- Drop in support
- Resilience as part of prevention

Recommendations

The Engagement Manager has made the following engagement recommendations:

1. **Continued Engagement** – Ensure that patients, carers, staff and partners have the opportunity to continually engage on the new STP Mental Health Strategy. Allow for regular sense checking, feedback and the opportunity to give their views.
2. **Co-production** – Ensure that patients, carers, staff and partners are able to co-produce ideas and solutions. Further co-production sessions should be held to enable people to be involved.
3. **Take note and engage deeper on the topics that have arisen** – Many of the themes that have arisen from the feedback are repeated throughout the survey. The Engagement Manager urges the project leads to take these themes into account when establishing the new strategy and recommends that further engagement work is done in order to obtain a greater understanding of the patient / public view and how these can shape a new service

Appendix

Appendix 1 – Survey Distribution List

Person or Group	Information Sent
Worcestershire Involvement Network	Survey Link and Information
Patient Advisory Group (PAG)	Survey Link and Information
Worcestershire Patient Participation Group (PPG) Lead Contacts	Survey Link and Information
Healthwatch Worcestershire	Survey Link and Information
Websites (Redditch and Bromsgrove CCG, Wyre Forest CCG, South Worcestershire CCG)	Survey Link and Information
Twitter (Redditch and Bromsgrove CCG, Wyre Forest CCG, South Worcestershire CCG)	Survey Link and Information
STP Comms and Engagement Group members	Survey Link and Information
One Hereford Network	Survey Link and Information
Herefordshire CCG patient and public newsletter	Survey Link and Information
Herefordshire CCG staff	Survey Link and Information
Worcestershire CCGs staff	Survey Link and Information
Public Health, Worcestershire	Survey Link and Information
Public Health, Herefordshire	Survey Link and Information
Wye Valley Trust	Survey Link and Information
Healthwatch Herefordshire	Survey Link and Information
Worcestershire Health and Care Trust	Survey Link and Information
2gether Trust	Survey Link and Information

Please note – this this is not exhaustive. In addition, those that have been contacted were encouraged to share the survey with their own groups and networks.

Appendix 2 – Survey Questions

1. What do you think works well for people with a mental health condition in the area where you live?
2. What doesn't work well?
3. What do you think the mental health strategy should focus on?

Appendix 3 – Demographics

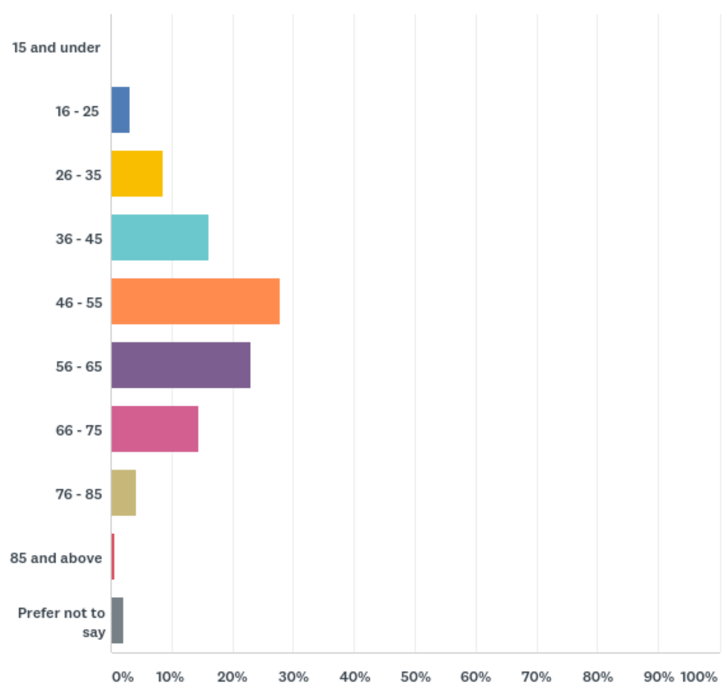
First part postcode

Answers	Count	Percentage %
HR1	18	9.73 %
WR11	11	5.95 %
HR4	11	5.95 %
WR1	10	5.41 %
HR2	10	5.41 %
WR5	9	4.86 %
DY10	9	4.86 %
WR3	9	4.86 %
DY11	9	4.86 %
B97	8	4.32 %
WR14	7	3.78 %
WR9	7	3.78 %
B61	6	3.24 %
HR6	5	2.70 %
WR4	5	2.70 %
WR2	5	2.70 %
B98	5	2.70 %
B60	4	2.16 %
DY12	4	2.16 %
DY9	4	2.16 %
DY13	3	1.62 %
HR9	3	1.62 %
	Answered question	185
	Skipped question (of those who were eligible to answer)	7

The majority (76%) of respondents who completed the survey were from Worcestershire. This figure correlates with the demographics of patient numbers in each county (overleaf).

Patients per CCG area	Count	Percentage %
Herefordshire CCG population	189,300	24.01 %
Redditch and Bromsgrove CCG population	170,000	21.57 %
South Worcestershire CCG population	313,000	39.71 %
Wyre Forest CCG population	116,000	14.72 %
	Total	779,300

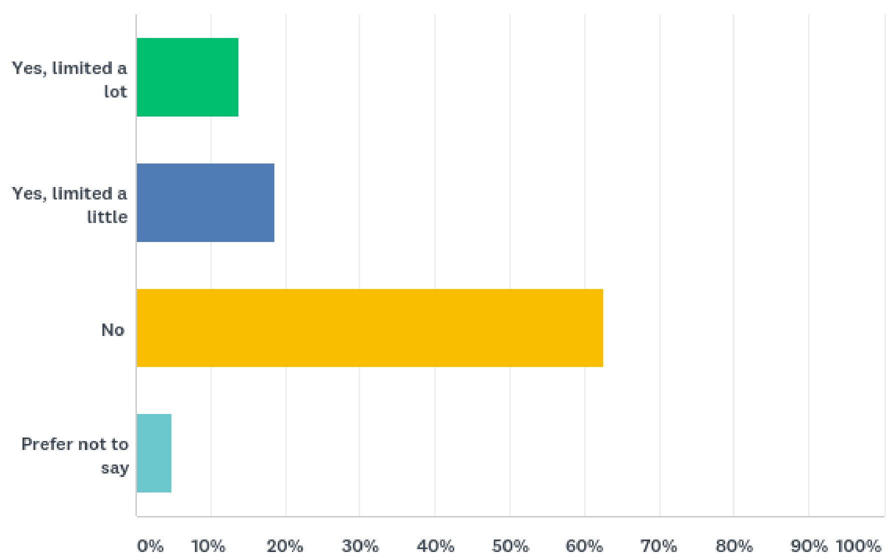
Age



Age Group	Count	Percentage %
15 and under	0	0.00%
16 - 25	6	3.21%
26 - 35	16	8.56%
36 - 45	30	16.04%
46 - 55	52	27.81%
56 - 65	43	22.99%
66 - 75	27	14.44%
76 - 85	8	4.28%
85 and above	1	0.53%
Prefer not to say	4	2.14%
	Total	*187*
	Skipped	*5*

The highest age group of respondents (52, 27.81%) were those aged between 46 – 55.

Day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months

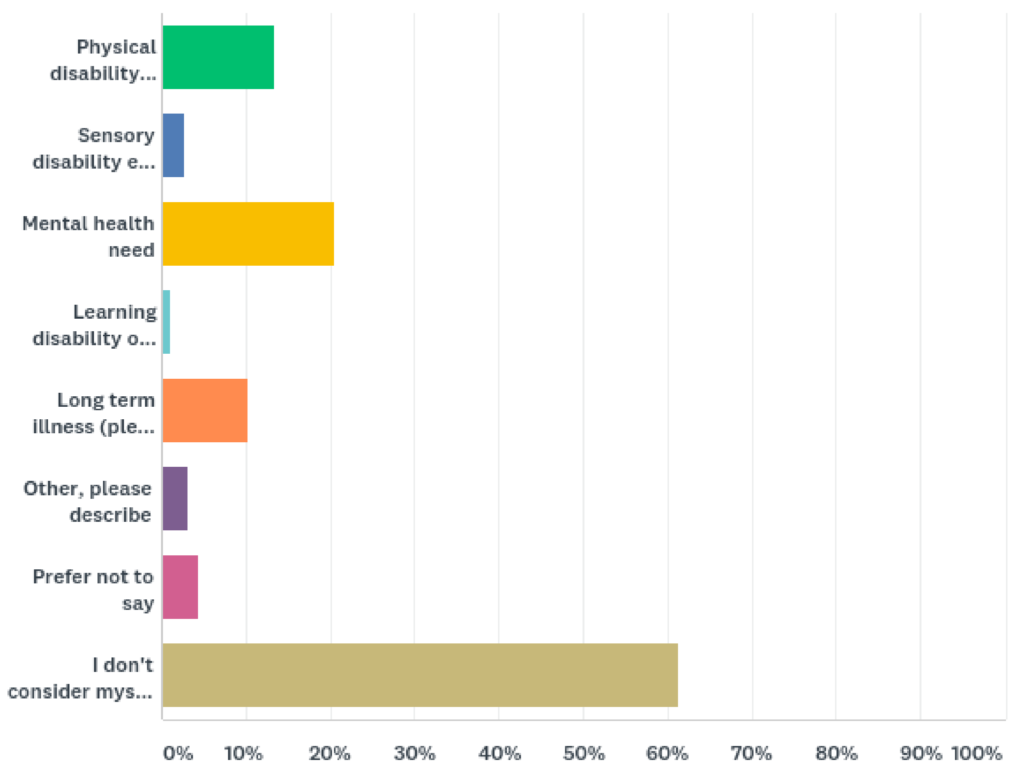


Age Group	Count	Percentage %
Yes, limited a lot	26	13.90%
Yes, limited a little	35	18.72%
No	117	62.57%
Prefer not to say	9	4.81%
	Total	*187*
	Skipped	*5*

The majority of respondents (117, 62.57%) stated that their day-to-day activities were not limited because of a health problem or disability.

Disability

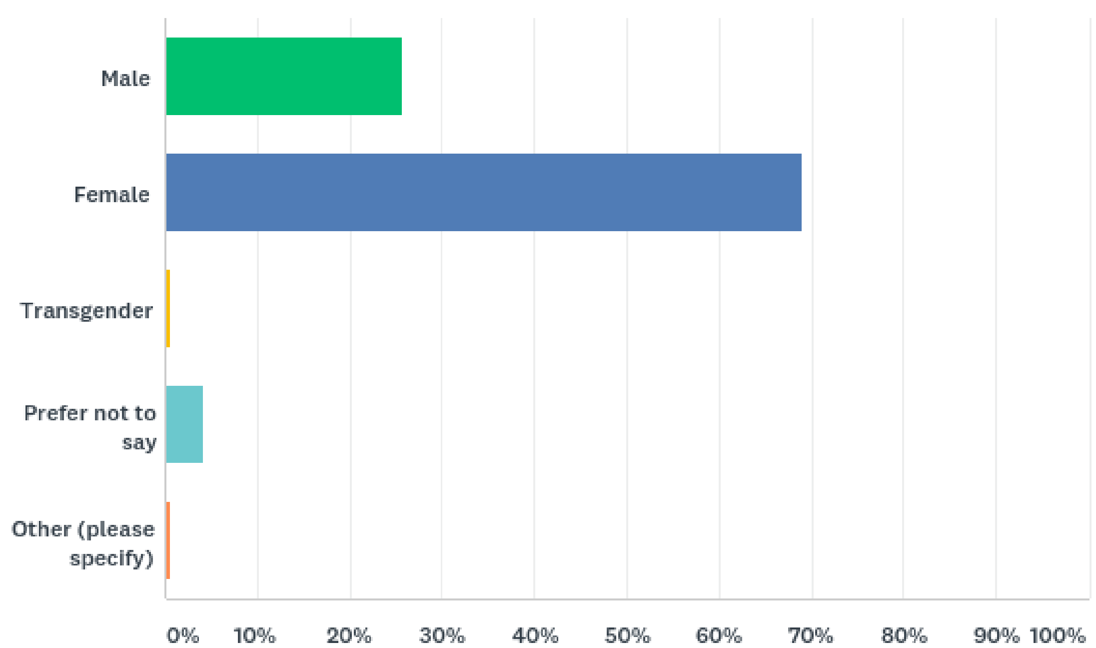
The Equality Act 2010 states a person has a disability if they have a physical or mental impairment which has a long term (12 month period or longer) or substantial adverse effects on their ability to carry out day to day activities.



Age Group	Count	Percentage %
Physical disability (please describe)	25	13.44%
Sensory disability e.g. Deaf, hard of hearing, Blind, visually impaired (please describe)	5	2.69%
Mental health need	38	20.43%
Learning disability or difficulty	2	1.08%
Long term illness (please describe)	19	10.22%
Other, please describe	6	3.23%
Prefer not to say	8	4.30%
I don't consider myself to have a disability	114	61.29%
	Total	*186*
	Skipped	*6*

The majority of respondents (114, 61.29%) did not consider themselves to have a disability. Of those that did report to have a disability, 20.43% (38) stated that they had a mental health need.

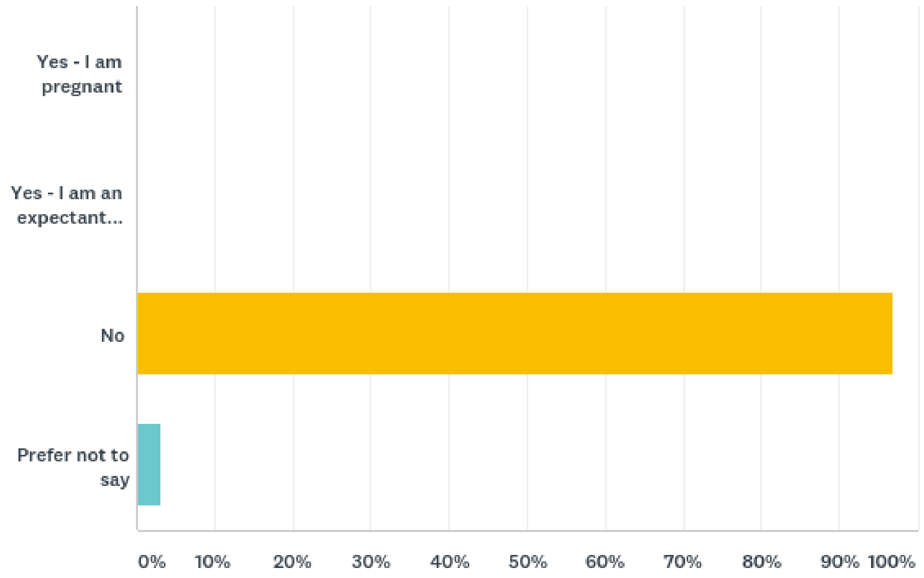
Gender identity



Gender Identity	Count	Percentage %
Male	48	25.67%
Female	129	68.98%
Transgender	1	0.53%
Prefer not to say	8	4.28%
Other (please specify)	1	0.53%
	Total	*187*
	Skipped	*5*

Most respondents (129, 68.98%) advised that they were female.

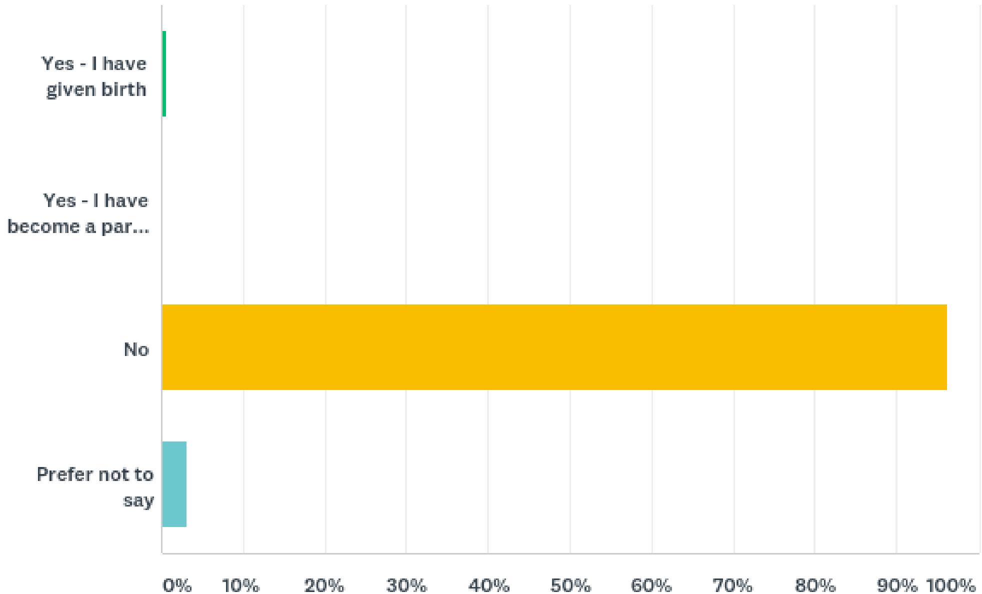
Pregnant or are the parent of an expectant child



Answer	Count	Percentage %
Yes - I am pregnant	0	0.00%
Yes - I am an expectant parent	0	0.00%
No	181	96.79%
Prefer not to say	6	3.21%
	Total	*187*
	Skipped	*5*

None of the respondents (0%) reported to be pregnant or an expectant parent.

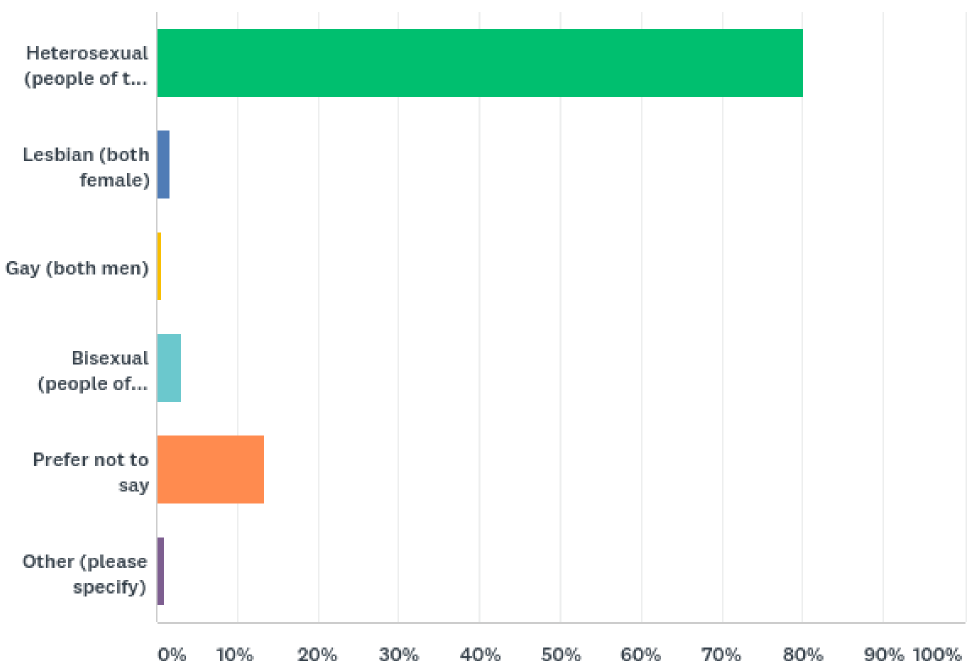
Recently given birth or have become a parent to a newborn baby (within the last 26 weeks)



Answer	Count	Percentage %
Yes - I have given birth	1	0.53%
Yes - I have become a parent to a newborn baby	0	0%
No	180	96.26%
Prefer not to say	6	3.21%
	Total	*187*
	Skipped	*5*

Most people who completed the survey stated that they had not recent given birth or had become the parent of a newborn baby.

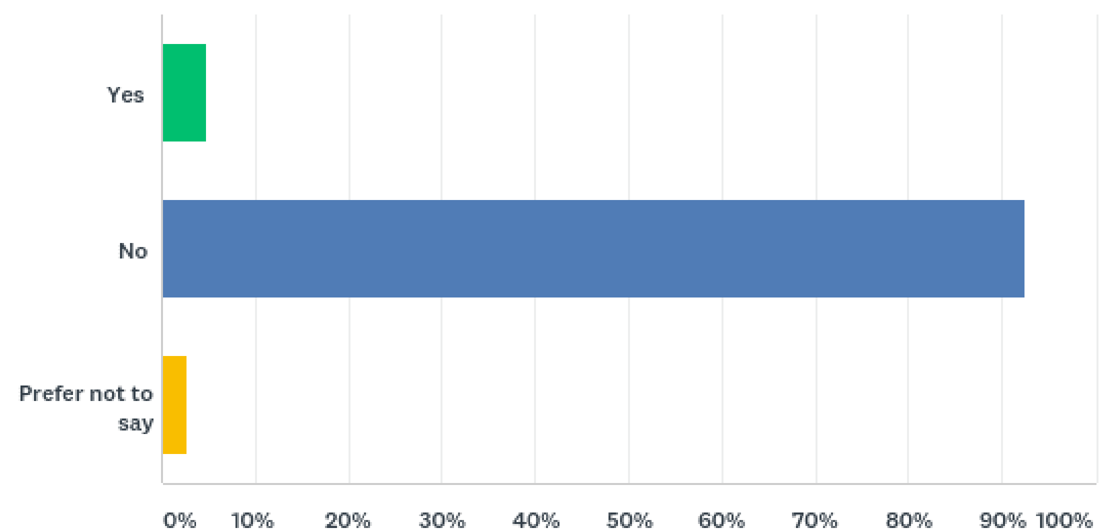
Sexual orientation



Answer	Count	Percentage %
Heterosexual (people of the opposite sex)	150	80.21%
Lesbian (both female)	3	1.60%
Gay (both men)	1	0.53%
Bisexual (people of either sex)	6	3.21%
Prefer not to say	25	13.37%
Other (please specify)	2	1.07%
	Total	*187*
	Skipped	*5*

Most respondents (150, 80.21%) stated that they were heterosexual.

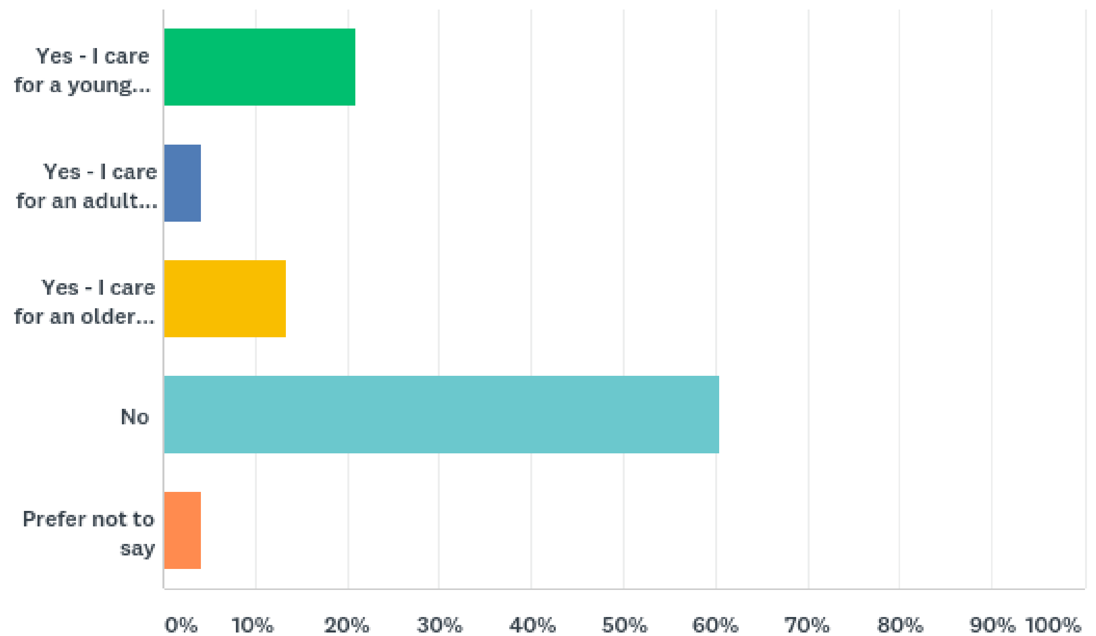
Serviced in the armed services



Answer	Count	Percentage %
Yes	9	4.81%
No	173	92.51%
Prefer not to say	5	2.67%
	Total	*187*
	Skipped	*5*

Only 4.81% (9) of respondents reported to have served in the armed services.

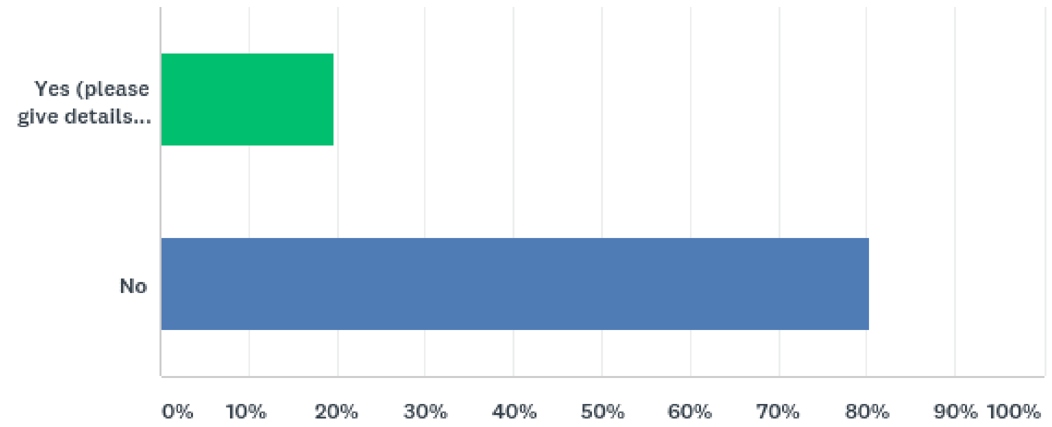
Carer status



Answer	Count	Percentage %
Yes - I care for a young person(s) aged between 0 – 24	39	20.86%
Yes - I care for an adult(s) aged between 25 – 49	8	4.28%
Yes - I care for an older person(s) aged over 50	25	13.37%
No	113	60.43%
Prefer not to say	8	4.28%
	Total	*187*
	Skipped	*5*

The majority (113, 360.43%) of respondents stated that they did not care for anyone.

Answering this survey on behalf of a staff group or organisation



Answer	Count	Percentage %
Yes (please give details below)	36	19.67%
No	147	80.33%
	Total	*183*
	Skipped	*9*

36 people (19.67%) reported to have answered the survey on behalf of an organisation. The organisations that gave their views were:

Organisations	
Age UK H&W	Mental Health
Alton Street Surgery / South and West PCN	NHS Herefordshire Mental Health & Learning Disability Service
Bromsgrove and Redditch Councils	North Worcestershire Basement Projects
Carers	Occupational Therapy - The Cart Shed Charity
Children's Services, Herefordshire	Our Way Self Advocacy
Citizens Advice	Ombersley Medical Practice Patient Participation Group
Elgar House Surgery	Simply Limitless
FE College	Social services adult's locality team
Garage Art Group in Evesham	The Fold Care Farm
Heart of Worcestershire College	Voluntary and Community Sector provider
Herefordshire mental health services	Worcester City Council
Herefordshire Council, Adult Social Care	Worcestershire Acute Hospitals
Unspecified GP surgery	Worcestershire County Council Adult Learning
Maggs Day Centre	Worcestershire Health and Care NHS Trust
Marches Counselling Service	Wyre Forest District Council

Health &Wellbeing Board
APPENDIX 3

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA)

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP	✓	Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust		Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Jack Lyons-Wainwright; Delivery Programme Manager

	Name	Job title	Email contact
Details of individuals completing this assessment	Jack Lyons-Wainwright	Delivery Programme Manager	jack.wainwright@nhs.net
Date assessment completed	08.08.2019		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Herefordshire & Worcestershire STP Mental Health Strategy**
What is the aim, purpose and/or intended outcomes of this Activity?	To develop a mental health strategy for the STP, to establish and lay out the aims for mental health services over the next 5 years.
Who will be affected by the development & implementation of this activity?	✓ Service User ✓ Patient ✓ Carers ❑ Visitors ✓ Staff ✓ Communities ❑ Other ______________ ❑
Is this:	❑ Review of an existing activity ✓ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, demographic information for patients / services / staff groups affected, complaints etc.	• Drivers of health inequality across Herefordshire and Worcestershire (2019) • Worcestershire JSNA Briefing on Mental Health (2016) • Worcestershire JSNA Primary Care Mental Health Needs Assessment (2015)

	• Worcestershire JSNA Briefing on Deaths from Suicide & Undetermined Intent (2017) • Worcestershire JSNA Homeless Health Profile (2018) • Worcestershire JSNA Briefing on Adverse Childhood Experiences (2018) • Herefordshire Mental Health Needs Assessment (2015) • Public Health Fingertips online profiles • Provider-reported access data for protected characteristics
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Communication and Engagement Plan in development, to be finalised and approved by the STP Communication and Engagement group.
Summary of relevant findings	There are many influences on mental health and this is reflected in the complexity of the wider determinants of mental health. Much of this complexity is caused by the fact that these wider determinants are not limited to individual attributes but also include social, economic and environmental factors. EIA to be reviewed during the life of the project.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	**Potential positive impact**	**Potential neutral impact**	**Potential negative impact**	**Please explain your reasons for any potential positive, neutral or negative impact identified**
Age	✓			Some aims within the NHS Long Term Plan, which will therefore be included within the strategy, relate specifically to improving services for particular age groups where inequality of provision currently exists.
Disability	✓			The strategy will lay out how services for people with mental health issues, a recognised disability, will be improved. Some aims within the NHS Long Term Plan, which will therefore be included within the strategy, relate to integrating physical and mental health services, which is expected to have a positive impact on services to people with co-morbid physical and mental health disabilities.
Gender Reassignment		✓		The strategy is not expected to have any significant impact on this equality group, subject to change following public engagement.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Marriage & Civil Partnerships		✓		The strategy is not expected to have any significant impact on this equality group, subject to change following public engagement.
Pregnancy & Maternity	✓			Some aims within the NHS Long Term Plan, which will therefore be included within the strategy, relate specifically perinatal mental health, to improve services for people in the ante-natal and post-natal phases of pregnancy and maternity.
Race including Travelling Communities	✓			Some aims within the current mental health programme, which will therefore be included within the strategy, relate specifically increasing access to mental health services among under-represented groups including BAME communities.
Religion & Belief		✓		The strategy is not expected to have any significant impact on this equality group, subject to change following public engagement.
Sex		✓		The strategy is not expected to have any significant impact on this equality group, subject to change following public engagement.
Sexual Orientation		✓		The strategy is not expected to have any significant impact on this equality group, subject to change following public engagement.
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	✓			Carers Carers are often of great importance to people with experiencing mental health illness, however the stresses of being a carer can significantly impact on the health and wellbeing of carers. It is expected that by improving mental health services, the experience of carers will also be improved. Homeless There is a well-documented link between people experiencing mental health illness and homelessness. The 2014 National Homeless Audit stated that 80% of homeless people reported some form of mental health issue. Some aims within both the NHS Long Term Plan and current mental health programme, which will therefore be included within the strategy, relate specifically to improving mental health services for homeless people.
Health Inequalities (any preventable, unfair & unjust differences in health	✓			There is a strong correlation between social and/or economic deprivation and mental ill health, and significant variation in deprivation

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				across Herefordshire and Worcestershire. Some aims within both the NHS Long Term Plan and current mental health programme, which will therefore be included within the strategy, include services targeted at particular areas of greater deprivation to improve service and outcomes for patients in those areas.

<u>Section 4</u>

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?	All actions undertaken as part of the development of the STP Mental Health Strategy will be overseen by the project working group, which reports into the STP Mental Health Programme Board.			
When will you review this EIA? (in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	EIA will be reviewed following completion of public and patient engagement events, or at any other time required.			

<u>Section 5</u> - Please read and agree to the following Equality Statement

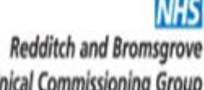
Equality Statement

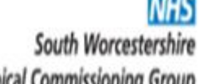
All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	08.08.2019
Comments	
Signature of Lead Person for this activity	
Date signed	08.08.2019
Comments	





V5 June 2019

Herefordshire and Worcestershire CCGs Addendum to the Equality Impact Analysis

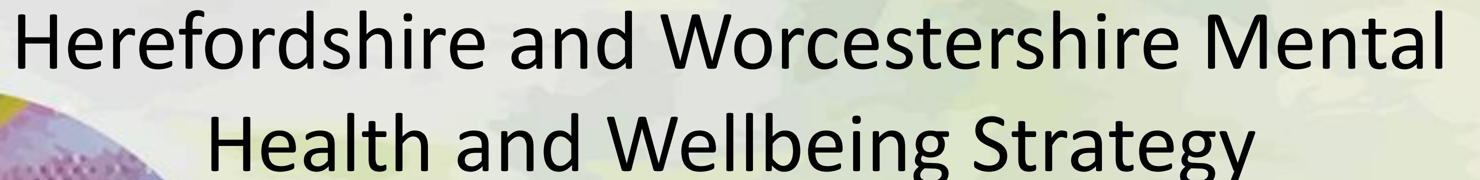
Human Rights Consideration

NHS organisations must ensure that none of their services, policies, strategies or procedures infringes on the human rights of patients or staff. You should analyse your document using the questions provided to determine the impact on human rights. Using human rights principles of fairness, respect, equality, dignity and autonomy as flags or areas to consider is often useful in identifying whether human rights are a concern.

Please answer the following Human Rights screening questions:

	Human Rights	Yes/No	Please explain
1	Will the policy/decision or refusal to treat result in the death of a person?	No	
2	Will the policy/decision lead to degrading or inhuman treatment?	No	
3	Will the policy/decision limit a person's liberty?	No	
4	Will the policy/decision interfere with a person's right to respect for private and family life?	No	
5	Will the policy/decision result in unlawful discrimination?	No	
6	Will the policy/decision limit a person's right to security?	No	
7	Will the policy/decision breach the positive obligation to protect human rights?	No	
8	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	No	
9	Will the policy/decision interfere with a person's right to participate in life?	No	

If any Human Rights issues have been identified in this section please get in touch with your Equality and Inclusion lead who will advise further and a full Human Rights Impact Assessment maybe required to be completed.

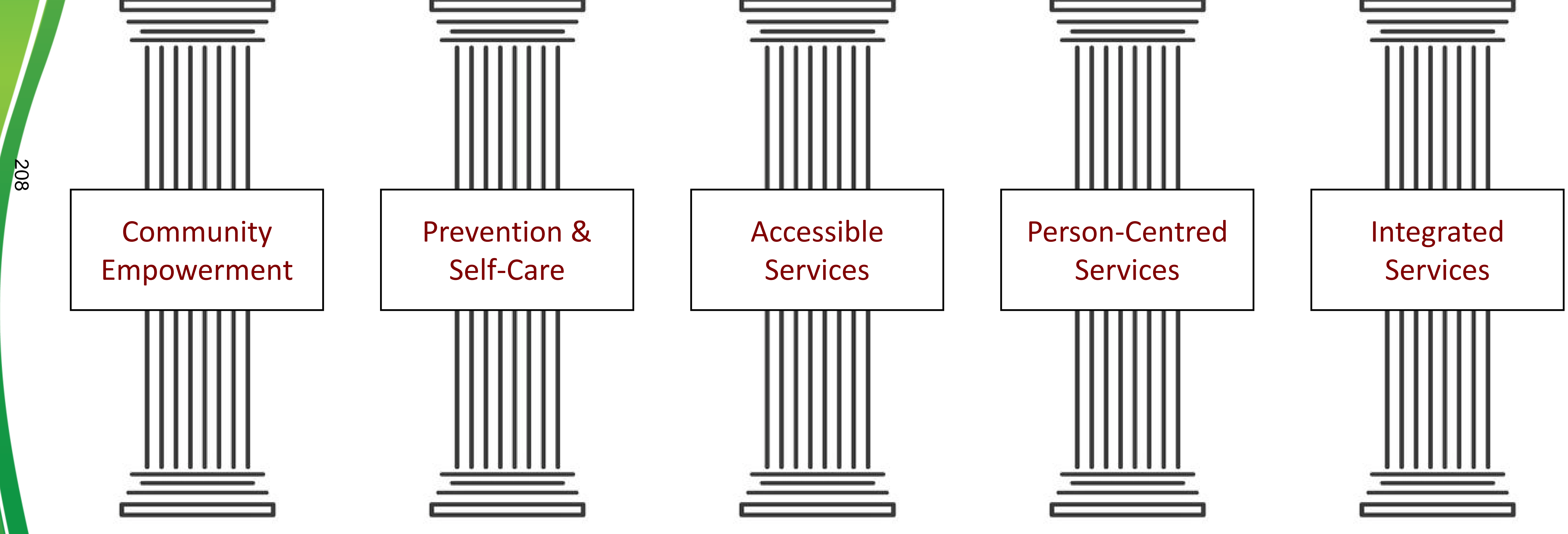


2021-2026

DRAFT

Herefordshire and Worcestershire
Integrated Care System

Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

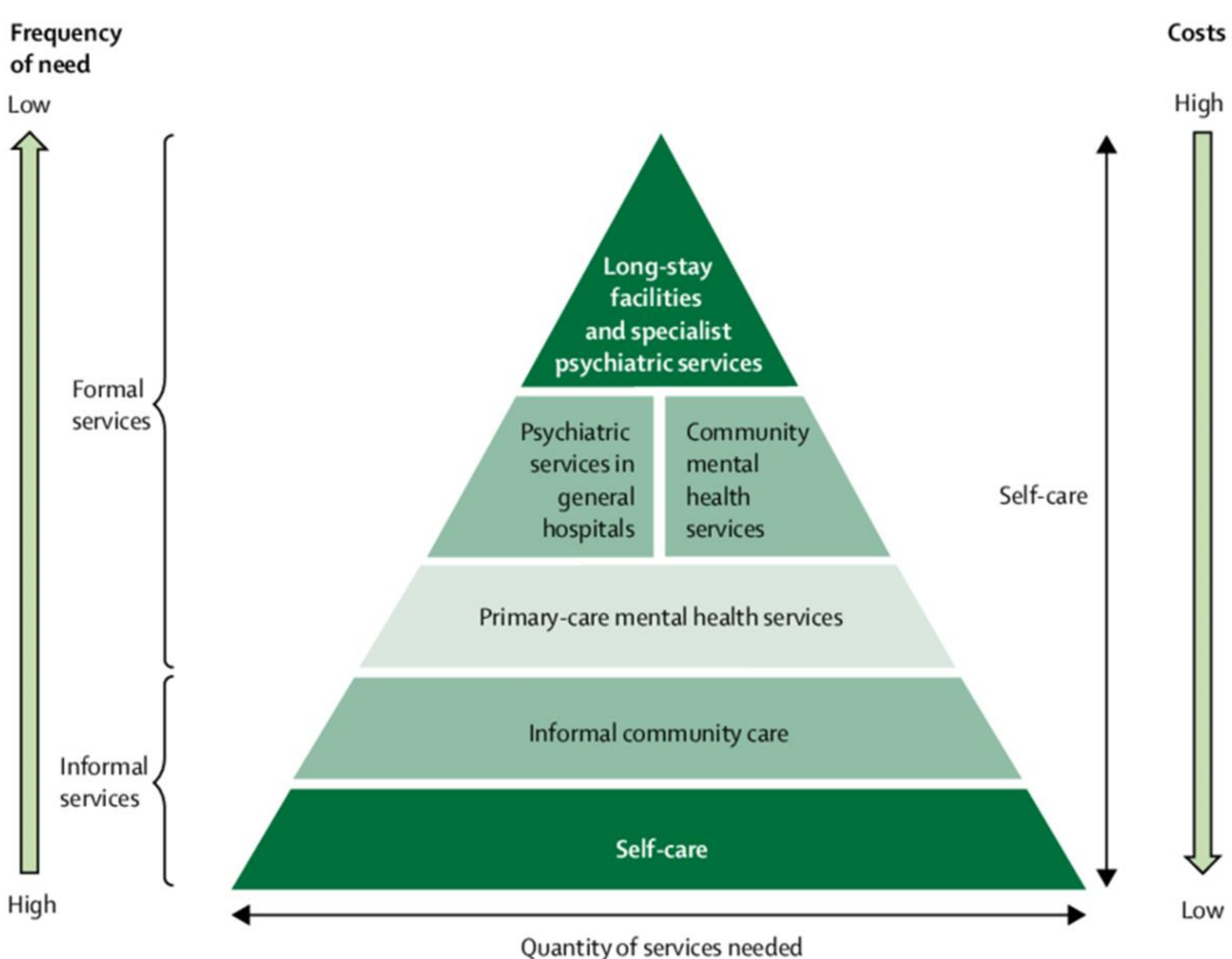


Herefordshire and Worcestershire's Vision for Mental Health & Wellbeing

Historically, mental health services have focused more on those with the most acute needs, at the top of the pyramid where frequency of need is lower but costs higher. In recent years focus on the lower tiers of the pyramid of need has increased, but this has largely focused on primary-care mental health services and some inconsistent wellbeing provision across the ICS. To continue this move toward the bottom of the pyramid and preventing mental ill health, there remains much to be done.

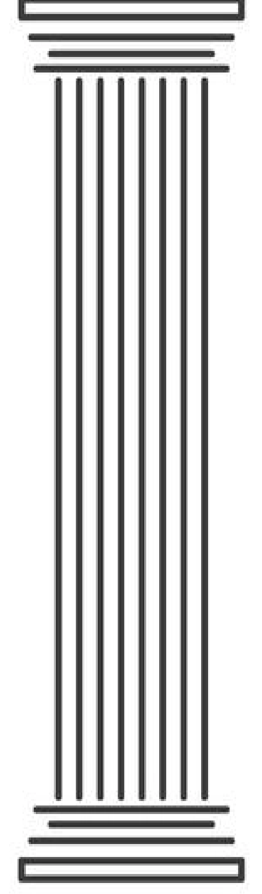
While the majority of the national priorities from the NHS Long Term Plan are rightly focused on increasing resources to and improving secondary care services where specific gaps have been identified, locally there is a real drive to increase wellbeing support, informal community care and self-care options. This has been clear from public engagement events and in some cases is already underway, including Talk Community and Integrated Wellbeing Offer for Worcestershire, as well as the Community Mental Health transformation programme. Mental health is a spectrum and it is important to remember that peoples' mental health can be good or bad, and that it will fluctuate, so self care and learning strategies to support this are essential in preventing mental health from deteriorating.

Transition of resources towards self care and more preventative services will be a gradual process, however this strategy represents a commitment to continue to move investment in this direction.

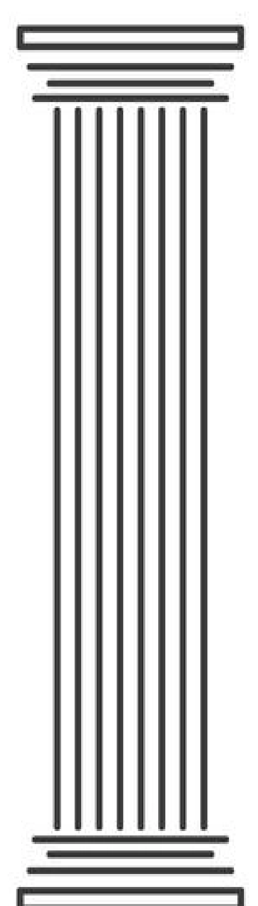


What you told us

Priorities identified:



Theme	Priorities
Accessible services	- Video consultations - Recovery college - Improved Information sharing - Increase of community based support i.e. drop-ins
Integrated services	- Co-locating services - Outcome framework - Shared discharge plans - Integrated dual diagnosis
Community empowerment	- Encouragement of joint working - Promotion of social prescribing - Outreach
Person-centred services	- Opportunity for face to face assessments - Create culture of greater compassion - Flexibility in interventions
Prevention and self-care	- Raise awareness of services to dispel stigma - Social media campaigns - Recovery and reablement approach



The Plan for Mental Health & Wellbeing

2021-22	2022-23	2023-24
Worcestershire multiagency pathway and collaborative commissioning arrangements for assessment and diagnosis of children with Autism Spectrum Condition to be implemented in Herefordshire.	Review of existing and potential complimentary crisis care alternatives across the ICS, including for CYP.	Establish additional crisis alternative provision, based on local need and co-production approach.
Review and redevelopment of mental health VCSE provision across Herefordshire and Worcestershire.		Move to alliance-based model of provision for mental health services across the ICS.
Review care pathways for Looked After Children, children and young people subject to a child protection plan, and children with ADHD.	Establish system-wide approach to career development, support and training for Peer Support workforce.	Closer joint working regionally with police and criminal justice, including Liaison and Diversion and Crisis Alternatives, to ensure people reach the right services as early as possible while reducing the burden on police and other blue light services.
Commission Qwell online mental health support and advice portal across ICS, and Mental Wellbeing service in most deprived schools in Worcestershire (where MHST not in place)	Length of hospital stay and delayed transfers of care to be reduced for children and young people.	
Consistent service models to be established across Herefordshire and Worcestershire, following move to a single NHS provider.		
Establish ICS Mental Health Inequalities Board to address health inequalities across system, including those exacerbated by COVID	CAMHS waiting times to be reduced utilising Quality Improvement methodology and best practice across two counties and nationally.	
Needs assessments to be undertaken focusing on: • Mental Health • Employability among vulnerable groups • Sexual abuse and trauma	New Drugs and alcohol strategy to be developed for Worcestershire in line with Dame Carol Black review recommendations, including increased training and integration with mental health services.	
Patient Shared Care Record to be developed to provide up to date information for patients and clinicians across organisations	Develop a model of care that will provide rehabilitation, or reduce the need for admissions, for young people who require more intensive support.	
Service redesign for public health nursing, health visiting and school nursing to improve integration of services and strengthen the mental health offer for young families, pregnant women and school age children.		

Local Vision

We will work with local people and communities so that everyone can be mentally well, or access services quickly when they need them, and that those services will work together in an integrated fashion to provide the best possible care.

What good looks like

We will:

- **Provide more mental health services to more people, as per the NHS Long Term Plan**
- **Decrease waiting time for assessment of Autistic Spectrum Condition in children**
- **Offer more opportunities for work, and career development, for Peer Support Workers**
- **Increase mental health support to young families, pregnant women and school age children**
- **Decrease waiting time for children to access mental health support in CAMHS**
- **Reduce how long children and young people stay as inpatients in acute wards**
- **Increase equality of access, outcomes and experience for all of our population**
- **Provide alternative services to people experiencing crisis**

COVID response for Mental Health & Wellbeing

Almost all mental health services in Herefordshire and Worcestershire were maintained throughout the pandemic, with only limited redeployments to support key services such as the 24/7 crisis line. As the impact of the pandemic on peoples' mental health became clear, recovery and restoration planning focused on expanding capacity of services wherever possible. As many of the mental health priorities within the NHS Long Term Plan are focused on expanding provision, many of these ambitions have subsequently been brought forward from 2022-23 to 2021-22 to support with increased demand.

Phase 1: Response

- 24/7 mental health crisis line established
- Systems put in place to segregate COVID positive inpatients. Closure of one older adult mental health ward and set up of hospital at home provision
- Proactive contact and support approach adopted to ensure patients on caseload were supported through first national lockdown
- Single Points of Access established for each county for help and support

Phase 2: Recovery

- Preparation for longer term increase in demand for mental health services, including actively recruiting in line with NHS Long Term Plan
- Establishment of enhanced psychological support for health and social care staff, including process to ensure BAME staff were considered and protected
- Ensuring 24/7 mental health crisis line is made permanent and sustainable
- Review of interagency suicide prevention plans for each county

Phase 3: Restoration

- Re-establishment of transformation programmes including crisis alternative services, mental health support teams in schools, 24/7 psychiatric liaison and phase 2 of the community mental health transformation.
- Early implementation of NHS Long Term Plan ambitions including CYP crisis resolution and home treatment services and increasing access to psychological therapies.
- Recovery trajectories in place for services impacted by COVID (e.g. physical health checks for people with severe mental illness

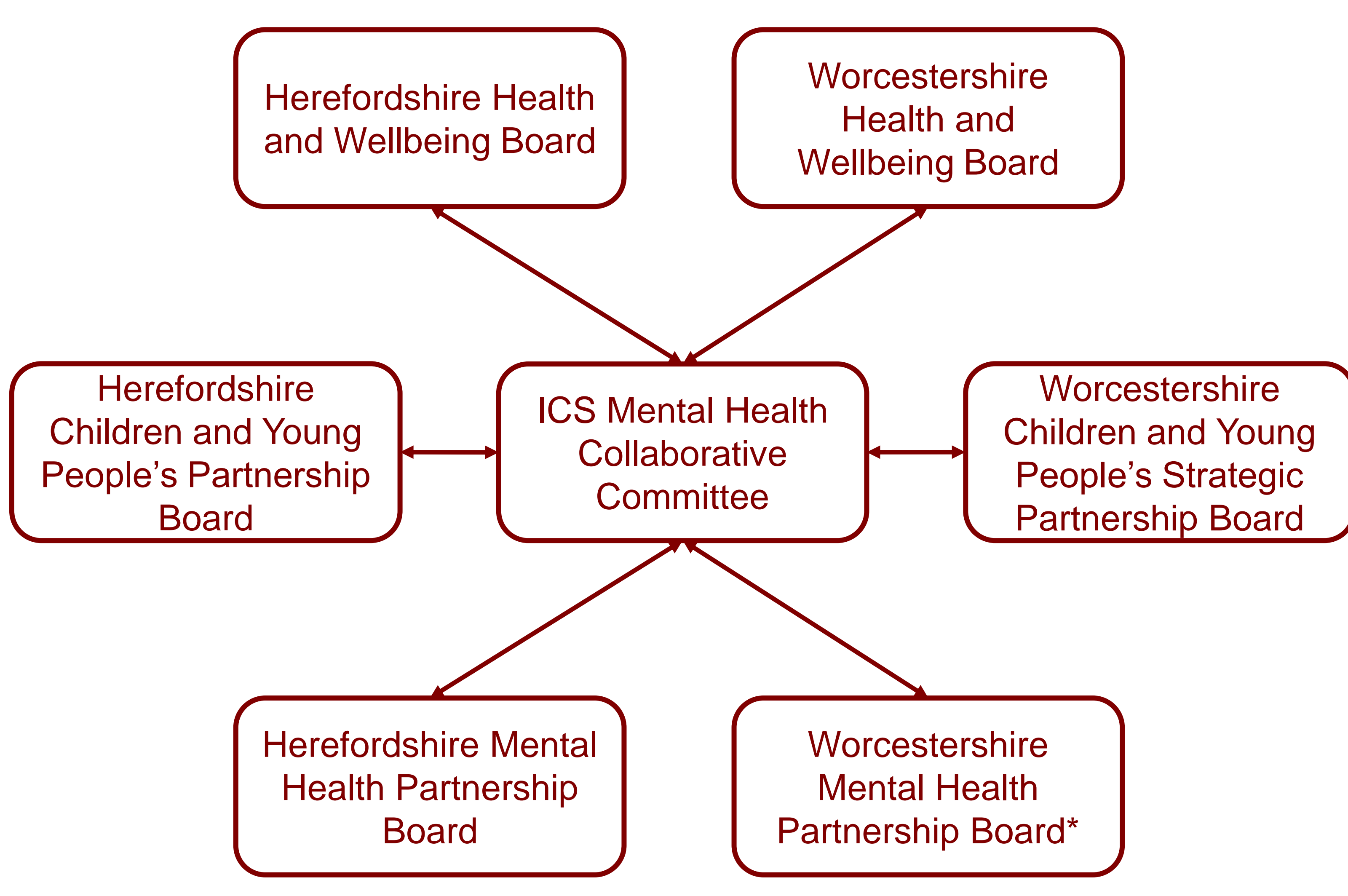
Delivery and accountability

From October 2021 the ICS Mental Health Programme Board will take on the broader remit of the ICS Mental Health Collaborative Committee. This committee will oversee delivery of the strategic aims within this strategy. The Mental Health Collaborative Committee will work closely with the Health and Wellbeing Boards in both counties, to ensure strong links between mental health and broader wellbeing services are maintained and built upon.

In Herefordshire there is an established Mental Health Partnership Board, comprising broad system partners and Experts by Experience, which will continue to be utilised to drive collaboration on key workstreams. In Worcestershire a similar county-level Mental Health Partnership Board will be established to fulfil the same role, ensuring a local voice for partners and Experts by Experience.*

In addition, the Mental health Collaborative Committee will also work closely with the Children and Young People's Partnership Boards in both counties to ensure collaboration at Executive, Strategic and operational levels.

This structure reflects the need for consistency of service offer and outcomes at an ICS level, but to be delivered at a more local level whether county, district or PCN, under the principle of proportionate universalism.



Title of report: Herefordshire's Better Care Fund (BCF) 2021-22

Meeting: Health and wellbeing board

Meeting date: Monday 6 December 2021

Report by: Senior Commissioning Officer, Adults and Communities

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose

To approve Herefordshire's Better Care Fund (BCF) plan 2021-22.

The BCF is a national programme across both local government and the NHS which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. In summary, the report identifies the following points:

- the key national conditions and national metrics for the BCF remain consistent from previous plans;
- Herefordshire partners remain committed to working together to deliver a local system 'where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people';
- The council and Herefordshire and Worcestershire Clinical Commissioning Group (HWCCG) continue to work together to deliver on the key priorities within the plan to achieve service redesign and improve the delivery of service in order to achieve the priorities of the health and wellbeing strategy in the most cost effective way;
- Herefordshire's BCF plan 2021-22 details the local approach to integration, plans to achieve metrics and plans for ongoing implementation of the High Impact Change Model (HICM) for managing transfers of care. The plan is 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

Further information on the subject of this report is available from
Marie Gallagher, Tel: 01432 260435, email: Marie.Gallagher1@herefordshire.gov.ukl

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.

An Executive Summary is available at **appendix 1** providing an overview of the plan.

Recommendation(s)

That:

a) **the Herefordshire Better Care Fund narrative plan and planning template 2021-22 at appendix 2 be approved.**

Alternative options

1. The board could decline to approve the submission. Although, in accordance with national deadlines, the content of the plan has already been submitted, the board may request changes prior to formally approving the plan on the basis of improving alignment with strategic plans and priorities or to provide further efficiencies. It is a national condition that the plan is approved by the Health and Wellbeing Board (HWB). If it is not approved then the national BCF escalation process, as detailed within the planning requirements (**appendix 3)**, will be implemented to support and ensure compliance.

Key considerations

2. Partners throughout the Health and Social Care system in Herefordshire continue to be committed to working together to deliver a local system “where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people”.

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

4. The BCF in 2021-22 will continue to provide a mechanism for personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital.

5. The BCF plan is the health and social care strategic and delivery plan for Herefordshire and is therefore fully aligned with the joint local vision for the county. The BCF plan is also aligned to a number of other key plans including the Herefordshire Public Health plan, the County Plan, Health and Wellbeing Strategy, Talk Community Plan and the NHS Long Term Plan.

6. The Department of Health and Social Care published the 2021-22 Better Care Fund Policy Framework on 19 August 2021. The framework sets out the national conditions, metrics and funding arrangements for the Better Care Fund (BCF) in 2021-22.

7. The BCF Planning Requirements were published on 30 September 2021 and sets out national conditions which are the key requirements for the Better Care Fund plan 2021-22, these are:

   a) That **a jointly agreed BCF plan**, between local health and social care commissioners must be signed off by the Health and Wellbeing Board (HWB), and by the constituent council and clinical commissioning group (CCG);

b) A demonstration of how the area will **maintain the level of spending on social care services** from the CCG minimum contribution in line with the uplift to the CCG's minimum contribution.

c) That a specific proportion of the area's allocation is invested in **NHS commissioned out of hospital services,** which may include seven day services and adult social care; and

d) That a clear plan on **managing transfers of care,** with an agreed approach to support safe and timely discharge, including ongoing arrangements to embed a home first approach is in place.

8. The BCF policy framework (**appendix 4**) sets out the national metrics for the BCF 2021-22, as follows:

Avoidable admissions to hospital	Unplanned admissions for chronic ambulatory care sensitive conditions
Admissions to residential and care homes	Annual rate of older people whose long term support needs are best met by admission to residential and nursing care homes
Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement
Length of stay	Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days or more
Discharge destination	Improving the proportion of people discharged home using data on discharge to their usual place of residence

9. Herefordshire's BCF submission, at appendix 2, details the local approach to integration, plans to achieve metrics and plans for ongoing implementation of the HICM for managing transfers of care. The changes between the previous plan and the 2021-22 plan are minimal. Partners across the system are continuing to work together towards their shared vision.

10. As per the requirements for the national programme, this was submitted by the national deadline of 16 November 2021. A regional assurance process will be undertaken by 7 December 2021 and approval letters should be received week commencing 11 January 2022.

11. At a strategic level, the BCF plan intends to support the One Herefordshire Partnership. For operational health and social care Herefordshire is divided into four localities co-terminus with four primary care networks and the fifth locality made up of two primary care networks. Community social work teams are organised to mirror the locality structure.

12. Herefordshire's approach to integrating care around the person includes the Talk Community programme. This is a partnership approach, led by the council, which links three fundamental elements to promote and maximise independence and wellbeing within Herefordshire's communities. Talk Community focuses on the people that make up our communities; the place and space, which those communities occupy; and the economy in which those communities work. At the heart of Talk Community is an ambition for innovation to make independence and wellbeing for Herefordshire citizens inevitable.

13. In addition to the prevention and areas identified above, the Herefordshire health and care system are committed to delivering and embedding key integrated areas that have been described in previous plans. These include:

- Urgent care investment
- Trusted assessor model for care homes
- Investment and delivery of a D2A model for pathway two and three
- Increasing and aligning community health and care capacity that supports early discharge and prevents (where possible) admissions to hospital, further investment from 2021-22 BCF will be invested in this part of the system to increase capacity further.

14. The existing governance arrangements for the BCF will remain in place for 2021-22, where the HWB is responsible for agreeing the BCF plan and for overseeing delivery through quarterly reports. The BCF plan and the programmes of integration work that are within the BCF and plan are reported to a number of council, system and CCG boards.

Community impact

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

16. The BCF plan is aligned and integral to delivering the NHS Long Term Plan by providing services at a locality level and supporting the council's corporate objective to 'enable residents to live safe, healthy and independent lives.'

17. 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.

18. The BCF plan is a critical component of One Herefordshire, and financially supports many of the integration services and redesign.

19. 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.

Environmental Impact

20. Herefordshire Council provides and purchases a wide range of services for the people of Herefordshire. Together with partner organisations in the private, public and voluntary sectors we share a strong commitment to improving our environmental sustainability, achieving carbon neutrality and to protect and enhance Herefordshire's outstanding natural environment.

21. Whilst this is a decision on back office functions and will have minimal environmental impacts, consideration has been made to minimise waste and resource use in line with the Council's Environmental Policy.

Equality duty

22. 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.

    d) The council and HWCCG 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. 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.

    e) 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.

    f) 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

23. Herefordshire's minimum fund contributions and additional contributions from each partner for 2021-22 are summarised below:

Herefordshire Section 75 Agreement Financial Plan Summary	
Pool 1- Minimum Mandatory Contributions	**2021/22** **£**
Planned Social Care Expenditure	£6,157,684.43
NHS Commissioned Out of Hospital Care	£8,164,199.70
Total Minimum Mandatory Contribution from CCG	£14,321,884.13
Disabled Facilities Grant (Capital)	£2,268,653.00
Total Pool 1	**£16,590,537.13**
Pool 2– Additional Voluntary Contributions	**2021/22** **£**
Herefordshire CCG Care Home Package Costs	£0.00
Herefordshire Council Care Home Package Costs	£0.00
Total Pool 2	**£0.00**

Pool 3- Improved Better Care Fund	2021/22
	£
IBCF Grant	£6,583,421.00
Total Pool 3	**£6,583,421.00**
Pool 4- Winter Pressures Funding	**2021/22**
	£
Winter Pressures Grant	£0.00
Total Pool 4	**£0.00**
Total Better Care Fund	**£23,173,958.13**
Pool 5- Children's Services	**2021/22**
	£
Children's Services- CCG Contribution	£857,216.67
Children's Services- Council Contribution	£4,630,185.92
Total Pool 5	**£5,487,402.58**
Pool 6- Integrated Community Equipment Store	**2021/22**
	£
ICES- CCG Contribution	£904,000.00
ICES- Council Contribution	£700,829.00
Total Pool 6	**£1,604,829.00**

24. The Herefordshire BCF plan 2021-22 maintains the key schemes identified in the 2017-19 submission. These include the integrated community equipment store, falls first response service, Home First service, Hospital at Home, brokerage, support for carers and discharge to assess.

25. The Disabled Facilities Grant (DFG) is a mandatory grant provided under the Housing Grants, Construction and Regeneration Act 1996. A clear DFG spending plan is in place, as instructed by BCF requirements.

26. Grant conditions for iBCF also require that the council pool the grant funding into the local BCF and report as required. Sufficient non-financial resources are also in place to deliver the proposed plan. Since 2020-21, funding that was previously paid as a separate grant for managing winter pressures has been included as part of the iBCF grant, but is not ringfenced for use in winter.

27. Where any procurement activities arise from the plan they will be procured in line with the council's contract procedure rules.

Legal implications

28. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund, which brings together health and social care funding. 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.

29. The agreed budget will be managed through a section 75 agreement between the council and the HWCCG, which is currently in place until 31 March 2022.

30. Section 75 of the National Health Service Act 2006 contains powers enabling NHS bodies (as defined in section 275 and 276 of the NHS Act 2006) to exercise certain local authority functions and for local authorities to exercise various NHS functions. The parties entered into a section 75 agreement in exercise of those powers under and pursuant of the NHS Regulations 2000.

31. The iBCF is paid directly to the council via a Section 31 grant from the Department of Levelling Up, Housing and Communities (DLUHC). The Government has attached a set of conditions to the Section 31 grant to ensure it is included in the BCF at local level and will be spent on adult social care. The council are legally obliged to comply with the grant conditions set.

Risk management

32. A risk register, specific to the BCF plan 2021-22, is being developed. Risks are also identified and managed through the adults and communities directorate risk register. Key risks are detailed below:

Risk / opportunity	Mitigation
Failure to agree a joint plan and meet the national conditions	Plan has been developed in partnership. Delivery and progress to be monitored on an ongoing basis.
Fail regional assurance process	The council and HWCCG have worked through the national guidance and requirements to ensure a robust response and that a comprehensive and detailed plan is submitted.
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.
Increasing demand due to the demography of expected older age population could outstrip the improvements made.	A number of the schemes support both prevention and the urgent care parts of the system to spread the risk. In addition, the council is leading development with communities and implemented strengths based assessments to reduce demand where possible.
Failure to achieve national metric ambitions	A robust process for monitoring activity on a monthly basis is in place and will be monitored through the joint strategic commissioning partnership group.

Consultees

33. The director for adults and communities confirmed the content of the BCF plan 2021-22 on behalf of the HWB prior to the national deadline of 16 November 2021, following consultation with the chairperson of the HWB, and with the agreement of the Herefordshire Council Chief Executive

and the accountable officer at the HWCCG. Views were sought from key stakeholders from across the health and social care system prior to submission.

Appendices

Appendix 1 – Executive summary

Appendix 2 – Herefordshire's BCF narrative plan and planning template 2021-22

Appendix 3 – Better Care fund planning requirements 2021-22

Appendix 4 – 2021-2022 Better Care Fund policy framework

Background papers

None

Report Reviewers Used for appraising this report:

Governance	Sarah Buffrey	Date 16/11/2021
Finance	Kim Wratten	Date 17/11/2021
Legal	Kate Coughtrie	Date 17/11/2021
Communications	Luenne Featherstone	Date 17/11/2021
Equality Duty	Carol Trachonitis	Date 19/11/2021
Procurement	Mark Cage	Date 18/11/2021
Risk	Paul Harris	Date 19/11/2021

Approved by	Paul Smith	Date 19/11/2021

Glossary

BCF	Better Care Fund
iBCF	Improved Better Care Fund
HWCCG	Herefordshire & Worcestershire Clinical Commissioning Group
HICM	High Impact Change Model
HWB	Health and Wellbeing Board
DFG	Disabled Facilities Grant
D2A	Discharge to Assess
DLUHC	Department of Levelling Up, Housing and Communities

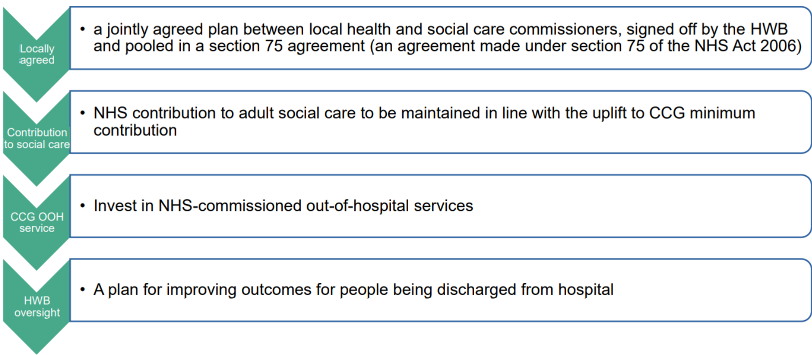
Adults and Communities Directorate

Executive Summary

Better Care Fund Plan 2021-22

- The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
- It is a national requirement for each Health and Wellbeing Board area to jointly agree a narrative BCF plan. A jointly agreed plan between local health and social care commissioners is approved by the Health and Wellbeing Board.
- BCF plans must be submitted for national assurance by 16 November 2021. The plan must be signed off by the Chief Executive and by the Accountable Officer of Herefordshire and Worcestershire NHS CCG.
- A draft plan has been submitted to Regional Better Care Manager for feedback. Observations were received and noted. National assurance will be carried out on final plans.
- Local areas were not required to submit BCF plans in 2020-21, given the exceptional pressures on systems due to the COVID-19 pandemic, but were required to agree use of the mandatory funding streams locally, to pool these into a joint agreement under section 75 of the NHS Act 2006 and to provide an end of year report.
- Due to ongoing pressures in systems, and the late publication of planning guidance, there is minimal change to the BCF in 2021-22. The 2021 to 2022 Better Care Fund policy framework aims to build on progress during the COVID-19 pandemic, strengthening the integration of commissioning and delivery of services and delivering person-centred care, as well as continuing to support system recovery from the pandemic.
- Cabinet has previously approved delegated authority to the Directors of Adults and Communities and Children and Families to agree annually the detail of the individual schemes, contracts and projects that make up the pooled budget. Decision - Herefordshire's Better Care Fund (BCF) and Integration plan 2019-20 and section 75 agreement - Herefordshire Council
- Financial Contributions have been agreed for the financial year 2021/22. The budget for each of the pools described in the s75 agreement were finalised as part of the budget setting process and agreed by the partners.
- The financial values of Herefordshire's pooled budgets with NHS Herefordshire and Worcestershire CCG were approved in September 2021 by variation to the framework partnership documents – Record of Officer Decision 13.09.2021. Partners agreed to vary Schedule 1 to reflect the revised financial plan.
- There is no impact on existing resources, including people, IT or property resources. There are no significant changes to existing arrangements and BCF and IBCF funding is confirmed for 2021/22, therefore posing no risks to jobs or services.

- Better Care Fund planning requirements 2021-22:
  - A narrative plan
  - A completed BCF planning template, including:
    - planned expenditure from BCF sources
    - confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
    - ambitions and plans for performance against BCF national metrics
    - any additional contributions to BCF section 75 agreements.
- Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG) continue to be paid to local authorities with a condition that they are pooled locally into the BCF and spent on specific purposes set out in the grant determinations and conditions.



Metrics

The BCF Policy Framework sets national metrics that must be included in BCF plans in 2021-22.

Systems are required to agree how the fund is spent over health, care and housing schemes or services, but need to agree ambitions on how this spending will improve performance against the following BCF 2021 to 2022 metrics:

- Avoidable admissions to hospital (Avoidable admissions to hospital (previously non-elective admissions metric – reflecting the focus of joint working to support people to live independently in their own home and prevent avoidable stays in hospital).
- Admissions to residential and care homes
- Effectiveness of reablement
- Length of stay
- Discharge destination

The narrative plan presented demonstrates that Herefordshire meets the required four national conditions and has set 'ambitions' for the national metrics.

The plan will be presented to Health and Wellbeing Board on 6 December 2021 for formal approval in line with the requirements of the Better Care Fund.

Cover

Health and Wellbeing Board(s)

Herefordshire

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

Ongoing discussions and meetings have enabled a range of key stakeholders to be involved in the preparation and review of proposals that sit within the BCF plan including; Wye Valley NHS Trust (WVT) Integrated Discharge Team, WVT Integrated Care Division, Herefordshire and Worcestershire Health and Care Trust, Primary Care Networks, Herefordshire Healthwatch, voluntary and community organisations along with Herefordshire council stakeholders. Engagement and involvement has been through a variety of system and internal meetings, including the One Herefordshire Partnership, which brings partners together at “Place” level as part of developing the Integrated Care System in Herefordshire and Worcestershire, and through sharing of data and wider documentation.

Executive Summary

This should include:

- *Priorities for 2021-22*
- *Key changes since previous BCF plan*

The BCF guidance 2021-22 sets out national conditions, which are the key requirements for the better care fund plan 2021-22.

a. a jointly agreed plan between local health and social care commissioners, signed off by the HWB
b. NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
c. invest in NHS-commissioned out-of-hospital services
d. a plan for improving outcomes for people being discharged from hospital

The BCF also has key national metrics for 2021-22.

Avoidable admissions to hospital	Unplanned admissions for chronic ambulatory care sensitive conditions
Admissions to residential and care homes	Annual rate of older people whose long term support needs are best met by admission to residential and nursing care homes
Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement
Length of stay	Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days or more
Discharge destination	Improving the proportion of people discharged home using data on discharge to their usual place of residence

The proposed targets and ambitions against these metrics include;

Admission avoidance

The BCF plan includes a new investment of £500k in admission avoidance as well as continuing and increasing investment in community strengthening and resilience via Talk Community. Achieving improvements in this metric in this financial year will be difficult as new upstream interventions take time to have an impact and up to now the Herefordshire BCF has been focussed much more on hospital discharge.

The ambition for reducing the percentage of hospital inpatients with a long length of stay is based on improving performance with a target of 11.1% by quarter 4 for 14 days and 5.7% for 21 days or more; current performance is 11.7% and 6.3% respectively.

The ambition for improving the percentage of people who return to their normal place of residence on discharge from acute hospital is set at 92.4%. Current performance is 91.5% with the ambition to capture data more effectively and understanding the relationship with D2A. The integrated discharge teams and strength-based assessments will continue to assist improvement.

We feel we can achieve moderate improvements in performance for length of stay and discharge destination. More significant improvements will be challenging for 2021/22 given that less than five months of the financial year remain and significant winter and COVID-19 pressures are being experienced throughout the system. Hospital Discharge funding for COVID-19 and Discharge to Assess continues to be of huge benefit; Herefordshire health and social care partners are planning for continuation of discharge to assess services funded through BCF, but this will require diversion of resources from other parts of the plan.

For long-term support needs of older people (age 65 or over), the ambition is to increase capacity in the Home First and Hospital at Home teams, leading to an increase in reablement and reducing permanent admissions to residential care homes. Maintaining the reduced levels of placements seen in 2020/21 will be difficult because COVID-19 depressed demand for care home placements considerably, but the Herefordshire health and social care plan remains focussed on citizens living well at home.

Associated with these developments, the reablement metric of increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, will be achieved by increasing capacity in the teams. This will enable delivery of the 80% target. The investment in Talk Community projects will contribute to this target by strengthening and supporting community resilience.

Recruitment and retention of health and social care workers, and the sustainability of home care and care home providers are major challenges across the country and in Herefordshire they are exacerbated by rurality and by a small working age population. The challenges will be increased by social care reforms and the uncertainty about future funding for social care.

Key to the successful delivery of the plan is to continue developing services that work in a more integrated way; redesigning services around the needs of individuals in a locality / place presents the best opportunity to improve health and well-being and reduce health inequalities. The system aim is to provide sufficient support in the community to enable people to remain independent in their own homes for longer, thereby reducing, hospital admissions and support discharges.

The priorities for 2021-22 are:

- Community Resilience & Prevention
- Hospital Discharge Support
- Partnerships and Integration Support
- Social Care Services
- Care Market Development
- Social Care Demand

In addition to the main BCF resources and plans, the Improved Better Care Fund (IBCF) allocation for Herefordshire adult social care in 2021-22 includes funding to be spent on the following:

a) meeting adult social care needs;
b) reducing pressures on the NHS including seasonal winter pressures;
c) supporting more people to be discharged from hospital when they are ready; and
d) ensuring that the social care provider market is supported

Partners have agreed to the following principles in relation to the allocation of the iBCF and are continuing to work together to implement robust spending plans:

a) to support market development and sustainability for social care providers in Herefordshire;
b) to support short term health initiatives that demonstrate future benefit to residents, and across the health and social care system;

BCF funding is used for key core social care and NHS community services - operational social work, brokerage, integrated discharge, community health and care services, DoLS, short-term and long-term placements in home care and care homes, and discharge to assess; it is central to the delivery of health and social care in the community. It is acknowledged that in due course, the legislative changes which will introduce Liberty Protection Safeguards (LPS) to replace DoLS, will require a review of the cost profile of those operational services.

Herefordshire is investing in a number of services to help improve 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.

Talk Community has emerged as one of the council's primary approaches to demand management and admission prevention.

Talk Community is bringing Herefordshire together to encourage residents, businesses, community leaders and our Council to play their part in making Herefordshire a better place to live and work. The aims of Talk Community are:

- Delivering the right support, in the right place at the right time
- Developing partnerships that inspire and impact through collaboration
- Coordinated community based support that:
  - Promotes and facilitates independence and wellbeing inevitable for all across all ages
  - Puts wellbeing, social value & strengths bases approaches in all practice, policy & decision making
  - Ensures that prevention & early intervention are prioritised by connecting people into communities
  - Applies a whole population approach that targets & reduces health & social inequalities
  - Help to bridge the gaps in health & wellbeing; care & quality; funding & finance
  - Robustly connects formal services & community support
  - Helps to improve the environment for the residents of Herefordshire

The Herefordshire system has put itself in a strong position to realign resources at a local level. This transformation began with the development of the Adults and Wellbeing Blueprint, which was adopted in 2015 and since has been developed into an agreed system integration blueprint which is now being updated to reflect the maturing of the integration relationship through the One Herefordshire Partnership. It has a focus on integrated care and support as the guiding approach to prevention and to supporting vulnerable people and continues to be integral. It places the individual at the centre and focuses on early intervention and upstream prevention to keep people as well as possible, remaining safely in their own homes as long as possible, and supporting people with eligible needs to be as independent as possible. This has evolved through comprehensive application of strengths based approaches in social work and wider practice, the continuing development of system wide relationships, and the implementation of Talk Community which is supported by all partners in the system as being core to our approach to community resilience.

Key changes since the previous BCF Plan

The main changes to the previous plan include funding for admission prevention (up to £500k) and for equipment loans. A number of services and schemes have also been consolidated under Talk Community. Overall, the BCF plan remains focussed on supporting hospital discharge but it is evolving to bring in more activities to prevent admissions to hospital and to long-term care placements.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

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

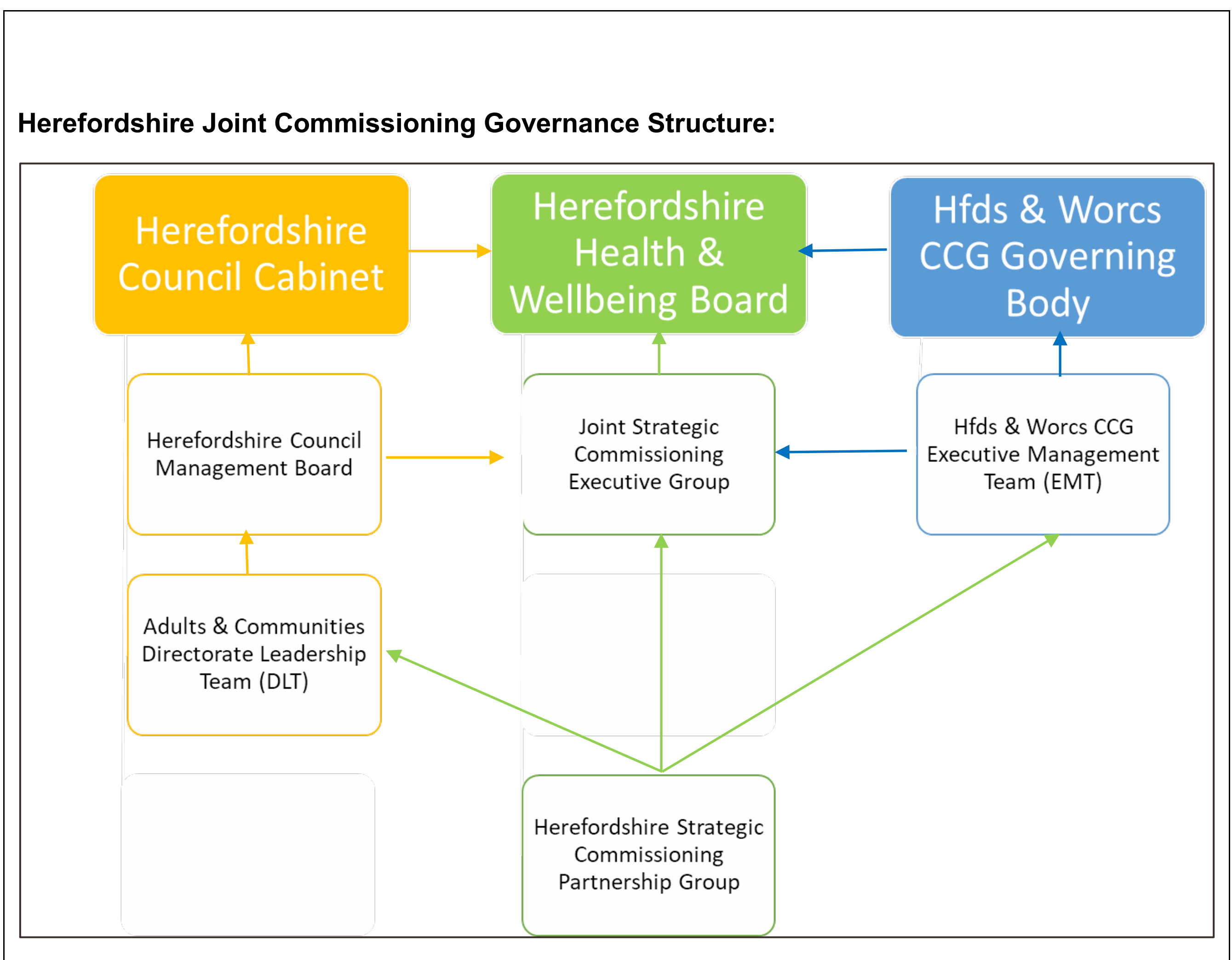
Oversight and responsibility for the BCF is embedded within the Senior Leadership Teams of both Adults and Communities within the council and the Herefordshire and Worcestershire Clinical Commissioning Group. In each organisation, this is led by chief officers and their senior leadership teams, who are able to maintain the profile of the shared agendas and ensure linkages to wider health and social care commissioning and delivery, as well as alignment with the council's wider purpose, articulated through the "County Plan"

The senior leaders of the two organisations have formed the Joint Strategic Commissioning Executive Group (JSCEG) which meets on a monthly basis to review progress on delivery and to agree next steps. This group links into the One Herefordshire Partnership to ensure that we continue to build an ambitious approach to integration as our system develops. JSCEG provides quarterly reports to the H&WB Board.

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

The governance arrangements will continue to be reviewed as the Integrated Care System and the role of "Place" develops.

Herefordshire Joint Commissioning Governance Structure:



Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- *Joint priorities for 2021-22*
- *Approaches to joint/collaborative commissioning*
- *Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.*

How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

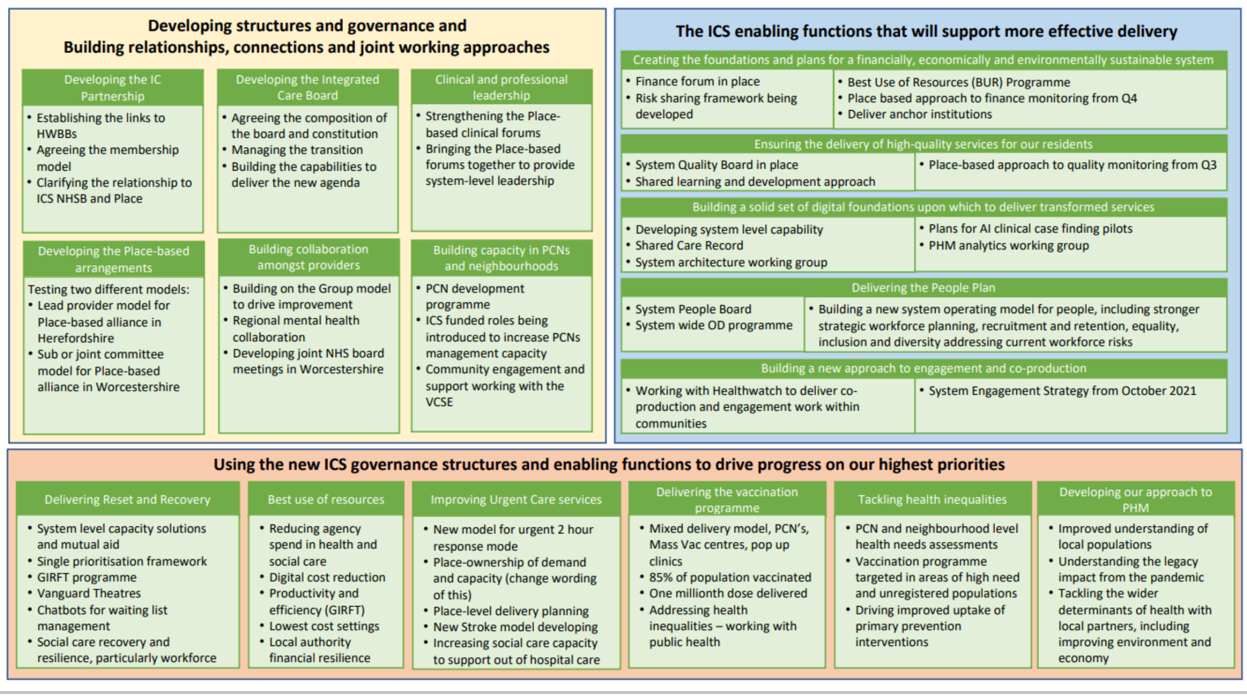
The integrated care system (ICS)

The Herefordshire and Worcestershire system has built a strong record of delivery and improvement over the last three years. The system has stable leadership across our two places and our primary care networks, with excellent support from our local authority and voluntary sector partners. Continuity of staff and an increasing number of joint posts contribute to a mature relationship between health and social care partners, including primary care and the voluntary sector. Organisations in Herefordshire have formed into the One Herefordshire Partnership and commissioning and operational changes and strategy are discussed at regular meeting of the One Herefordshire Partnership Board. For operational health and social care Herefordshire is divided into four localities co-terminus with four primary care

networks and the fifth locality made up of two primary care networks. Community social work teams are organised to mirror the locality structure.

Integration has enabled the delivery of a successful COVID vaccination programme, which has proactively targeted reducing health inequalities by working with patient representatives, communities, PCNs, local authorities and NHS providers to increase uptake. By working collectively, it has been possible to develop mutual aid and secure Vanguard Theatres in both counties, which support a Reset and Recovery Programme. With a commitment to improve clinical productivity through implementing 'Getting it right first time' and deliver an ambitious Best Use of Resources programme.

The plan on a page shows a summary of the development plan. The top left section describes the key six strategic development initiatives that will shape the overall operating model for the ICS going forward. The top right describes the enabling functions that are required to support delivery of this operating model and the bottom section is the way in which this new way of working will be used to deliver improved services and outcomes for the local population.



Joint priorities for 2021-22 include:

- Discharge facilitation;
- Recovering from COVID; and
- Admission avoidance and prevention.

Response to the coronavirus pandemic has seen greater integration of discharge, intermediate care and reablement services. While reforms to NHS structures bed-in and reforms to social care take shape, Herefordshire continues to integrate services at an operational level. Service developments are discussed by all partners at the One Herefordshire Partnership Board before any changes are made. New integrated developments include redesigning and recommissioning falls prevention services, developing a business case for investment in technology enabled living and developing discharge to assess services into a recurrently-funded and financially sustainable model.

One Herefordshire partnership identified '**Falls**' as a key priority area in 2020/21. The partnership recognised the importance of ensuring that organisation's across the health and social care sector in

Herefordshire work together to provide a single and effective system wide Falls Prevention Approach, to keep residents safe and well and maintain their independence and to reduce the pressures on the county's health systems.

The Falls Responder Service continues to work well, with community teams referring to therapy where appropriate.

Joint options are currently being scoped for a joined up falls service delivery model. Services continue to be delivered, and extra elements are added via Talk Community, including; a toolkit being made available to anyone at risk or prone to falls or anyone who comes into contact with vulnerable adults who are at risk of or prone to falling. The falls prevention toolkit is available on the Talk Community website; a free booklet is also available.

The **Community Interface Team** (CIT) (WVT) is a new umbrella term for five responding assets that have integrated to provide a unified response in line with newly mandated two-hour crisis response targets.

The five responding assets of the CIT are:

- Hospital at Home Therapy – (Wye Valley NHS Trust) Established Admission Avoidance and early support discharge service. Joint/interdisciplinary working with nurses, support workers and therapists is commonplace for patients requiring both routine monitoring and 2-hour response interventions.
- Hospital at Home Nursing - (Wye Valley NHS Trust)
- Home First - (Local Authority service) provides 'reablement' social care and therapy support at home.
- Virtual GP (vGP) - (Taurus Healthcare)
- Community Advanced Clinical Practitioners (ACPs) - (Wye Valley NHS Trust)

In addition, all components of the CIT work closely with District Nurses, aiming to integrate working whenever possible for those patients shared across both caseloads. Duplicate visits will be minimised by effective communication and information sharing.

Planned funding is directed towards the implementation of **Care Act** related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF; these include

1) Independent Mental Health Advocacy; DoLs/AMHPs – professional staff for liberty protection and mental health assessments and advocacy for users of social care.
2) Carers advice, respite and support

The **Care Home Clinical Practitioners** are working within the Integrated Care Division, Wye Valley Trust (WVT) and in close partnership with Herefordshire Council (HC) Quality Assurance Division.

The team has been working to identify individual provider needs to inform day to day activity; enhance individual care through collaborative working using evidence based education as a resource to broaden knowledge and skills to ensure the successful delivery of clinical support and advice to Residential and Nursing Homes across Herefordshire.

Visits and support calls are based around consolidating knowledge, embedding practice and learning around Infection Prevention and Control (IPC), PPE, Hand Hygiene, Brass Bands England (BBE) and social distancing guidelines.

Overriding long term aims are to support home staff within five key areas:

- Recognising the Deteriorating Patient
- Respiratory Support
- Slips, Trips and Falls
- Continence
- Tissue Viability

Integrated Care Home Support and Development

Throughout 2020/21 the Integrated Care Home Support and Development Programme consisted of 2 key workstreams – the Herefordshire Care Home Tactical Plan and the Directed Enhanced Service (DES) and the Enhanced Health in Care Homes specification.

The purpose of this delivery plan is to enable partners to continue to work collaboratively to support and further develop the care home market throughout Herefordshire and to bring the previous 2 workstreams together into a single plan. The plan will be in place from April 2021 to March 2023 with an annual review.

Health and social care partners are committed to working together to provide an integrated approach to supporting the care home market throughout Herefordshire to:

- provide demand management through strength based approach and developing models and services that will support the principle that "home and family can be best";
- create a versatile, cost effective and sustainable market at a Primary Care Network (PCN) level;
- increase and improve services that support complex and challenging behaviours such as autism or dementia;
- enhance support for those who fund their own care;
- work across health services, children and young people and adult services to integrate our commissioning and market management approach where appropriate;
- invest in early help prevention and community services;
- improve and embed mental health and wellbeing in all services design;
- support and develop the health, family support and social care workforce;
- embed technology where it delivers benefits across pathways and services; and
- promote an inclusive customer focus to ensure fair access to services.

To support these intentions, the delivery plan focuses upon 5 key work stream areas:

1. Outbreak Prevention
2. Workforce
3. Market Management
4. Health and wellbeing
5. Technology and digitalisation

Integrated Community Equipment

Herefordshire Council and NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG) have statutory requirement duties under various legislation to provide community equipment for people with an assessed eligible social or health care need. The Integrated Community Equipment Service is central to the delivery of the prevention and wellbeing priorities of the council and its partners with changing demand in social and health care, this service continues to evolve to meet the demands of stakeholders.

The service continues to see an increase in both client numbers and overall equipment spend compared to monthly averages in 2020/21. The increase evidences the ongoing focus to provide equipment to enable people to remain in their own homes, to reduce the need for the interventions of domiciliary care, care home placements and avoidable hospital admissions, whilst facilitating hospital discharge.

An element of the **IBCF Minor Investments** fund has been utilised to redesign the Herefordshire Care Heroes website to 'Herefordshire Cares'. This has been undertaken through a new approach co-produced with the local care market. The new marketing campaign will be delivered to promote the local (Herefordshire) care market and job opportunities, through a new look website and social media engagement strategy. The new approach will improve local recruitment and entrants to the local care sector. The new approach aims to engage both potential and existing care workers as the Herefordshire 'go to place' for news, information, opportunities, support and developments at national, regional and local level.

A **Postural Support** training pilot, which follows the Later Life model, 1-hour sessions over 24 weeks' is currently in place. The agreement is for the delivery of 12 courses across the county, with a review upon completion. Referrals are currently via the WVT falls service, but discussions have taken place at PCN level and further referrals with also be taken via this route.

A Management of Deterioration Pilot in Supported Living Settings East – Pilot site NHSE/ADASS

Herefordshire is part of a regional pilot programme that will provide an evidence base to support national planning for a wider strategy for the improvement of care and outcomes for people with learning disabilities who reside in supported living environments.

The Learning from Lives and Deaths of People with a Learning Disability and/or Autism (LeDeR) programme and reports, have highlighted significant difference in life expectancy between people with learning disabilities and the general population. There is evidence that health deterioration is not always detected promptly and that people with learning disabilities die prematurely from conditions that could have been prevented or treated.

The programme is facilitated by the East and West Midlands Academic Health Science Network (AHSN) and the Association of Directors of Adult Social Services (ADASS) and funded by NHS England/Improvement (NHSE/I), the pilot's key partners are the Local Authority and Health in Nottinghamshire and Lincolnshire for the East Midlands and Walsall and Hereford in the West Midlands.

The **Tackling Health Inequalities Board** (Herefordshire and Worcestershire) continues to work collaboratively with the draft LeDeR Strategy submitted to NHS England and completion and publication of LeDeR annual report for 2020/21.

LeDeR reviews - Reviewers have been trained and 93% of reviews undertaken within a 6-month timeframe. The 3-year NHS plan improvement target of 100% for Learning Disability Mortality Reviews to be completed within a 6 month timeframe.

Health Actions Plans - All GP practices within the county ensure that all people with learning disabilities are invited to attend an annual health check to an agreed standard. The current performance is 85%. The NHS plan has extended this now to include people with autism, which will increase the population by 10%.

Developing Services for Autistic people Group (Herefordshire and Worcester)

To enable access to mainstream healthcare, we are working collaboratively with CCG to establish up to 15 (one per PCN) clinic space which is low stimulus and sensory integrated, with accompanying

guidance for practices to ensure the whole experience is reasonably adapted to meet sensory needs. The CCG will part-fund adaptations and equipment.

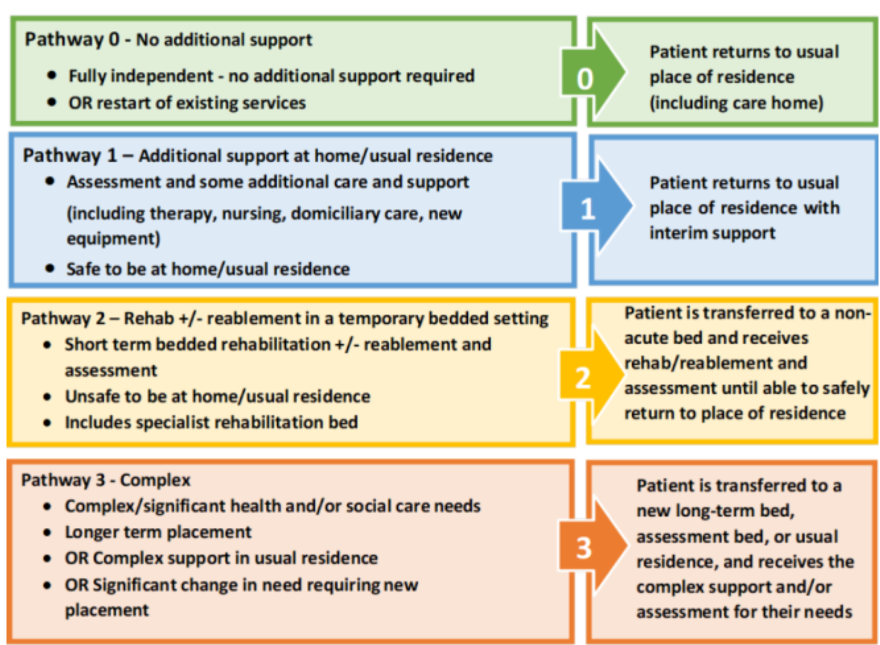
Plans are in place to commission an autism support service from April 2022 for age 16 years upwards. The specification is being co-produced across the sector.

A jointly commissioned Framework for Complex Needs is now in place across the Herefordshire/Worcestershire footprint. The complex needs pathway is for people that have a diagnosis of a Learning Disability and/or Autistic Spectrum Condition whose needs are assessed as complex, due to comorbidity. Individuals on the pathway will require support and intervention that is over and above support offered within a supporting living specification. These people present with behaviours that have challenged services and led to multiple placement breakdowns and/or in-patient admissions. The pathway is being developed to support this group of people and the provision will be inclusive of a multi-disciplinary team. This pathway will aim to develop and provide services to people with complex needs identified on our Dynamic Support Register (DSR). This will be across the health and social care footprint.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital? How is BCF funded activity supporting safe, timely and effective discharge?

Herefordshire Council provides a Reablement service, funded by BCF, which offers therapy-led services aligned with a Reablement model. People are discharged from a hospital setting by a fully integrated discharge team who provide a proportionate assessment in line with the Discharge to Assess (D2A) model.



Pathway 1 (Home) being the optimum pathway for patients who need additional support.

Herefordshire is expanding Pathway 1 services to enable more people to return home, where safe to do so, and reduce the number of people sent to a bed-based facility.

Awareness across the services of the high risk of Hospital Acquired Functional Decline underpins our practice. A recruitment drive is scheduled, to commence 26th October 2021, to increase the reablement workforce.

Outcomes continue to be measured for people who are in the Reablement service, in terms of levels of independence and requirements for ongoing care following the discharge to assess period. The integrated working with health colleagues has been improved with regards to therapy and access to longer term service provision to ensure people maximise opportunities for independence.

Improvement of the access to therapy has been made for those people discharged via Pathway 2 and 3, by changing the referral route through an integrated therapy hub; this ensures equity across the pathways.

Equipment continues to be readily available to support the person's journey and opportunity for independence.

Locality teams within adult social care provide the assessments for ongoing care within the D2A period.

Strengthening integration of social care and health teams has been the aim of the Herefordshire partners throughout. We now have a number of joint management roles, which provides more opportunity for joined up ways of working.

Length of Stay

A snapshot of the integrated teams' actions currently being undertaken to reduce 21 days are listed below.

- Twice weekly Length of Stay reviews on all 7 day stranded patients
- Daily ward/board rounds
- Integrated discharge team providing 7 day services
- Escalation daily of "criteria to reside"
- Capacity meetings – 4 daily meetings to escalate barriers to discharge
- System escalation through specific joint roles for health and social care
- Out of county discharge staff on site daily
- Daily huddle WVT and ASC community response teams
- Access to Early Supported Discharge pathway

WVT is an integrated acute and community provider and has set the 21-day target based on all beds. The BCF metric is based on acute beds where current performance is slightly worse than the national average and the ambition is to improve performance to meet the national average for acute beds by the end of the year.

Trusted Assessors

The 'Trusted Assessor' is an initiative driven by the NHS to reduce the number of delayed discharges. The underlying principle of the approach is to promote safe and timely discharges from NHS Trusts to adult social care services. The approach allows adult social care providers to adopt and use assessments carried out while people are still in hospital, as long as the assessment is carried out under a suitable 'Trusted Assessor Agreement'.

The Trusted Assessor model was implemented in Herefordshire during 2018-19, and continues to be a valued resource in helping to reduce the number of delayed discharges.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The DFG is a capital grant pooled into the BCF to promote joined-up approaches to meeting people's needs to help support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care and strategic use of the DFG can support this.

The strategic direction for DFG is to continue to work to deliver the goal of maximising independence and people living well at home. The council's Independent Living Service is to be restructured and strengthened, and in conjunction with the integrated Telecare service will work to increase the use of technology in home adaptations, telehealth and telecare. The council and CCG are working on a joint 'Technology Enabled Living' business case to maximise the use of digital technology in overcoming Herefordshire's challenges around workforce, rurality and ageing population. Working with the councils' Housing services we look to use DFG to help increase the amount of suitable available housing in Herefordshire to enable more people to remain at home, living well for longer.

Plan for DFG 2022/23

Implementation of a new Home Adaptations & Assistance Policy is currently under review. Consultation is taking place with key stakeholders to ensure that the policy includes key priorities for stakeholders, and maximises contribution of discretionary options to help meet priority needs.

A new Independent Living Service staffing structure is proposed that will assist the OT service to ensure assessments are allocated and completed in a timely manner, and ensure that the HIA can progress and complete adaptations requests within agreed performance targets.

During 2022/23 the use of the dynamic procurement system put into place during 2021/22 will be extended to allow competitive pricing, works allocation and design by contractors for most works, with certain exceptions of larger building works.

Works are ongoing with RSL partners to review and streamline the existing landlord applications process, RSL's contribution towards maintaining accessible homes register and maximising use of adapted properties to ensure longer-term effective use of DFG funds within social housing stocks.

Targets include:

- 100% OT/AEO assessments started within a maximum of 20 days
- 100% DFG requests received at Home Improvement Agency allocated to a caseworker within 10 working days
- Minimum of 60% major adaptations <£15K completed within 30 weeks of receipt of request
- 200 DFGs and 20 Discretionary Grants completed
- Memorandum of Understanding agreed and in place with RSL partners
- Home Adaptations & Assistance Policy to enable adaptations to properties sourced for the relief of homelessness

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- *Changes from previous BCF plan.*
- *How these inequalities are being addressed through the BCF plan and services funded through this.*
- *Inequality of outcomes related to the BCF national metrics.*

Herefordshire is a predominantly rural county, with the fourth lowest population density in England. The city of Hereford, in the middle of the county, is the centre for most facilities; other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington. 95 per cent of the land is classified as rural, with 53 per cent of the county's population living in rural areas.

The Joint Strategic Needs Assessment, published by Herefordshire Council, is the main source that has informed the population assumptions, in addition the Older People Needs Assessment (2018) has qualified levels of frailty and dementia across our population.

The main challenges for Herefordshire are rurality, sparsity of population, and ageing population. The BCF metrics bear this out as older adults are more likely to have longer lengths of stay and less likely to be discharged home. The BCF plan aims to address these challenges through improved integrated discharge, integrated and expanded community services, increased reablement through discharge to assess, upstream interventions to reduce hospital admissions and by strengthening community resilience through Talk Community.

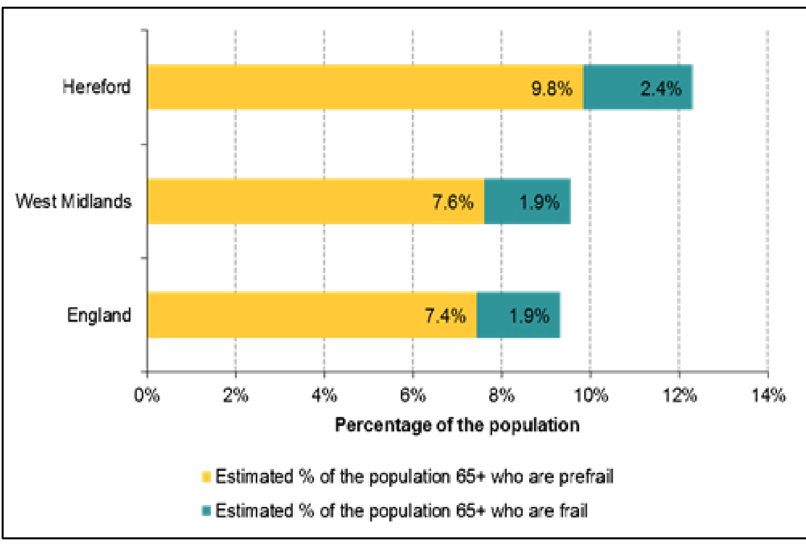
The current estimate of the county's resident population is 193,615 (mid-2020), an increase of 4,115 people (2.17 per cent) since mid-2016. There are 36,029 children and young people (0-17 years old) and 157,586 people (aged 18 to 64 years old) in our county.

Herefordshire's age profile is markedly older than that of England and Wales as a whole. People aged 65 and over constitute 25 per cent of the county's population (48,458 people), in comparison with 18 per cent nationally. There are 6,463 people aged 85 and over. By 2031, there is projected to be 50,180 65-84-year-olds (nearly 33 per cent more than in 2016) whilst the number age 85+ will rise to 9,316.

The trajectory for population growth suggests that a significant proportion of our population could be impacted by frailty. Frailty is "a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves". Frailty is not an inevitable part of ageing, but an under recognised health state. Older people with frailty are more vulnerable to minor illnesses and are at an increased risk of hospitalisation, admission to a care home and death.

It was estimated that in 2016 there were 4,600 people aged 65 and over with frailty living in the community in Herefordshire. However, the total number is likely to be higher as this calculation did not consider the number of people with frailty living in care homes. By 2025, the number of people aged 65 and over with frailty living in the community in Herefordshire is estimated to rise by approximately 28 per cent to approximately 5,900 people. There are also estimated to be around 18,600 with pre-frailty living in the community in Herefordshire. The prevalence of frailty increases with age with 4% of those aged 65 to 69 estimated to be frail, rising to 26% among those aged 85 and over.

Estimated percentage of the population aged 65 and over who had pre-frailty and frailty in 2016:



All partners are committed to equality and diversity using the scope of the 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.

All partners in the Integrated Care System are members of the Inequalities Collaborative Board which has developed a framework to support our system in working together to address inequalities. Implementation of this framework will be at “Place” level.

It is fundamental that individuals are at the heart of all activities and services. The CCG and the Council will work together with wider partners to ensure vulnerable people such as those with a learning disability and/or autism have equal access to services. Collaborative working is undertaken to implement the council’s learning disability and autism strategy.

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.

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in ‘yellow’. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “CCG minimum” then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:

- Please select the ‘Provider’ commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:

- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme

- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.

The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:

- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

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

Health and Wellbeing Board:	Herefordshire, County of
Completed by:	Adrian Griffiths
E-mail:	adrian.griffiths@hotmail.com
Contact number:	01432 383 809

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Paul Walker / Simon Trickett
Name:	Chief Executive Herefordshire Council / Accountable Officer Herefo

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Mon 06/12/2021	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Pauline	Crockett	Pauline.Crockett3@herefordshire.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Mr	Simon	Trickett	simon.trickett@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	N/A	Not Applicable	Not Applicable	Not@Applicable
	Local Authority Chief Executive	Mr	Paul	Walker	Paul.Walker@herefordshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Paul	Smith	Paul.Smith@herefordshire.gov.uk
	Better Care Fund Lead Official	Mr	Ewen	Archibald	Ewen.Archibald@herefordshire.gov.uk
	LA Section 151 Officer	Mr	Andrew	Lovegrove	Andrew.Lovegrove@herefordshire.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Joint Strategic Finance Lead	Mr	Adrian	Griffiths	adrian.griffiths2@herefordshire.gov.uk
	Senior Commissioning Officer	Ms	Marie	Gallagher	Marie.Gallagher1@herefordshire.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Herefordshire, County of

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,268,653	£2,268,653	£0
Minimum CCG Contribution	£14,321,369	£14,321,369	£0
iBCF	£6,583,421	£6,583,421	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£23,173,443**	**£23,173,443**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£4,069,727
Planned spend	£8,163,907

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,157,462
Planned spend	£6,157,462

Scheme Types

Assistive Technologies and Equipment	£292,938	(1.3%)
Care Act Implementation Related Duties	£1,226,823	(5.3%)
Carers Services	£478,314	(2.1%)
Community Based Schemes	£8,119,252	(35.0%)
DFG Related Schemes	£2,268,653	(9.8%)
Enablers for Integration	£610,645	(2.6%)
High Impact Change Model for Managing Transfer of (	£1,400,897	(6.0%)
Home Care or Domiciliary Care	£298,523	(1.3%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£3,453,041	(14.9%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£2,667,256	(11.5%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£424,696	(1.8%)
Residential Placements	£1,518,607	(6.6%)
Other	£413,798	(1.8%)
Total	**£23,173,443**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	513.7	729.4

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	LOS 14+	11.7%	11.1%
	LOS 21+	6.3%	5.7%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	0.0%	92.4%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	435	408

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Herefordshire, County of

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Herefordshire, County of	£2,268,653
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,268,653**

iBCF Contribution	Contribution
Herefordshire, County of	£6,583,421
Total iBCF Contribution	**£6,583,421**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Herefordshire CCG	£14,321,369
Total Minimum CCG Contribution	**£14,321,369**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£14,321,369**	

	2021-22
Total BCF Pooled Budget	**£23,173,443**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Herefordshire, County of

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,268,653	£2,268,653	£0
Minimum CCG Contribution	£14,321,369	£14,321,369	£0
iBCF	£6,583,421	£6,583,421	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£23,173,443**	**£23,173,443**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£4,069,727	£8,163,907	£0
Adult Social Care services spend from the minimum CCG allocations	£6,157,462	£6,157,462	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
51	Falls First Response	First responder for non-injury falls	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£41,420	Existing
51	Community Development	Commissioning & Development of Community Based	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum CCG Contribution	£281,473	Existing
52	Integrated Discharge Lead	Joint post to manage integrated discharge team	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			NHS Acute Provider	Minimum CCG Contribution	£32,684	Existing
52	Home First Service	Home First Reablement	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,384,210	Existing
52	Admission Prevention	Schemes to prevent admission to hospital or to long-term social care	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£284,523	New
52	Community Equipment	Community Equipment Loan Store- Hospital Discharge	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum CCG Contribution	£127,926	New
52	Residential Care	Long-Term Residential Placements	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Private Sector	Minimum CCG Contribution	£200,000	Existing

52	Housing Hospital Discharge	Service to assist with discharges delayed by housing issues	High Impact Change Model for Managing Transfer	Housing and related services		Social Care		LA			Local Authority	Minimum CCG Contribution	£79,520	Existing
52	Brokerage	Service to commission care placements	High Impact Change Model for Managing Transfer	Monitoring and responding to system demand		Social Care		LA			Local Authority	Minimum CCG Contribution	£217,777	Existing
52	Social Care Urgent Care	Social work professionals focussed on hospital discharge	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£787,489	Existing
53	Partnerships & Integration	Staff to support and develop joint commissioning,	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum CCG Contribution	£247,714	Existing
54	DoLs / AMHPs	Professional staff for liberty protection and mental health	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum CCG Contribution	£833,928	Existing
54	Social Care Complex Needs	Social care professionals for specialist assessments and	Other		Social workers assessing specialist or	Social Care		LA			Local Authority	Minimum CCG Contribution	£413,798	Existing
54	Carers Support Contracts	Carers respite and support	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£225,000	Existing
51	Falls First Response	First responder for non-injury falls	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£122,551	Existing
52	Discharge to Assess Beds	Intermediate Care beds- D2A pathway 3	Residential Placements	Discharge from hospital (with reablement) to		Community Health		CCG			Private Sector	Minimum CCG Contribution	£837,198	Existing
52	Admission Prevention	Schemes to prevent admission to hospital or to long-term social care	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£125,173	New
52	Community Equipment	Community Equipment Loan Store- Hospital Discharge	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			Private Sector	Minimum CCG Contribution	£165,012	New
57	Acorns Children's Hospice	Carers Respite placements	Carers Services	Respite services		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£31,617	Existing
57	St Michael's Hospice Carer's Support	Carers Respite placements	Carers Services	Respite services		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£256,976	Existing
60	Integrated Community Care	Community Healthcare services	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£6,296,786	Existing
60	Hospital at Home Physiotherapy (2020/21 Inflation)	Physiotherapy support to hospital at home service	Reablement in a persons own home	Preventing admissions to acute setting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£239,046	Existing
60	Head of Integrated Care Services (2020/21 Inflation)	Manager of Integrated Community and Discharge teams	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£89,548	Existing
33	DFG	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£2,268,653	Existing
151	Talk Community	Support to and development of communities and	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	iBCF	£1,377,022	Existing

151	Care Navigator Frequent Fallers	Assessment of and support to frequent fallers	Reablement in a persons own home	Preventing admissions to acute setting		Social Care		LA			Charity / Voluntary Sector	iBCF	£44,000	Existing
151	Advocacy	Advocacy for users of social care	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Charity / Voluntary Sector	iBCF	£167,895	Existing
152	Trusted Assessors	Trusted assessment for care home placements	High Impact Change Model for Managing Transfer	Trusted Assessment		Social Care		LA			Private Sector	iBCF	£102,875	Existing
152	Additional Costs of D2A	Intermediate Care beds- D2A pathway 3	Residential Placements	Discharge from hospital (with reablement) to		Community Health		LA			Private Sector	iBCF	£218,783	Existing
153	Joint Strategic Finance Lead	Finance business partner for joint commissioning and integration	Enablers for Integration	Integrated models of provision		Social Care		LA			CCG	iBCF	£102,704	Existing
153	Minor Investments	Small grants and investments in health promotion and	Prevention / Early Intervention	Other	Miscellaneous small grants and payments to aid	Social Care		LA			Local Authority	iBCF	£15,000	Existing
154	Locality Social Work Teams	Social work professionals aligned to PCNs	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£3,453,041	Existing
154	Social Care Business Delivery & Practice	Professional development for social care staff- strengths-	Enablers for Integration	Workforce development		Social Care		LA			Local Authority	iBCF	£260,227	Existing
154	Shared Lives	Social care staff commissioning Shared Lives placements	Residential Placements	Other	Shared Lives	Social Care		LA			Local Authority	iBCF	£142,720	Existing
156	Care Home Practitioners	Nurses to support care homes	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Social Care		LA			NHS Community Provider	iBCF	£91,004	Existing
401	Block Nursing Home Beds (Leominster)	Long Term Care Home Placements	Residential Placements	Nursing home		Social Care		LA			Private Sector	iBCF	£119,906	Existing
401	Hard to place Home Care (Katherine Harriet)	Home Care placements	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£298,523	Existing
401	Additional short-term respite placements	Short Term Care Home Placements	Carers Services	Respite services		Social Care		LA			Private Sector	iBCF	£189,721	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	513.7	729.4	2020/21 actuals based on local data. It will be difficult to deliver significant improvement with less than half of the current year remaining. Target set to maintain 2019/20 levels because admissions artificially depressed in 2020/21 by COVID-19.

>> link to NHS Digital webpage

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	11.7%	11.1%	Ambition is based on improving performance to match the national average. Specific actions include: • Twice weekly Length of Stay reviews on all 7 day stranded patients • Daily ward/board rounds • Integrated discharge team providing 7 day services • Escalation daily of "criteria to reside"
	Proportion of inpatients resident for 21 days or more	6.3%	5.7%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.4%	Ambition is based on improving performance to match the national average. Better data capture will lead to some improvement, as will understanding the relationship between this target and D2A. Practical improvements will stem from

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	550	543	435	408	Increasing capacity in Home First and Hospital at Home teams as part of discharge to assess should increase reablement and reduce permanent admission to residential care homes. However the 20-21 actual is artificially low due to COVID-19 depressing demand for care home placements.
	Numerator	260	259	211	202	
	Denominator	47,301	47,666	48,458	49,541	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	76.9%	80.0%	Increasing capacity in Home First and Hospital at Home teams should maintain current good performance. Talk Community projects will strengthen and support community resilience
	Numerator	80	93	320	
	Denominator	100	121	400	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Herefordshire, County of

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Classification: Official

Publication approval reference: PAR898

Better Care Fund planning requirements 2021-22

30 September 2021

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Introduction

1. The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have published a Policy Framework[1] for the implementation of the Better Care Fund (BCF) in 2021-22. The Framework forms part of the NHS mandate for 2021-22.

2. Local areas were not required to submit BCF plans in 2020-21, given the exceptional pressures on systems due to the COVID-19 pandemic, but were required to agree use of the mandatory funding streams locally, to pool these into a joint agreement under section 75 of the NHS Act 2006 and to provide an end of year report.

3. As set out in the BCF Policy Framework, the requirements of the planning process have been kept simple and focused on continuity in 2021-22, while enabling areas to agree plans for integrated care that support recovery from the pandemic and build on the closer working many systems developed to respond to it. Collection of BCF plans will recommence in 2021-22 and plans will be assured at regional level. Use of BCF mandatory funding streams (clinical commissioning group [CCG] minimum contribution, improved Better Care Fund [iBCF] grant and Disabled Facilities Grant [DFG]) must be jointly agreed by CCGs and local authorities to reflect local health and care priorities, with plans signed off by Health and Wellbeing Boards (HWBs).

4. BCF plans should include stretching ambitions for improving outcomes against the national metrics for the fund. In the case of length of stay, these ambitions should align to local NHS trust plans to reduce the number of inpatients who have been in hospital for 21 days or over, and should be developed with hospital trusts. Further guidance on setting ambitions for these metrics is set out in Appendix 4.

5. From March 2020, in response to the pandemic, the Hospital Discharge Service Requirements suspended previous performance standards on delayed transfers of care (DToC) and set out revised processes for hospital discharges in all areas, including a requirement that people should be discharged the same day that they no longer need to be in an acute hospital; and implementation of a 'home first'

[1] Better Care Fund policy framework: 2021 to 2022 - GOV.UK (www.gov.uk)

approach. This policy is supported by additional funding in 2021-22 for health and social care activity to support recovery outside hospital and implement a discharge to assess model.

6. This additional funding is drawn down by CCGs separately to the BCF, based on incurred spend on eligible services. Policy and finance[2] guidance has been published setting out the arrangements. The guidance highlights that planning for discharge services should be done at HWB level and should be a joint process.

7. BCF plans must be submitted by 16 November 2021. Optional draft plans can be submitted to Better Care Managers (BCMs) by 19 October 2021 for feedback. Assurance will be carried out on final plans.

8. As in previous years, this guidance forms part of the core NHS Operational Planning and Contracting Guidance. CCGs are therefore required to have regard to this guidance by section 14Z11 of the NHS Act 2006. It is being published jointly with the Government to disseminate it directly to local government.

9. The Framework for the fund derives from the Government's mandate to the NHS for 2021-22, issued under section 13A of the NHS Act 2006, which sets an objective for NHS England to ringfence £4.26 billion to form the NHS contribution to the BCF. These planning requirements set allocations for each CCG from this ringfence and apply conditions to their use. BCF plans and their delivery should comply with the conditions as part of the delivery of CCGs' duties under sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency, etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006.

10. Improved Better Care Fund (iBCF) and Disabled Facilities Grant (DFG) continue to be paid to local authorities with a condition that they are pooled locally into the BCF and spent on specific purposes set out in the grant determinations and conditions.

11. For 2021-22, BCF plans will consist of:

- a narrative plan
- a completed BCF planning template, including:
  - planned expenditure from BCF sources

[2] Hospital discharge and community support: policy and operating model - GOV.UK (www.gov.uk)

- confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
- ambitions and plans for performance against BCF national metrics
- any additional contributions to BCF section 75 agreements.

Mandatory funding sources

12. The following minimum funding must be pooled into the BCF in 2021-22.

Source	2020-21 (£m)	2021-22 (£m)	Percentage change
CCG minimum contribution	4,048	4,263	5.3%
Improved Better Care Fund	2,077	2,077	-
Disabled Facilities Grant	573*	573	-

*Including additional funding on £68 million announced in December 2020.

13. Allocations of the CCG minimum have been published alongside this document on the NHS England website. This document sets out contributions from CCGs to the BCF overall and also the ringfenced sums for each CCG that must be spent on CCG commissioned out-of-hospital services under National condition 3.

National conditions

14. The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved. These are:

A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.

NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.

Invest in NHS commissioned out-of-hospital services.

Plan for improving outcomes for people being discharged from hospital.

15. Compliance with the national conditions will be confirmed through the planning template and narrative plans. Spend applicable to these national conditions will be calculated in the planning template based on scheme-level expenditure data.

National condition 1: Plans to be jointly agreed

16. National condition 1 requires that a plan for spending all funding elements is jointly agreed by local authority and CCG partners and placed into a pooled fund, governed by an agreement under section 75 of the NHS Act 2006. Plans will need to confirm that individual elements of the mandatory funding have been used in accordance with their purpose as set out in the BCF Policy Framework, relevant grant conditions and these planning requirements.

17. Plans must be agreed by the local authority chief executive and CCG accountable officer, prior to being signed off by the HWB.

18. Areas can agree to pool additional funds into their BCF plan and associated section 75 agreement(s). These additional contributions are not subject to the conditions of the BCF but should be recorded in the planning template.

19. Systems should review the assessment of health inequalities and equality for people with protected characteristics from their 2020-21 plans and update these, where appropriate. Narrative plans should briefly set out any changes to local priorities in terms of health inequality or equality for people with protected characteristics, and how BCF-funded services are being delivered to address these, including data where this is appropriate. Where data is available, local areas should also consider any differential outcomes for people from groups with protected characteristics and other vulnerable groups in relation to the metrics of the BCF and how actions in their plan can contribute to reducing these.

20. Data on avoidable admissions and on discharge to be used in the BCF for 2021-22 will be made available on the Better Care Exchange. This will include ethnicity and age information to support analysis as well as links to guidance and documents on equality. CCGs will also need to take into account NHS England's planning expectations for implementing phase 3 of the NHS response to the COVID-19 pandemic,[3] issued on 7 August 2020. This letter set out eight actions for NHS systems to take to address inequalities, particularly those highlighted by the

[3] https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-covid-19-pandemic/

COVID-19 pandemic. The implementation guidance[4] for health systems for the first half of 2021-22 distilled these into five priorities.

Mandatory components of the Better Care Fund

CCG minimum contribution to the Better Care Fund

21. NHS England has published allocations[5] from this national ringfence for each CCG for 2021-22 as part of the main operating and contracting guidance.[6] The allocations for all mandatory funding sources are pre-populated in the BCF planning template at HWB and CCG level.

22. The national CCG contribution to the BCF has been increased in line with average NHS revenue growth from 2019 to 2024 (5.3%). Local allocations are based on the BCF allocations formula, which uses both the local government relative needs formula (RNF) and the core CCG allocations formula. This means that percentage uplifts at HWB level will vary from area to area.

23. The allocation for each CCG continues to include funding to support local authority delivery of reablement, carers' breaks and implementation of duties to fund carer support under the Care Act 2014. Local allocations of these elements of the CCG minimum are not set for each area, and it is for local government and CCGs to agree the funding to allocate to these services as part of their local BCF plans.

24. When agreeing plans for use of BCF funding to support reablement, areas should consider how this expenditure and the approach to commissioning these services aligns to wider plans, such as those funded through the NHS Long Term Plan, to implement improved access to reablement and the two-day response standard, additional reablement services commissioned with Hospital Discharge funding, as well as council-funded reablement.

25. National conditions 2 and 3 apply only to spend from the CCG minimum contribution and are set out below.

[4] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf
[5] NHS England » Better Care Fund
[6] https://www.england.nhs.uk/operational-planning-and-contracting/

National condition 2: NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution

26. National condition 2 requires that, in each HWB area, the contribution to social care spending from the minimum CCG contribution is maintained in line with the percentage uplift in the CCG minimum contribution to the BCF in that HWB. The uplift applies to the minimum expectation for social care spend in 2020-21 plans for the HWB.

27. The purpose of this condition is to ensure that support from the NHS for social care services with a health benefit is maintained in line with the overall growth in the CCG minimum contribution to the BCF.

28. As in previous years, the minimum expectations in each HWB will be confirmed in the BCF planning template. Any schemes where the spend type is 'social care' and the funding source is the CCG minimum will count towards this expectation. It is for local areas to agree the schemes that will be funded from this minimum. CCGs and councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

Revisions to baselines for social care maintenance

29. Baselines for social care contributions are based on local agreements for maintaining the financial contribution from the NHS to social care (baselined from 2016-17).

30. Areas were able to query the baselines in 2017 to 2019. However, if since then, an area has identified that the baseline used for calculating the minimum contribution is wrong – they can request that the figure is reviewed. This can only be done, by exception, in cases where activity has been miscoded and the request must be made by the HWB. Further details are set out in Appendix 2.

National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services

31. A minimum of £1.121 billion of the CCG contribution to the BCF in 2021-22 is ringfenced to deliver investment in out-of-hospital services commissioned by CCGs, while supporting local integration aims. Each CCG's share of this funding is set out as part of the CCG allocations to the BCF and will need to be spent as set out in National condition 3. This condition will be assured through the planning template,

based on spend allocated to primary, community, social care or mental health care, that is commissioned by CCGs from the CCG minimum contribution.

Grant funding to local government

Improved Better Care Fund (iBCF) grant

32. The grant determination for the iBCF was issued in May 2021. Since 2020-21, funding that was previously paid as a separate grant for managing winter pressures has been included as part of the iBCF grant, but is not ringfenced for use in winter. Overall allocations for BCF revenue and capital grants to local government for each local authority remain the same in cash terms as in 2020-21.

33. The grant conditions remain broadly the same as in 2020-21.

34. The funding may only be used for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready
- ensuring that the social care provider market is supported.

35. iBCF funding can be allocated across any or all of the four purposes of the grant in a way that local authorities, working with CCG(s), determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the purposes.

36. The grant conditions for the iBCF also require that the local authority pool the grant funding into the local BCF and report as required through BCF reporting.

37. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care (National Condition two).

Disabled Facilities Grant

38. Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local authorities. The statutory duty to provide DFGs to those who qualify for them is placed on local housing authorities. Therefore, each area must ensure that sufficient funding is allocated from the DFG

monies to enable housing authorities to continue to meet their statutory duty to provide adaptations to the homes of eligible people of all ages.

39. In two-tier areas, decisions around the use of DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government must be passed down to the relevant housing authorities (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans.

40. The DFG is pooled into the BCF to promote joined-up approaches to meeting people's needs to help support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care, and strategic use of the DFG can support this.

41. Where some DFG funding is retained by the upper tier authority, plans should be clear that:

- the funding is included in one of the pooled funds as part of the BCF
- as DFG funding is capital funding, the funding can only be used for capital purposes
- the funding supports a strategic approach to housing and adaptations that supports the aims of the BCF
- the use of the funding in this way has been developed and agreed with relevant housing authorities.

42. Since 2008/09, the scope for how DFG funding can also be used includes to support any local authority expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables local government to use specific DFG funding more flexibly. There are numerous case studies of innovative use of DFG funding on the Better Care Exchange and Foundations websites.

43. This discretionary use of the funding can help improve delivery and reduce the bureaucracy involved in the DFG application process, helping to speed up the process. The Care Act also requires local authorities to establish and maintain an information and advice service in their area. The BCF plan should consider the

contribution that can be made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues.

National condition 4: Managing transfers of care

44. Local partners should ensure that they have an agreed approach to support safe and timely discharge, including ongoing arrangements to embed a home first approach.

45. BCF plans already include expenditure to support discharge and plans for 2021-22 should set out how BCF funding (including any voluntarily pooled funding) aligns in support of discharge. This should include:

- how collaborative commissioning of discharge services is supporting this. Systems should have regard to the guidance on collaborative commissioning published by the Local Government Association (LGA), in partnership with the BCF Programme[7]
- providing details in the BCF planning template of planned spend on discharge-related activity. Scheme types have been updated to collect better information on discharge expenditure in the BCF
- how joint health and social care activity will contribute to the improvements agreed against BCF national metrics for discharge (reducing the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days).

46. Additional funding of £1.072 billion has been made available by government to support hospital discharge in 2021-22. This funding is drawn down from central funds by CCGs, based on eligible spend and is not a mandatory funding stream in the BCF. The finance guidance that supports this funding advises areas to consider using section 75 arrangements for commissioning using these funds, particularly where one body acts as a lead commissioner. BCF section 75 agreements can be used for this and, if planned spend from the hospital discharge policy (HDP)[8] funding is pooled, it should be shown as an additional contribution from the CCG.

47. Local authorities and CCGs are expected to continue to pool pre-existing expenditure on discharge alongside the separate funding for additional costs linked

[7] Top tips for implementing a collaborative commissioning approach to Home First | Local Government Association
[8] Hospital discharge and community support: policy and operating model - GOV.UK (www.gov.uk)

to the HDP. Where this expenditure is from BCF sources, this should be indicated in the BCF planning template by selecting the appropriate scheme type and subtype in the expenditure worksheet.

48. The BCF Policy Framework sets out that NHS England will focus its oversight on approval and permission to spend from the CCG ringfenced contribution, particularly on plans linked to National condition 4. This will include confirmation that ambitions set for reducing the proportion of hospital inpatients with a long length of stay are sufficiently stretching.

49. The High Impact Change Model for Managing Transfers of Care was refreshed in 2019 and has been further updated in 2020 to reflect changes to discharge introduced to support the response to COVID-19. Detailed narratives and progress against individual elements of the High Impact Change Model for Managing Transfers of Care will not be collected in 2021-22, but systems should note that this model[9] remains best practice and underpins the revised Hospital Discharge Policy.

Agreement of local plans

50. National condition 1 requires that plans for use of all mandatory pooled funds are agreed by local authority chief executives and CCG accountable officers, and are signed off by HWBs.

51. Areas will need to agree a short narrative plan and confirm agreed expenditure and compliance with the requirements of the fund in the BCF planning template. Local NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans. Plans for hospital discharge and ambitions for discharge metrics should be developed and agreed with local NHS trusts.

52. Final narrative plans and completed planning templates should be submitted by 16 November 2021. Optional draft narrative plans can be submitted to BCMs by 19 October 2021 for light touch review and feedback.

53. Narrative plans should reflect how commissioners will work together in 2021-22 to:

[9] https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high

- continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally
- overarching approach to support people to remain independent at home
- a narrative on the approach in the area to jointly improving outcomes for people being discharged from hospital, and for reducing the percentage of hospital inpatients who have been in hospital for more than 14 and 21 days. (**National condition 4**)

54. Narrative plans will not be collected in the main BCF planning template. A narrative template has been made available on the Better Care Exchange site, but areas are not required to use this.

BCF planning template

55. The planning template will be used to collect expenditure details, confirmed funding contributions and confirmation that planning requirements are met.

56. The template will be pre-populated with

- minimum funding contributions for all mandatory funding sources
- minimum ringfenced amounts from the CCG minimum for:
  - the contribution to social care (National condition 2)
  - spend on CCG commissioned out-of-hospital services (National condition 3).

57. The template will calculate spend applicable to each of these national conditions automatically.

58. Areas will need to confirm:

    a. That all mandatory funds have been pooled and agreed.

    b. Scheme level spend by:
       - funding source
       - scheme type and sub type
       - brief scheme description
       - amount of spend in 2021-22
       - area of spend (ie social care, community health, continuing care, primary care, mental health, acute care)

- commissioner type
- provider type.

c. Performance ambitions for metrics and how BCF activity will contribute to making progress against these metrics.

59. A separate confirmation sheet will collect yes/no confirmation that the following requirements are met:

- In two tier local government areas, that DFG funding has either been passed to district/borough councils, or that there is agreement with district/borough councils on the use of any retained grant.
- Funding for reablement, Care Act duties and carers breaks have been identified in spending plans.

60. The specific scheme types and subtypes have been updated to reflect the revised Hospital Discharge Policy and collect information on how BCF funding streams support discharge and implementation of the home first policy. This information will support future policy development and areas should aim to record these scheme types as accurately as possible in their spending plans.

61. When completing the BCF planning template, areas should, as far as possible, avoid classifying scheme types as 'other' where a specific scheme category can be used. With narrative scheme descriptions and metrics plans stripped out from the planning process, the clarity of the remaining information is important in being able to account properly for the effective use of the funding pooled into the BCF. Local areas may be asked for further information on spend classed as 'other' through the assurance process.

Metrics

62. The BCF Policy Framework sets national metrics that must be included in BCF plans in 2021-22. Ambitions should be agreed between the local authority and CCG(s) and signed off by the HWB. The framework retains two existing metrics from previous years:

- effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)

- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.

63. The previous measure on non-elective admissions will be replaced with a measure of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions). Areas should agree expected levels of avoidable admissions and how services commissioned through the BCF will minimise these.

64. The LGA recently published a high impact change model for reducing preventable admissions to hospital and long-term care which may support local systems in considering these issues.[10]

Discharge metrics

65. In June 2021, updated hospital discharge service guidance was published. The guidance set out revised processes for hospital discharges in all areas, including implementing a 'home first' approach. The revised policy also suspended reporting of DToC (from March 2020). New measures have been introduced to reflect the revised policy more clearly.

66. From May 2021, revised metrics to track the implementation of the discharge policy are being collected via the Acute Daily Situation Report.

67. This data is not currently collected at a local authority footprint in national reporting. Discharge metrics for the BCF will therefore be based on information available through hospital patient administration systems, available through the Secondary Uses Service (SUS) database (which is available on a local authority footprint). Local systems should agree a plan to improve outcomes across the HWB area for the following measures:

- reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days
- improving the proportion of people discharged home using data on discharge to their usual place of residence.

[10] https://www.local.gov.uk/reducing-preventable-admissions-hospital-and-long-term-care-high-impact-change-model#:~:text=Reducing%20preventable%20admissions%20to%20hospital%20and%20long-term%20care,need%20for%20acute%20hospital%20or%20long-term%20bed-based%20care.

68. Areas should agree plans for improving outcomes against these measures and include ambitions within their final plans. These ambitions should align to local NHS trust plans to reduce the number of inpatients who have been in hospital for 21 days or over, and should be developed with hospital trusts. These should be stretching, and areas with above average numbers of inpatients with long lengths of stay should ensure that their ambitions aim to reduce this gap.

69. Reducing length of stay relies on action before and during a person's stay in hospital, with co-ordination at the point of discharge being only one element. Plans for reducing the number of long stay patients should involve HWBs and hospitals and reflect a whole-system approach to improving outcomes by supporting people to return home from hospital as quickly as possible and with the right support. HWBs also have a role, through their duty to promote the health and wellbeing of their residents; to ensure that hospitals are doing all they can to ensure that patients only stay in hospital as long as is necessary; and, working with hospitals, to ensure that internal and system-wide processes are being optimised.

70. Appendix 4 contains additional guidance for areas to support setting these ambitions. Data on historical performance in relation to length of stay at local authority and hospital trust footprints is available on the Better Care Exchange.

71. The BCF team will use the situation report and local authority level data to oversee progress and, in discussions with national partners, consider whether areas facing challenges may require additional support.

72. Hospital trusts, local authorities and CCGs should work together to continue to improve the use of situation reporting and other data to understand the effectiveness of their local implementation of the Hospital Discharge Policy. This should include analysis of discharges into each pathway, differences in delays by reason type, and outcomes for people discharged into intermediate care at a HWB level. NHS England will work with partners to support the process for collecting and reporting these metrics in this way, with an aim to have more detailed pathway and other information available on a local authority footprint from 2022.

73. As set out in paragraphs 19 and 20, in setting ambitions for these metrics areas should consider specific actions that they will take to address health inequalities and promote equality for people with protected characteristics under the Equality Act 2010.

Assurance

74. Assurance processes will confirm that national conditions are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed.

75. Assurance of final plans will be led by better care managers (BCMs) with input from NHS England and local government representatives. It will be a single stage exercise based on a set of key lines of enquiry (KLoEs).

76. Recommendations for approval will be signed off by NHS regional directors – this will include confirmation that local government representatives were involved in assurance and agree the recommendations.

77. NHS England will approve BCF plans in consultation with DHSC and DLUHC. NHS England, as the accountable body for the CCG minimum contribution to the fund, will write to areas to confirm that the CCG minimum funding can be released.

78. NHS England will focus its oversight particularly on approval and permission to spend from the CCG ringfenced contribution on plans linked to National condition 4 and ambitions for reducing long length of stay. This will include an assessment at regional level of the ambitions, with a further review of plans at national level. Plans will still need to meet all the requirements and national conditions to be approved.

Table 1: BCF assurance categories

Category	Description
Approved	• Plan agreed by HWB • Plan meets all national conditions • Agreed ambitions for BCF metrics are sufficiently stretching • Agreement on use of local authority grants (DFG and iBCF) • No or only limited work needed to gather additional information on plan – where there is no impact on national conditions
Not approved	• One or more of the following apply: – plan is not agreed – one or more national conditions not met – no local agreement on use of local authority grants (DFG and iBCF)

79. Where plans are not initially approved, the BCF team may implement a programme of support, with partners, to help areas to achieve approval as soon as possible or consider placing the area into formal escalation.

80. Escalation will be considered in the event that:

- CCGs and local authority are not able to agree and submit a plan to their HWB or
- the HWB does not approve the final plan or
- regional assurers rate a plan as 'not approved'.

81. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. This will initially be a regional process, facilitated by the BCF programme and team. If regional escalation is not able to address the outstanding planning requirements, senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to a National Escalation Panel meeting to discuss concerns and identify a way forward.

82. If a plan is not approved, the area should not proceed with the finalisation of BCF section 75 agreements.

Monitoring and continued compliance

Updating BCF plans in year

83. It is recognised that places may wish to amend plans in-year, following sign off and assurance, to:

- modify or decommission schemes
- increase investment or include new schemes.

84. In such instances, any changes to assured and approved BCF plans arising in-year must be jointly agreed between the local authority and the CCGs and continue to meet the conditions and requirements of the BCF.

85. In both cases, revisions to plans should be approved by the HWB and confirmed in the end-of-year reporting template with an accompanying rationale. If the need arises to amend BCF plans in-year, please contact the relevant BCM in the first instance.

Monitoring compliance with BCF plans

86. BCMs and the wider BCF team will monitor continued compliance against the national conditions through their wider interactions with local areas.

87. Where an area is not compliant with one or more conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan and risking the national conditions not being met, then the BCF team, in consultation with national partners, may make a recommendation to initiate an escalation process. Any intervention will be proportionate to the risk or issue identified.

88. The intervention and escalation process (outlined in subsequent sections) could lead to NHS England exercising its powers of intervention provided by the NHS Act 2006, in consultation with DHSC and DLUHC, as the last resort.

Reporting in 2021-22

89. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy-making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

90. These reports are discussed and signed off by HWBs (or with appropriate delegation) as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into section 75 agreements. Monitoring will include confirmation that the section 75 agreement is in place.

91. Quarterly reporting will recommence in 2021-22 and will cover progress in implementing BCF plans, progress against metrics and ongoing compliance with the national conditions of the fund. Timely submission of quarterly and end-of-year

reports is a requirement for the BCF, including as a condition of the iBCF. Therefore, areas that do not comply with the reporting timescales and detail may be subject to the procedures set out in Appendix 1 on support, escalation and intervention.

Timetable

92. The timescales for agreeing BCF Plans and assurance are set out below:

BCF planning requirements published	30 September 2021
Optional draft BCF planning submission submitted to BCM	By 19 October 2021
Review and feedback to areas from BCMs	By 2 November 2021
BCF planning submission from local HWB areas (agreed by CCGs and local government). All submissions will need to be sent to the local BCM, and copied to england.bettercarefundteam@nhs.net	16 November 2021
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	16 November to 7 December 2021
Regionally moderated assurance outcomes sent to BCF team	7 December 2021
Cross-regional calibration	9 December 2021
Approval letters issued giving formal permission to spend (CCG minimum)	From 11 January 2022
All section 75 agreements to be signed and in place	31 January 2022

Appendix 1: Support, escalation and intervention

1. Where performance issues or concerns over compliance with the requirements of the BCF are identified, the BCF team and BCM will take steps to return the area to compliance. Broadly this will involve the following steps:

1. **Trigger:** a. Concern during planning process that a compliant plan will not be agreed b. BCF plan not submitted c. BCF plan submitted does not meet one or more planning requirement d. Area is no longer compliant with their approved plan (in year)	The BCM and regional partners in consultation with the BCF team will consider whether to recommend specific support or if the area should be recommended for escalation. Initially support may be appropriate or a defined timescale set for the issue to be rectified.
2. Informal support	If appropriate, the BCM will work with the area to advise on the issue and consider, with local leaders, what further support may be provided. This may include support through regional NHS or local government structures. Alternatively, it may be decided that it is appropriate to move straight to formal support or a formal regional meeting.
3. Formal support	The BCM will work with the BCF team to agree provision of support.
4. Formal regional meeting	Areas will be invited to a formal meeting with regional NHS and local government representatives and the BCF team to discuss the concerns, plans to address these and a timescale for addressing the issues identified.
5. **Commencing escalation** as part of non-compliance	If, following the regional meeting, a solution is not found or issues are not addressed in the timescale agreed, escalation to national partners will be considered. If escalation is recommended, BCF national partners will be consulted on next steps. To commence escalation, a formal letter will be sent, setting out the reasons for escalation, consequences of non-

	compliance and informing the parties of next steps, including date and time of the Escalation Panel.
6. The **Escalation Panel**	The Escalation Panel will be jointly chaired by DLUHC and DHSC senior officials, supported by the BCF team, with representation from: • NHS England and NHS Improvement • LGA. Representation from the local area needs to include the: • health and wellbeing board chair • accountable officers from the relevant CCG(s) • senior officer(s) from local authority.
7. **Formal letter and clarification** of agreed actions	The local area representatives will be issued with a letter summarising the Escalation Panel meeting and clarifying the next steps and timescales for submitting a compliant plan. If support was requested by local partners or recommended by the Escalation Panel, an update on what support will be made available will be included.
8. **Confirmation** of agreed actions	The BCM will track progress against the actions agreed and ensure that the issues are addressed within the agreed timescale. Any changes to the timescale must be formally agreed with the BCF team.
9. Consideration of **further action**	If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious, then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include: • agreement that the Escalation Panel will work with the local parties to agree a plan • appointment of an independent expert to make recommendations on specific issues and support the development of a plan to address the issues – this might be used if the local parties cannot reach an agreement on elements of the plan • appointment of an advisor to develop a compliant plan, where the Escalation Panel does not have confidence that the area can deliver a compliant plan • directing the CCG as to how the minimum BCF allocation should be spent.

	The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off.

2. NHS England has the ability to direct the use of the CCG funds where an area fails to meet one of the BCF conditions and NHS England considers that the CCG(s) in question is failing, has failed or is at significant risk of failing to discharge any of its functions. This includes the duties under sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency, etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006. If a CCG fails to develop a plan that can be approved by NHS England or if a local plan cannot be agreed, any proposal to direct use of the fund and-or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DHSC and DLUHC ministers. The final decision will then be taken by NHS England. Once a decision has been taken any directions would be made under section 14Z21 of the NHS Act 2006.

3. The Escalation Panel may make recommendations that an area should amend plans that relate to spending of the DFG or iBCF. This money is not subject to NHS England powers to direct. A BCF plan will not be approved, however, if there is no agreement between health and local government partners on the use of these grants (a requirement of national condition one). Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue not to be met.

Appendix 2: Querying baseline for social care maintenance contributions

1. Required contributions to social care from CCG minimum contributions at HWB level have been calculated from locally agreed figures assured in 2016-17 BCF plans, uprated in line with growth in that area's CCG contribution in each subsequent year.

2. In 2021-22, if local areas believe that this baseline is not correct, they will be able to request that it be reviewed. A review can only be requested where the baseline is not correct because historical schemes have been incorrectly coded. A review can be requested because the current baseline overstates or understates social care spend

Process

3. Areas should inform their better care manager (BCM) if they believe that the baseline for maintaining social care spend is incorrect, setting out their reasoning, confirming the miscoded schemes and any supporting documents. Areas must confirm that both the relevant CCG(s) and local authority(ies) agree that the baseline is not correct.

4. The query and supporting evidence will be reviewed by the BCF team with the BCM. Recommendations for amending a baseline will be made to the BCF Programme Board. If the board agrees to amend a baseline, areas will be notified as soon as possible.

Appendix 3: Detailed definitions of BCF metrics

Metric 1: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Outcome sought	Overarching measure: Delaying and reducing the need for care and support.
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups admission to residential or nursing care homes can improve their situation.
Definition	**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by NHS Digital. **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework NHS Digital (SALT) Population statistics (ONS)
Reporting schedule for data source	Collection frequency: annual (collected April to March) Timing of availability: data typically available 6 months after year end.
Historical	Data first collected 2014/15 following a change to the data source.

Metric 2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services

Outcome sought	Delaying and reducing the need for care and support. When people develop care needs, the support they receive is provided in the most appropriate setting and enables them to regain their independence.
Rationale	There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, to minimise their need for ongoing support and dependence on public services. This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from SALT collected by NHS Digital. **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December.

	This data is taken from SALT collected by NHS Digital Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework
Reporting schedule for data source	Collection frequency: annual (although based on 2 x 3 months of data – see definition above) Timing of availability: data typically available 6 months after year end.
Historical	Data first collected 2011/12 (currently five years' final data available: 2011/12, 2012/13, 2013/14, 2014/15 and 2015/16).

Metric 3 Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Outcome sought	Improved health status for people with chronic ambulatory care sensitive conditions
Rationale	This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. The numerator is given by the number of finished and unfinished admission episodes, excluding transfers, for patients of all ages with an emergency method of admission and with a primary diagnosis of an ambulatory care sensitive condition such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, pulmonary oedema.
Definition	**Denominator:** Mid-year population estimates for England published by the Office for National Statistics (ONS) annually – National Statistics. Available in June following end of reporting year. **Numerator:** Hospital Episode Statistics (HES) admitted patient care (APC), provided by NHS Digital – National Statistics Final annual and quarterly HES data are usually released in the November following the financial year-end.
Source	NHS Outcomes Framework
Reporting schedule for data source	Monthly
Historical	Quarterly and annual data from 2003/04 Q1 for all breakdowns

Metric 4 Discharge Indicator Set

Outcome sought	a) Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days. b) Improving the proportion of people discharged home using data on discharge to their usual place of residence.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. There is evidence that recovery and independence for people who have been admitted to hospital are improved if they are discharged to their own home. This indicator measures (a) percentage of hospital patients whose stay is 14 and 21 days or longer and (b) the percentage of discharges that are to a person's usual place of residence.
Definition	**Denominator:** The proportion of hospital patients whose stay is 14 and 21 days or longer and the proportion of discharges that are to a person's usual place of residence **Numerator:** All completed hospital spells recorded in SUS – calculation on monthly total.
Source	NHS Secondary Uses Service (SUS)
Reporting schedule for data source	Monthly
Historical	Monthly data from 2018/19 Q1 for all breakdowns.

Appendix 4: Setting ambitions for length of stay

1. Better Care Fund plans must set out ambitions at local authority level for reducing the percentage of hospital inpatients who have been resident for 14 days or more and 21 days or more. These ambitions should be based on:

- **Local agreement:** ambitions should reflect a joint local government, CCG and provider agreement, and a co-ordinated approach to discharge.
- **Trust-level ambitions:** for patients in hospital for 21 days and over, NHS England has agreed a 12% ambition. BCF ambitions in each HWB area should reflect the level of ambition agreed for local trusts.
- **Current performance data:** A range of performance data has been made available on the Better Care Exchange showing recent data on 14 day and 21 day length of stay for people resident in each upper tier local authority. This data is taken from the NHS Secondary Uses Service (SUS) database and uses the local authority of residence shown on Hospital systems.

3. Ambitions should be set as the average proportion of long stay patients for quarter three and four of 2021-22.

4. The BCF planning template include space for a supporting narrative. This should set out:

- a short rationale for the ambitions
- how BCF-funded schemes and local approaches to commissioning will support performance
- any other significant actions that will be taken by systems to minimise long length of stay in hospitals.

If you have any queries about this document, please contact the Better Care Fund Team at: england.bettercarefundteam@nhs.net

For further information on the Better Care Fund, please go to: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/

For more information and regular updates on the Better Care Fund, sign up to our fortnightly bulletin and the Better Care Exchange by emailing england.bettercarefundexchange@nhs.net

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Policy paper

2021 to 2022 Better Care Fund policy framework

Updated 1 October 2021

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Introduction

The government is committed to person-centred integrated care, with health, social care, housing and other public services working together to provide better joined up care. Enabling people to live healthy, fulfilled, independent and longer lives will require these services to work ever more closely together towards common aims. The response to the coronavirus (COVID-19) pandemic appears to have accelerated the pace of collaboration across many systems and the government is keen to maintain momentum and build upon positive changes.

The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires clinical commissioning groups (CCGs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

The response to the COVID-19 pandemic has demonstrated how joint approaches to the wellbeing of people, between health, social care and the wider public sector can be effective even in the most difficult circumstances.

Given the ongoing pressures in systems, there will be minimal change to the BCF in 2021 to 2022. The 2021 to 2022 Better Care Fund policy framework aims to build on progress during the COVID-19 pandemic, strengthening the integration of commissioning and delivery of services and delivering person-centred care, as well as continuing to support system recovery from the pandemic.

The continued focus on improving how and when people are discharged from hospital is described below.

The non-elective admissions metric is being replaced by a metric on avoidable admissions. This reflects better the focus of joint health and social care work to support people to live independently in their own home and prevent avoidable stays in hospital. Wider work on the metrics for the BCF programme will continue in 2021 to 2022 to take into account improvements to data collection and to allow better alignment to national initiatives such as the Ageing Well programme.

We will undertake a full planning round in 2021 to 2022 with areas required to formally agree BCF plans and fulfil national accountability requirements. The 2021 to 2022 BCF planning requirements (https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2021-22/) sets out further details of the national planning and assurance processes.

Funding

This policy framework confirms the conditions and funding for the BCF in 2021 to 2022.

Table 1: minimum contributions to the BCF in 2021 to 2022

BCF funding contributions	2021 to 2022 (£ million)
Minimum NHS (CCG) contribution	4,263
Improved Better Care Fund (iBCF)	2,077
Disabled Facilities Grant (DFG)	573
Total	6,913

NHS CCG minimum contribution to the BCF

The National Health Service Act 2006 ('the NHS Act') gives NHS England the powers to attach conditions to the amount that is part of CCG allocations.

NHS England will consider conditions (including those that allow for recovery of funding), in consultation with the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government where the national conditions are not met. These powers do not apply to the amounts paid directly to local authorities from government. The expectation remains that, in any decisions around BCF plans and funding, ministers from both departments will be consulted.

The government is keeping under review further support for the COVID-19 response and recovery, including funding for the hospital discharge policy. We expect initial BCF plans to be submitted by September. Final BCF spending plans for the second half of the year should take into account future funding decisions relating to the hospital discharge policy. Plans will need to continue to meet the conditions of the fund.

The flexibility of local areas to pool more than the mandatory amount will remain.

As in previous years, the NHS contribution to the BCF will still include funding to support the implementation of the Care Act 2014, which will be set out via the Local Authority Social Services Letter.

Funding previously earmarked for reablement and for the provision of carers' breaks also remains in the NHS contribution.

Disabled Facilities Grant (DFG)

Funding for the DFG in 2021 to 2022 is £573 million. This was paid to local government via a section 31 grant in May 2021. The DFG capital grant must be spent in accordance with an approved joint BCF plan, developed in keeping with this policy framework and the planning requirements.

As in previous years, in 2-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers of local government (county and district councils) working jointly to support integration ambitions. Full details were set out in the DFG grant determination letter.

Improved Better Care Fund (iBCF) funding

The total allocation of the iBCF in 2021 to 2022 is £2.077 billion. The iBCF grant was paid to local government via a section 31 grant in May 2021. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

BCF national conditions and metrics for 2021 to 2022

The national conditions for the BCF in 2021 to 2022 are:

1. a jointly agreed plan between local health and social care commissioners, signed off by the HWB
2. NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
3. invest in NHS-commissioned out-of-hospital services
4. a plan for improving outcomes for people being discharged from hospital

National condition 1: a jointly agreed plan between local health and social care commissioners and signed off by the HWB

The local authority and CCGs must agree a plan for their local authority area that includes agreement on use of mandatory BCF funding streams. The plan must be signed off by the HWB.

BCF plans should set out a joined-up approach to integrated, person-centred services across local health, care, housing and wider public services. They should include arrangements for joint commissioning, and an agreed approach for embedding the current discharge policy in relation to how BCF funding will support this.

National condition 2: NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution

The 2020 spending round confirmed the CCG contribution to the BCF will rise in actual terms by 5.3% to £4,263 billion. Minimum contributions to social care will also increase by 5.3%. The minimum expectation of spending for each HWB area is derived by applying the percentage increase in the CCG contribution to the BCF for the area to the 2020 to 2021 minimum social care maintenance figure for the HWB.

These minimum expectations will be published alongside the BCF planning requirements. HWBs should review spending on social care, funded by the CCG contribution to the BCF, to ensure the minimum expectations are met, in line with the national condition.

National condition 3: invest in NHS commissioned out-of-hospital services

BCF narrative plans should set out the approach to delivering this aim locally, and how health and local authority partners will work together to deliver it.

Expenditure plans should show the schemes that are being commissioned from BCF funding sources to support this objective.

National condition 4: plan for improving outcomes for people being discharged from hospital

This national condition requires areas to agree a joint plan to deliver health and social care services that support improvement in outcomes for people being discharged from hospital, including the implementation of the hospital discharge policy, and continued implementation of the High Impact Change Model for Managing Transfers of Care.[footnote 1]

Reporting of Delayed Transfers of Care was suspended in March 2020 and replaced with a situation report that reflects the revised hospital discharge policy. This data is currently only available nationally in an aggregated form at acute trust level. In 2021 to 2022, performance on discharge at a HWB footprint will be monitored using data collected from hospital systems through the NHS Secondary Uses Service (SUS), and used to inform support offers to systems.

The joint BCF plan should focus on improvements in the key metrics below:

1. reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days
2. improving the proportion of people discharged home using data on discharge to their usual place of residence

Further details on measuring discharge will be set out in the BCF planning requirements. Health and social care partners should continue to use the daily situation report data (using the published discharge information for 2021 to 2022) to understand progress in implementing effective discharge, and work with acute hospitals to identify information at local authority level and ensure discharge reporting is integrated into electronic patient records.

Metrics

Beyond this, areas have flexibility in how the fund is spent over health, care and housing schemes or services, but need to agree ambitions on how this spending will improve performance against the following BCF 2021 to 2022 metrics:

- Discharge Indicator Set (set out above)
- avoidable admissions to hospital
- admissions to residential and care homes
- effectiveness of reablement

Plans under national condition 4 (discharge) should describe how HWB partners will work with providers to improve outcomes for a range of discharge measures, covering both reductions in the time someone remains in hospital, and effective decision making and integrated community services to maximise a person's independence once they leave hospital.

Systems will be asked to set expectations for reductions in avoidable admissions (classified as the rate of emergency admissions for ambulatory sensitive conditions) and for metrics related to discharge from quarter 3.

Further details will be set out in the planning requirements.

Planning and assurance of BCF plans for 2021 to 2022

Plans will be developed locally in HWB areas by the relevant local authority and CCGs. Areas should look to align with other strategic documents such as plans for integrated care systems, and with wider programmes such as Ageing Well. BCF partnerships will need to submit a planning template, signed off by the HWB, that briefly sets out key changes to the BCF since 2020 to 2021, taking the COVID-19 pandemic into consideration. Plans will be assured and moderated regionally. There will be one round of assurance after which, plans deemed compliant by assurers at regional level will be put forward for approval. Further information will be set out in the BCF planning requirements for 2021 to 2022.

As the accountable body for the NHS element of the BCF, NHS England will focus its oversight on approval and permission to spend from the CCG ringfenced contribution particularly on plans linked to condition 4, having consulted the respective Secretaries of State for Health and Social Care and Housing, Communities and Local Government.

Local authorities are legally obliged to comply with section 31 grant conditions.

The BCF review

In 2018, and as part of the NHS Long Term Plan, the government committed to a review of the functioning and structure of the BCF to make sure it supported the integration of health and social care. The review included extensive stakeholder engagement and a review of evidence of the fund's performance, to better understand how the BCF impacted integration and to seek views on the future direction of the fund.

The review concluded that:

- the BCF as a mandated pooled budget scheme has been effective in encouraging and incentivising areas to work together more effectively, with 93% of areas saying that the BCF had improved joint working in their locality
- feedback from local areas suggested an imbalance between the NHS and local government influence, and that the mixed objectives and lack of effective measurements of integration had led to some confusion over aims of the BCF

The review recommendations included that:

- a fund should continue, as any attempt to remove or dismantle it would be a clear backward step on integration
- the NHS contribution to social care from the fund should be maintained
- there should be more clarity around the fund's policy aims and objectives. This is likely to be explored over the course of 2021 to 2022 with a view to incorporating changes in future years

The response to the COVID-19 pandemic has demonstrated how joint approaches between health, social care and the wider public sector, can help to improve the wellbeing of people even in the most difficult of circumstances. The government is keen to ensure those positive changes are built upon while also recognising that areas are at different stages of their journey towards better joint working.

While the BCF in 2021 to 2022 remains largely unchanged from previous years, to support ongoing response and recovery to COVID-19, the government recognises that upcoming changes on the horizon, such as the proposals set out in the Health and Care Bill, will likely impact longer-term system thinking and planning. The government will work with stakeholders to ensure future BCF arrangements support the proposals in the Health and Care Bill, outcomes from the Spending Review and explore with NHS England options to introduce incentives linked to improved discharge outcomes in each area, supporting local accountability for outcomes.

Future iterations of the BCF may require local areas to consider their response to upcoming changes as part of their strategic planning. This could take the form of:

- setting out an approach to integrated or joint commissioning, including developing a shared view of demand and capacity
- plans to help prevent the need for long-term services and to keep people out of hospital and independent in their own homes for as long as possible
- plans on how to stimulate the market, approaches to workforce management and development of asset based and community approaches to pricing to support delivery of quality and value in a sustainable market
- consideration of the guidance in:
  - the joint Local Government Association (LGA) and NHS Clinical Commissioners guide to Integrated Commissioning for Better Outcomes (https://www.local.gov.uk/icbo)
  - the Institute of Public Care's guidance on place-based market shaping (https://ipc.brookes.ac.uk/docs/market-shaping/Place-based%20Market%20Shaping%20-%20co-ordinating%20health%20and%20social%20care.pdf) (produced in consultation with government, the LGA, the Association of Directors of Adult Social Services (ADASS) and the Care Provider Alliance)
  - the conclusions in the Care Quality Commission's Beyond Barriers report (https://www.cqc.org.uk/sites/default/files/20180702_beyond_barriers.pdf)

Local areas are not required to set out this detail in their 2021 to 2022 BCF plan, but may wish to do so in preparing the ground for greater integration and future BCF plans.

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1. This replaces the national condition from the 2019 to 2020 policy framework related to hospital discharge that required systems to set out detailed plans to reduce the rate of delayed transfers of care and make progress towards centrally set expectations for Delayed Transfers of Care.

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