Herefordshire Council

Agenda

Health and Wellbeing Board

Date:	**Monday 9 June 2025**
Time:	**2.00 pm**
Place:	**Conference Room 1 - Herefordshire Council, Plough Lane Offices, Hereford, HR4 0LE**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Ben Baugh, Democratic Services** Tel: 01432 261882 Email: Ben.Baugh2@herefordshire.gov.uk

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Agenda for the meeting of the Health and Wellbeing Board

Membership

Chair	Councillor Carole Gandy	Cabinet Member Adults, Health and Wellbeing, Herefordshire Council
Vice-Chair	Jane Ives	Managing Director, Wye Valley NHS Trust
Members	Stephen Brewster	Voluntary and Community Sector representative
	Jon Butlin	Assistant Director (Prevention), Hereford & Worcester Fire and Rescue Service
	Zoe Clifford	Director of Public Health, Herefordshire Council
	Ross Cook	Corporate Director for Economy and Environment, Herefordshire Council
	Kevin Crompton	Independent Chair, Herefordshire Safeguarding Adults Board
	Hilary Hall	Corporate Director for Community Wellbeing, Herefordshire Council
	Susan Harris	Director of Strategy and Partnerships, Herefordshire and Worcestershire Health and Care NHS Trust (representative of the Trust)
	Dr Mike Hearne	Herefordshire General Practice
	Councillor Jonathan Lester	Leader of the Council, Herefordshire Council
	David Mehaffey	Executive Director: Strategy, Health Inequalities and Integration - NHS Herefordshire and Worcestershire Integrated Care Board
	Councillor Ivan Powell	Cabinet Member Children and Young People, Herefordshire Council
	Christine Price	Chief Officer, Healthwatch Herefordshire
	Tina Russell	Corporate Director for Children and Young People, Herefordshire Council
	Superintendent Helen Wain	Superintendent, West Mercia Police

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

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

3. DECLARATIONS OF INTEREST

To receive any declarations of interest from members of the board in respect of items on the agenda.

4. MINUTES

To receive and approve the minutes of the meeting held on 17 March 2025.

HOW TO SUBMIT QUESTIONS

The deadline for the submission of questions for this meeting is 5.00 pm on Tuesday 3 June 2025.

Questions must be submitted to councillorservices@herefordshire.gov.uk

Questions sent to any other address may not be accepted.

Accepted questions and the responses will be published as a supplement to the agenda papers prior to the meeting. Further information and guidance is available at www.herefordshire.gov.uk/getinvolved

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any accepted written questions from members of the public.

6. QUESTIONS FROM COUNCILLORS

To receive any accepted written questions from councillors.

7. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) SUMMARY 2024 9 - 84

The board is asked to note formally the publication of the 2024 Joint Strategic Needs Assessment (JSNA) Summary, which collates the latest strategic level understanding of the health and wellbeing needs of Herefordshire's population. It also aims to ensure the JSNA is used to inform the strategic planning and commissioning of relevant services pertinent to addressing the building blocks of good health and wellbeing by the council, NHS and other stakeholders.

8. NHS FIVE YEAR JOINT FORWARD PLAN UPDATE FOR 2025/26 85 - 178

NHS partners (Integrated Care Boards (ICB) and all NHS Trusts in the ICB's geography) are required to produce a Five-Year Joint Forward Plan (JFP). The Health and Wellbeing Board is asked to reconfirm its endorsement of the refreshed plan given the updates that have been included in 2025/26 iteration, and to agree any amended wording to its supporting opinion as necessary.

9.	**VERBAL UPDATE ON NATIONAL CHANGES OF INTEGRATED CARE BOARDS** There is currently a national programme, initiated by the Department of Health and Social Care (DHSC) and NHS England, to reduce the scope of responsibilities for Integrated Care Boards (ICBs), and subsequently the size of the organisations. This initiative will require NHS Herefordshire and Worcestershire Integrated Care Board to reduce it's running costs by 43% from the 2024/25 outturn, by the end of the 2025/26 financial year. A verbal update on the latest position regarding this work will be provided at the meeting.	Verbal Report
10.	**UPDATE TO THE BOARD ON THE GOOD MENTAL WELLBEING THROUGHOUT LIFETIME IMPLEMENTATION PLAN** To provide an update on the progress of the implementation plan for the board's strategic priority of 'Good Mental Wellbeing (GMW) throughout Lifetime'.	179 - 208
11.	**HEREFORDSHIRE SUICIDE PREVENTION STRATEGY** The Herefordshire Suicide Prevention Strategy is brought to the attention of the board for information.	209 - 234
12.	**BETTER CARE FUND (BCF) REPORTING 2024-2025** To review and approve the Better Care Fund (BCF) reporting for 2024/2025.	235 - 302
13.	**HEREFORDSHIRE'S BETTER CARE FUND (BCF) PLAN 2025-26** To update Health and Wellbeing Board members on Herefordshire's Better Care Fund (BCF) Plan 2025/26 and seek formal Health and Wellbeing Board approval.	303 - 340
14.	**WORK PROGRAMME** To consider the work programme for the board.	341 - 342
15.	**DATE OF NEXT MEETING** The note the date of the next scheduled board meeting in public, Monday 15 September 2025, 2.00 pm.	

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You have a right to:

- 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.
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- 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. The council's constitution is available at www.herefordshire.gov.uk/constitution
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Bus maps are available here: www.herefordshire.gov.uk/downloads/download/78/bus_maps

Herefordshire Council

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 and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

AGENDA ITEM 7

Herefordshire Council

Title of report: Joint Strategic Needs Assessment (JSNA) Summary 2024

Meeting: Health and Wellbeing Board

Meeting date: Monday 9 June 2025

Report by: Director of Public Health, Intelligence Unit Team Leader

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

The board is asked to note formally the publication of the 2024 Joint Strategic Needs Assessment (JSNA) Summary, which collates the latest strategic level understanding of the health and wellbeing needs of Herefordshire's population. It also aims to ensure the JSNA is used to inform the strategic planning and commissioning of relevant services pertinent to addressing the building blocks of good health and wellbeing by the council, NHS and other stakeholders.

Recommendation(s)

That:

a) The board notes formally the publication of the 2024 JSNA Summary (Appendix 1) as the shared understanding of the overall health and wellbeing needs of Herefordshire;

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

c) Board members agree to facilitate the effectiveness of the JSNA by ensuring the JSNA Summary is used within their organisations and other system networks, and

d) Board members agree to engage with the JSNA Strategic Partnership Group to develop a joint intelligence forward plan.

Further information on the subject of this report is available from
Zoe Clifford, email: zoe.clifford@herefordshire.gov.uk or
Charlotte Worthy, email: charlotte.worthy@herefordshire.gov.uk

Alternative options

1. There are no alternative options. Herefordshire Council and the Integrated Care Board have a joint statutory responsibility to produce a JSNA on behalf of the Health and Wellbeing Board.

Key considerations

2. It is a statutory requirement for a JSNA to be produced on behalf of the Health and Wellbeing Board. The JSNA provides an evidence base to inform the priorities of the board, and service planning and commissioning decisions of stakeholders. Local areas are free to choose the JSNA approach and outputs which best meet their local circumstances.

3. The goal of the JSNAs is to identify health and social care needs in Herefordshire that can be met or be influenced by the local authority in collaboration with the NHS and other partners. This will includes addressing the wider factors (social determinants) that affect health outcomes, as well as by addressing health and social care needs directly.

4. Herefordshire's JSNA is formed of three parts:

   a. a range of overarching strategic documents, including the three-year JSNA Summary, the ten-year Health and Wellbeing Strategy, the Integrated Care Strategy and the annual Director of Public Health reports.

   b. topic-specific needs assessments to provide the detail needed for service-level commissioning decisions, and

   c. monitoring and surveillance information to inform ongoing operational decisions.

5. The three-yearly summary provides an overview of the latest understanding of the overall health outcomes of Herefordshire's population and the factors that affect them. It is designed to be a shared resource for all stakeholders, providing high level insights and signposting to more detailed work as envisaged by our partners.

6. The 2024 Summary starts with the context of current and future demographics, before looking at the conditions that people live with and what they die from, and the extent of the lifestyle risks that affect both. It then covers aspects specific to different stages of life: children and young people, adults and ageing well.

7. Some of the main messages from the 2024 JSNA Summary are described in the following paragraphs (numbered 8 to 20)

8. Overall health outcomes are good compared to England: Herefordshire was either similar to or significantly better than the national value on 90% of indicators on the Public Health Outcomes Framework (PHOF) as of November 2024. Areas for improvement included coverage of some national vaccination and screening programmes.

9. Herefordshire's rurality and demographics are two fundamental factors which influence most aspects of life and providing services in the county. 190,000 residents are scattered over a relatively large rural area (2,180 square kilometres) largely reliant on a network of B and C roads. The average age of the population was 48 according to the 2021 Census, compared to 40 nationally, and to 44 in 2011.

10. The population structure has been getting older for many years: 26% of residents were over 65 in 2023, compared to 19% in 2001. This has been mainly driven by the natural ageing of the post war 'baby boom' generation and will continue with those born in the 1960s.

11. The number of people aged 65+ and 85+ increased by 21% between 2013 and 2023, compared to a 3% growth in the total population. If recent demographic trends were to continue (not taking account of any future house building targets), total population growth

would be another 3% by 2041: around 600 people a year. The natural ageing of the existing population structure means that there will continue to be a disproportionate increase in the number of older people.

12. Healthy life expectancy has not kept up with improvements in overall life expectancy in recent decades either nationally or locally, meaning that people are spending more years of lives in (self-defined) poor health: with 2021-23 estimates suggesting 20 years for females and 16 for males in Herefordshire.

13. The biggest risk factors for poor health are high blood pressure, smoking and being overweight. There are currently substantial numbers of people in these categories: 35,700 GP patients with diagnosed hypertension (18%), 15,700 adult smokers (10%) and two-thirds of adults being overweight.

14. The risk of poor health and living with long-term conditions increases with age, so even if overall prevalence were to remain the same, the ageing of the population structure could mean 3,000 more patients living with one of the Integrated Care System priority long-term conditions by 2031 (diabetes, heart failure, asthma and chronic obstructive pulmonary disease - COPD).

15. Mental wellbeing is an important protective factor for good health. In 2023, almost 60% of Herefordshire adults had "good" mental wellbeing, but 25% had high anxiety levels. Resilience is critical to being able to cope with life's difficulties, but only 24% of primary and 13% of older pupils had a high resilience score (based on answers to what they do if something goes wrong or if they don't succeed).

16. Cancer and circulatory disease are the two biggest causes of death, accounting for half of the 2,400 deaths in 2023. Increasing proportions are recorded as due to conditions normally associated with old age, for example dementia, Alzheimer's, Parkinsons and frailty. One fifth of Herefordshire deaths between 2001 and 2023 were classified as avoidable – either through effective treatment or prevention. Males account for two-thirds of preventable deaths.

17. The Health Foundation liken "building a healthy society to constructing a sturdy building: to succeed, we need all the right building blocks in place. When we don't have what we need to heat our homes or buy healthy food, for example, and are constantly worrying about making ends meet, it can lead to chronic stress, poor health and lives being cut short." Models of health outcomes suggest that collectively, socio-economic and environmental factors are equally as important in determining health outcomes as health behaviours and clinical care.

18. Considering the strengths and challenges in relation to the wider determinants of health in Herefordshire (see p. 58 of Appendix 1):

    a. The county is rich in nature with good access to green space, communities are strong and resilient, and generally safe places to live

    b. On the other hand, its geography presents barriers to providing and accessing services, and to economic growth. With a higher proportion of large, old homes than nationally, the nature of the housing stock means that many are difficult and expensive to heat. Excess cold is the biggest housing-related risk to health.

    c. Herefordshire also faces many of the same challenges as other areas in terms of healthy behaviours and financial security and is affected by the same drivers as nationally in terms of economic activity and education. For example, although below national rates, unemployment remains higher than before the pandemic and cost of living crisis. In the 2021 census, more 16- to 64-year-olds weren't working due to ill-health or disability (4,900) than because they couldn't find a job (3,500).

    d. Furthermore, the structure of the local economy is very different, for example higher employment in manufacturing and agriculture. This impacts on earnings and the types of jobs available to local people. In 2023, average weekly earnings were £540, compared

to £620 in England. This is the main driver of the long-standing issue of housing affordability, with average house prices almost 10 times higher than average earnings.

19. Inequalities in health outcomes for different groups of people are highlighted throughout the 2024 JSNA Summary.

    e. The ultimate inequality is in life expectancy. Females born in the most deprived areas of Herefordshire can expect to live 4.0 years fewer than those in the least deprived; males 5.4 years. They are also more likely to be living with a long-term condition or in bad health.

    f. Lifestyle risk factors such as smoking and excess weight are more common amongst people living in the most deprived areas, and protective factors such as good mental wellbeing, good work and digital inclusion are less common.

20. The JSNA Summary also includes summaries of detailed work on the following topics undertaken since 2021:

    a Children with special educational needs and disabilities (SEND)

    b Mental health

    c Smoking

    d Substance misuse

    e Sexual health

    f Domestic abuse

    g Unpaid carers

    h Armed Forces personnel and veterans

    i Falls prevention

21. The 2024 JSNA Summary has been published on the Understanding Herefordshire website, and a programme of presentations to key groups or meetings is underway (see appendix 2). Board members are invited to identify any further strategic opportunities to share the findings and are asked to disseminate the report and messages through their own organisational channels.

22. A JSNA Strategic Partnership was established in 2024, to deliver an improved JSNA process and outputs following a review in 2023. It includes officers in strategic roles from partner organisations. The group's priority for 2025 is to identify and agree our approach to keeping the JSNA up to date and implementing the actions identified. By engaging with this group, Health and Wellbeing Board member organisations can help ensure that Herefordshire's JSNA is as effective and up to date as possible.

Community impact

23. The JSNA provides an overview of the main 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.

24. The constitutions of Herefordshire Council, Herefordshire and Worcestershire Integrated Care Board and the NHS all include commitments to transparency, accountability and principles of

good corporate governance. Being clear about the reasons for decisions is an important element of these shared principles and the JSNA contains this underpinning evidence.

25. 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.

26. One of the main purposes of the JSNA process is to highlight inequalities between different groups of people, and this includes children and young people with experience of the care system where information is available. Doing so will enable other services to understand the inequalities and work to address them.

Environmental impact

27. As well as health outcomes directly, the JSNA is about understanding the wider determinants of health and wellbeing: the building blocks to good health. This includes the environment in which people live.

28. The 2024 JSNA Summary includes information on environmental measures such as access to green space, climate change, sustainability and transport. The intention is to provide partners with a holistic view of wider health and wellbeing needs, to inform joint strategic decisions.

Equality duty

29. The Public Sector Equality Duty which came into force on 5 April 2011 requires the Council to consider how it can positively contribute to the advancement of equality, good relations and demonstrate that it is paying 'due regard' in our decision making in the design of policies and in the delivery of services.

30. One of the purposes of the JSNA is to highlight existing inequalities across various sections of the community, to inform the commissioning of services that are equitable and accessible for all residents with the aim of reducing health inequalities.

31. The JSNA includes information about numbers of people in Herefordshire with protected characteristics, which provides a benchmark to which services can compare their customers. For example, according to the 2021 Census:

- 16,600 residents (9%) identified as being of an ethnic background other than 'white British'.

- 34,800 residents (19%) had a long term condition which would qualify as being disabled under the Equality Act 2010.

32. As described above (paragraph 18), the 2024 summary highlights the poorer health outcomes and higher likelihood of risk factors experienced by people living in the most deprived areas of Herefordshire.

33. It also identifies health inequalities between the sexes, with males having a shorter life expectancy and being more likely to die prematurely (before the age of 75) than females, particularly due to cancer and cardiovascular disease (CVD). Males are also three times more likely than females to die by suicide.

Resource implications

34. The recommendations have no direct financial implications, but the JSNA process is intended to play a significant role in guiding the allocation of resources by all partners in their strategic priority setting and commissioning plans.

Legal implications

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

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

37. 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. Statutory Guidance indicates that although there is not prescribed period for this to be reassessed, however Health and Wellbeing Boards need to assure themselves that their priorities are up to date to inform commissioning plans.

38. 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

39. 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.

40. 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.

41. Lack of partner engagement or data sharing may impact the completeness and timeliness of the JSNA. This can be mitigated by ongoing collaboration through the Health and Wellbeing Board and formalised data-sharing arrangements will support a comprehensive and regularly updated JSNA.

42. The risks associated with the publication and use of the JSNA Summary 2024 have been identified and are being managed in line with the council's Risk Management Strategy. Ongoing oversight through the Health and Wellbeing Board ensures appropriate governance, monitoring, and escalation to maintain a reliable evidence base for strategic planning and resource allocation.

Consultees

43. One Herefordshire Partnership members were consulted on the structure of the 2024 JSNA Summary before the content was written, to ensure that it reflected their needs as users of the insights.

44. Advice was sought from commissioners and service leads throughout the process of drafting the summary, and interpretation was checked with relevant leads for individual topics.

45. A complete draft was shared with the above stakeholders before publication, and amendments made accordingly.

Appendices

Appendix 1 Herefordshire Joint Strategic Needs Assessment Summary 2024

Appendix 2 JSNA Summary 2024 presentation for Health and Wellbeing Board, June 2025 (to follow)

Background papers

None identified.

Understanding Herefordshire
People and places

.

Herefordshire Joint Strategic Needs Assessment Summary 2024

Herefordshire Council Intelligence Unit

January 2025

Version 1.1 (amendments April 2025)

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Version control log

Version number	Status	Date issued	Description of change	Page number
1.0	Issued	30 Jan 2025	First published	
1.1	Issued		Correction to statement about drug related deaths	45
1.1	Issued		Change to clarify that earnings figure is weekly median	57
1.1	Issued		Correction to statement about access to green space	59
1.1	Issued		Hyperlinks added to recently published source documents: mortality and unpaid carers	28 & 51

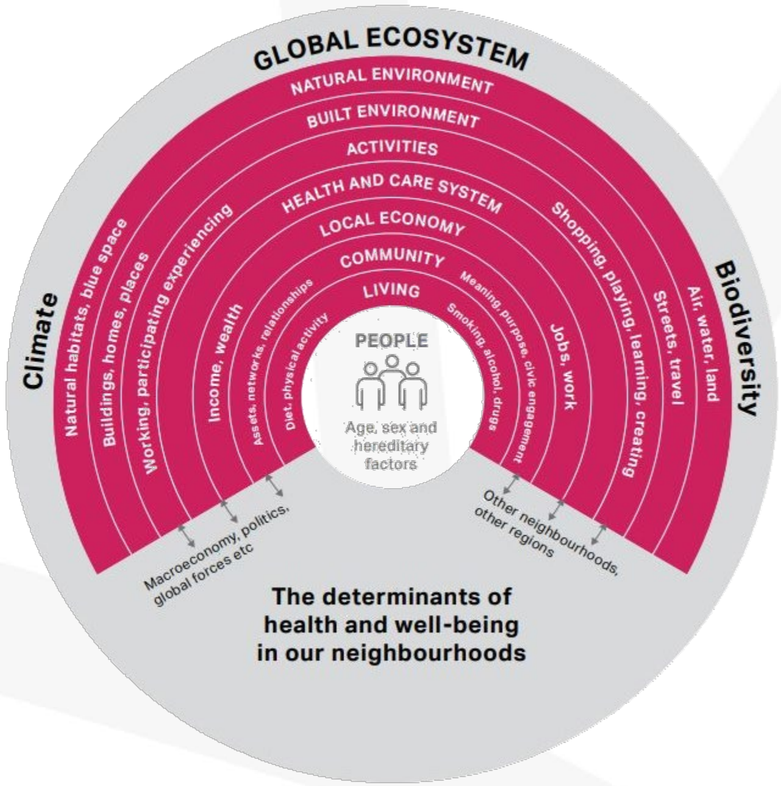
Section 1: Introduction

‘Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact. The determinants of health include:

- The social and economic environment,
- The physical environment, and
- The person’s individual characteristics and behaviours.’

World Health Organization, October 2024

This report summarises the latest understanding about the overall health outcomes of Herefordshire’s population and the factors that affect them. Starting with the context of current and future demographics, it looks at the conditions that people live with and what they die from, and the extent of the lifestyle risks that affect both. It then covers aspects specific to different stages of life: children and young people, adults and ageing well.



Source: Future of London, adapted from Dahlgren and Whitehead (1991).

What is Herefordshire's Joint Strategic Needs Assessment?

Welcome to Herefordshire's Joint Strategic Needs Assessment (JSNA) Summary 2024, produced by Herefordshire Council's Intelligence Unit on behalf the Health and Wellbeing Board (HWBB) as a resource for all those working to improve the health and wellbeing of Herefordshire residents.

The council and local NHS Integrated Care System (ICS) have a statutory duty under the Health and Social Care Act 2012 to produce a JSNA, which should reflect our local circumstances. In Herefordshire, the JSNA process is made up of routine monitoring, a rolling programme of needs assessments, and overarching documents, including this three-yearly summary.

The JSNA is a continuous process of assessment of the current and future health and social care needs of the local community that can be influenced by the council, NHS and local partners. It addresses those areas where Herefordshire is significantly different to nationally, where things have changed recently, or which were identified in the Joint Local Health and Wellbeing Strategy 2023 - 2033 (JHWBS) as priorities for attention (see p.6).

The JSNA covers the wider building blocks of health that impact on our communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. It looks at the whole population, ensuring that mental health receives equal priority to physical health and is an opportunity to bring together needs assessments and other important pieces of analysis which have taken place since the last JSNA summary in 2021, where possible placing them in the context of the latest published data.

This summary report of current, strategic level understandings of health and wellbeing in Herefordshire, together with the Understanding Herefordshire website that forms the wider JSNA evidence base, feeds into assessing need as part of strategic planning (see diagram). It is not intended to be a holistic summary of all aspects of life in the county.

Source: Commissioning cycle, NHS England.

Herefordshire in context

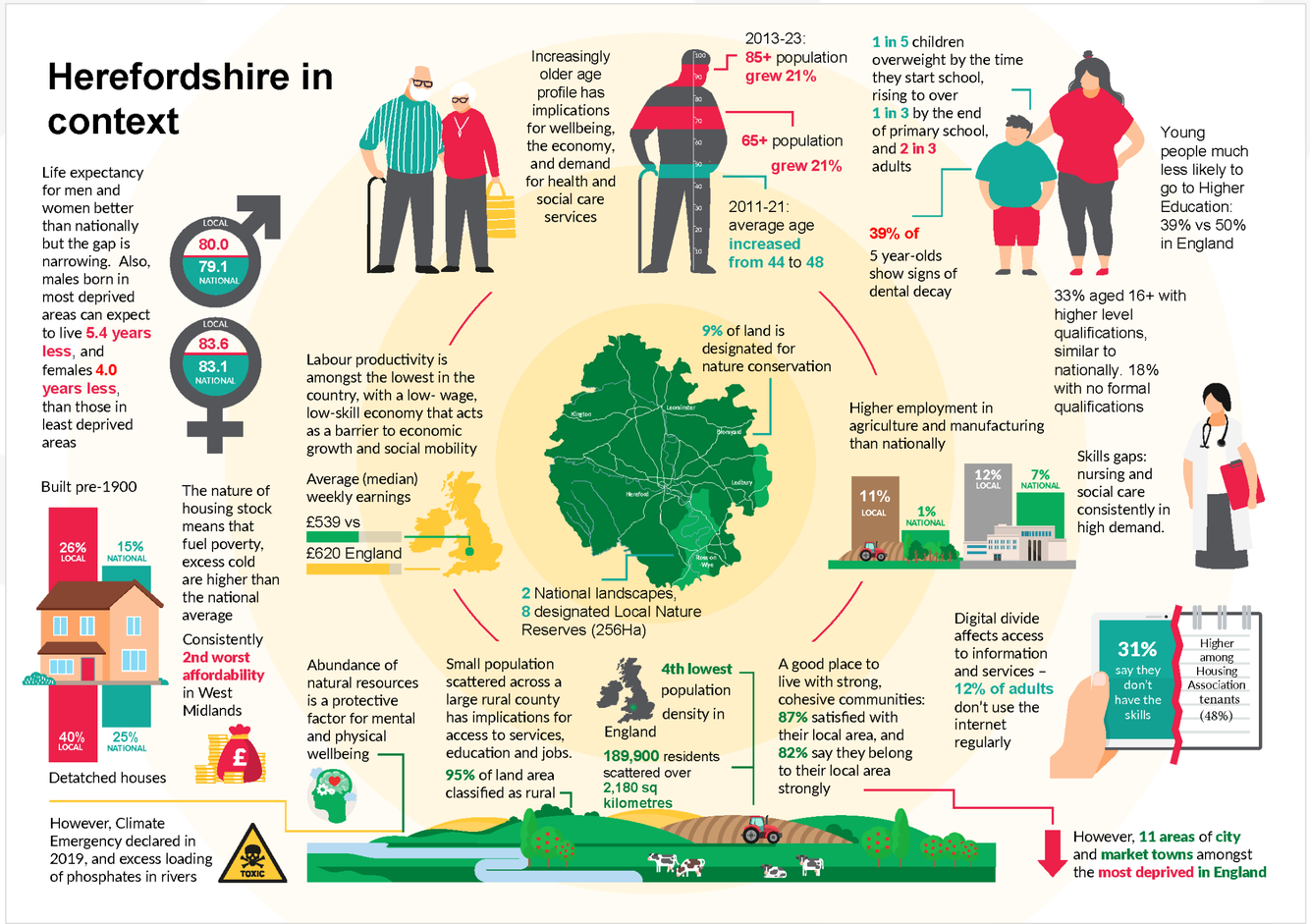
Herefordshire is characterised by its rurality and demography, both of which influence many of the other factors affecting life in the county. 189,900 residents are scattered across 2,180 square kilometres mainly reliant on a network of B and C roads, posing an almost unique challenge for providing services. The average age of 48 is eight years older than England's, and older age groups continue to grow disproportionately to the rest of the population.

The makeup of the economy influences the county's relatively low productivity and average earnings. This combined with the nature of housing stock (dominated by large, older properties) means that housing affordability is a long-standing issue, as is fuel poverty.

There is a strong sense of community and local identity, and the county is a nature-rich and attractive place to live, although the environment faces threats from climate change and pollution. Overall deprivation and poverty is relatively low compared to the rest of England, but there are persistent pockets in the city and market towns. Although life expectancy is better than nationally, the gap is narrowing and people born in the most deprived areas can expect to live at least four years less than other parts of the county.

Technology provides opportunities to make it easier for people to access services, and there has been significant investment in infrastructure to improve connectivity – but there is still a digital divide whereby some people are less likely than others to have the skills needed to use the internet.

Many of these topics are explored in more detail throughout this document.



Joint Local Health and Wellbeing Strategy 2023 to 2033: priorities and progress

The vision: ‘Good health and wellbeing for everyone’

The JHWBS sets out how the council and its local partners plan to address the health and wellbeing needs of the population. It is a key document that is jointly owned and promotes collective action to meet those needs.

Having taken into account the views and comments from residents and partners and what was known about the issues from the data, two core priorities of ‘best start in life’ and ‘good mental wellbeing across the life course’ were identified. These are underpinned by six supporting priorities and combine with shared principles and ambitions to work towards the vision of good health and wellbeing for everyone.

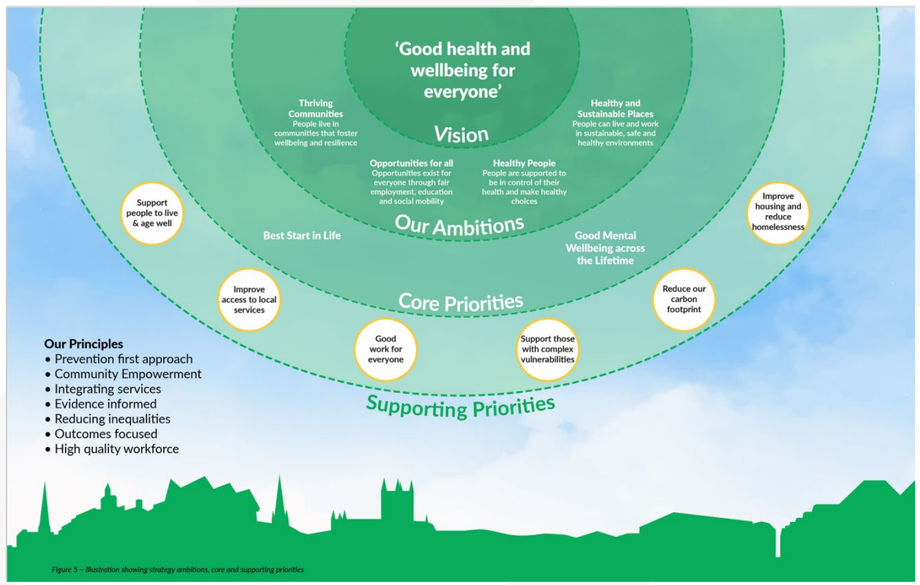


Figure 5 – Illustration showing strategy ambitions, core and supporting priorities

Source: JHWBS

Progress to date

A range of data are being used to measure the impact of the JHWBS and will be monitored by the HWBB. Many of these are covered in the relevant sections of this report. Progress during 2023-24 includes:

Best start in life

- 45 mainstream and 3 special educational settings (covering 1,700 children) actively participating in supervised tooth brushing every day.
- High numbers of new registrations for the Solihull parenting programme.
- Behavioural support and products offered to help reduce smoking in pregnancy.

Good mental wellbeing

- Implementation of the real time suicide surveillance system to bring organisations together, take a holistic view, monitor activity and take forward actions.
- Developing a personal, social, health and economic education (PSHE) toolkit within a partnership organisation that will form part of a healthy schools offer.
- Delivery of a children and young people’s survey to gather insights about our children and young people locally.

Herefordshire and Worcestershire Integrated Care Strategy

Integrated Care Systems (ICSs) are partnerships bringing together NHS organisations, local authorities and others to collectively plan services, improve health and reduce inequalities across local areas. They also have a role to play in improving population health through the wider determinants; health behaviours and lifestyles; and the places and communities that people live in.

The Herefordshire and Worcestershire (H&W) ICS has set out a vision of ‘working together to enable better health, fulfilment, and safety in our residents’ lives’. Its 2022 strategy identified three shared priorities, aligned to the health and wellbeing strategies of the two counties: providing the best start in life; living, ageing and dying well; and reducing ill-health and premature deaths from avoidable causes.

Recent good news stories

Reflecting the ambitions of the JHWBS, the majority of this JSNA summary focuses on challenges and areas for improvement.

However, there are plenty of positives; as evidenced by the fact that Herefordshire is doing equally as well as, or better than, England on 90% of Public Health Outcomes Framework (PHOF) measures (see p.9).

This page summarises some of the areas of service delivery which the council, NHS and partners can influence, and where Herefordshire is doing well currently, either in terms of recent improvement, or being better than nationally.

Coverage of NHS Health Checks improved significantly in 2023-24. Having been below England since 2019-20, both invitatations and receipt are now better than nationally. (see p.27)

The EHCP assessment process appeared to be working well locally. 77% of new EHCPs were developed within the 20 week national requirement in 2023, notably higher than the 50% nationally. (see p.37)

In 2023 Herefordshire Council was ranked as the top performing local authority in the West Midlands on sustainability action for the third year in a row. (see p.59)

Smoking in pregnancy has improved, falling from 14% in 2017-18 to 8% in 2023-24. Having been worse, it is now in line with England. (p.35)

There has been some sign of improvement in excess weight in the youngest children, with fewer overweight (including obese) when starting primary school in the last two years (2023 and 2024) than previously. (p.38)

The number of people sleeping rough in Herefordshire fell from an average of 19 on any given night in 2022-23 to 12 in 2023-24. (p.62)

Having been higher since 2018, the infant mortality rate fell back in line with England in the latest period (2020-22). (p.36)

Herefordshire is ranked highest nationally for the proportion of adult social care service users reporting that they had as much social contact as they would like (2022-23). (p.48)

Latest data (2022-23) show that, at 4.3%, the proportion of 16 to 17 year-olds who are not in education, employment or training (NEET) or whose status was unknown is lower than in England. (p.63)

Understanding inequalities and deprivation across Herefordshire

'Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.' (Place Based Approach on Health Inequalities, NHS England)

Inequalities can be experienced by groups of people who share common characteristics such as those protected under the Equality Duty, including age, gender, ethnic group, or disability. Geography and vulnerabilities like economic disadvantage are also over-lapping factors, with strong evidence of inequalities for people living in deprived areas.

The NHS is taking an approach termed 'CORE20 Plus Five' to tackle health inequalities. As explained in the Herefordshire & Worcestershire Inequalities Strategy 2023-2026, this means targeted action for:

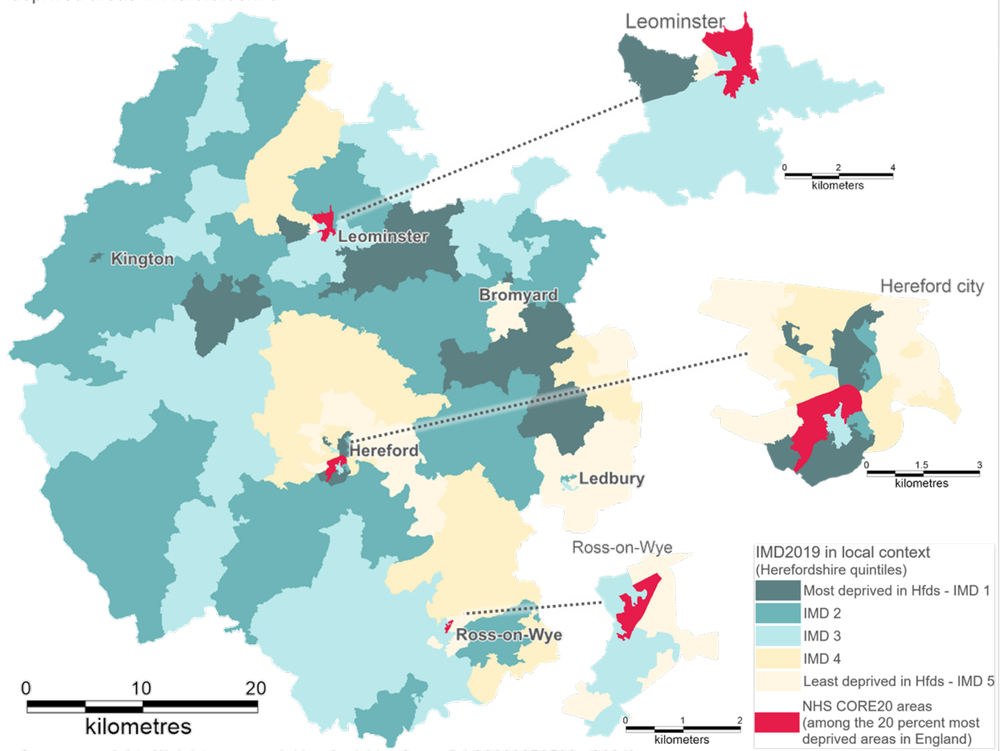
- People living in the nine areas of south Hereford, Leominster and Ross-on-Wye which are among the 20% most deprived in England ('CORE20').
- 'Plus' locally identified priority groups: rurally dispersed; travelling community; unregistered individuals.
- 'Five' key clinical areas: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension case finding, plus the overarching priority of smoking cessation.

Examples are highlighted by topic throughout this report, often referring to 'the most deprived areas of Herefordshire' and making comparisons between 'Index of Multiple Deprivation (IMD) quintiles', which rank 117 local areas (lower super output areas (LSOAs)) in order of overall deprivation and divide them into five equal groups (quintiles). A broader range of areas are included in the 'most deprived' than the CORE20 definition, covering parts of north Hereford, Bromyard and Kington, as well as Weobley and other rural areas (see map).

Find out more in Herefordshire Inequalities and Deprivation (2024), including profiles of the most deprived areas of the county and links to tools to explore variation and inequalities in more detail, such as the local health inequalities dashboard.

Relative levels of deprivation across Herefordshire

Lower Super Output Areas by Index of Multiple Deprivation (IMD) 2019 quintiles, highlighting the 20% most deprived areas in Herefordshire



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ONS LSOA boundaries are reproduced with the permission of HMSO

Data source: English Indices of Deprivation, 2019. Ministry of Housing, Communities and Local Government. Last accessed 9 December 2024.

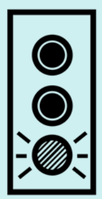
Section 2: Public Health Outcomes Framework indicators

This section outlines Herefordshire's performance on the whole range of Public Health Outcomes Framework (PHOF) measures: compared to England as a whole and in terms of recent trends.

Overall, in November 2024, Herefordshire was either the same or significantly better than England on 90% of comparable PHOF indicators.

The 10% where things were significantly worse in Herefordshire gives an indication of priority areas to focus on.

As of November 2024, there were 160 indicators in PHOF with values for Herefordshire.

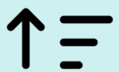


143 indicators were comparable to England:

- 48% significantly better
- 42% similar
- 10% significantly worse

79 indicators had a recent trend:

- 17% getting better
- 13% getting worse



Indicators that were significantly worse than England but recent trend is improving:

- Hospital admissions caused by unintentional and deliberate injuries in children
- PPV (pneumonia and meningitis for 65 years and older)

Indicators that were significantly worse than England and their recent trend is worsening:

- % of children achieving the expected level in communication skills at 2 to 2½ year-olds
- % of children achieving the expected level in personal social skills at 2 to 2½ year-olds

Indicators that were significantly better than England but recent trend is worsening:

- Children in absolute low income families
- Cancer screening: breast cancer, cervical cancer (aged 25 to 49)

Public Health outcomes summary

The PHOF is a nationally defined set of measures of population health. It helps local authorities, like Herefordshire, and health and care partners compare outcomes with other areas and track changes over time.

The framework includes two overarching indicators:

- Life expectancy (length of life)
- Healthy life expectancy (length of life spent in good health)

These are supported by indicators across four additional domains:

- Wider determinants of health
- Health improvement
- Health protection
- Healthcare and premature mortality

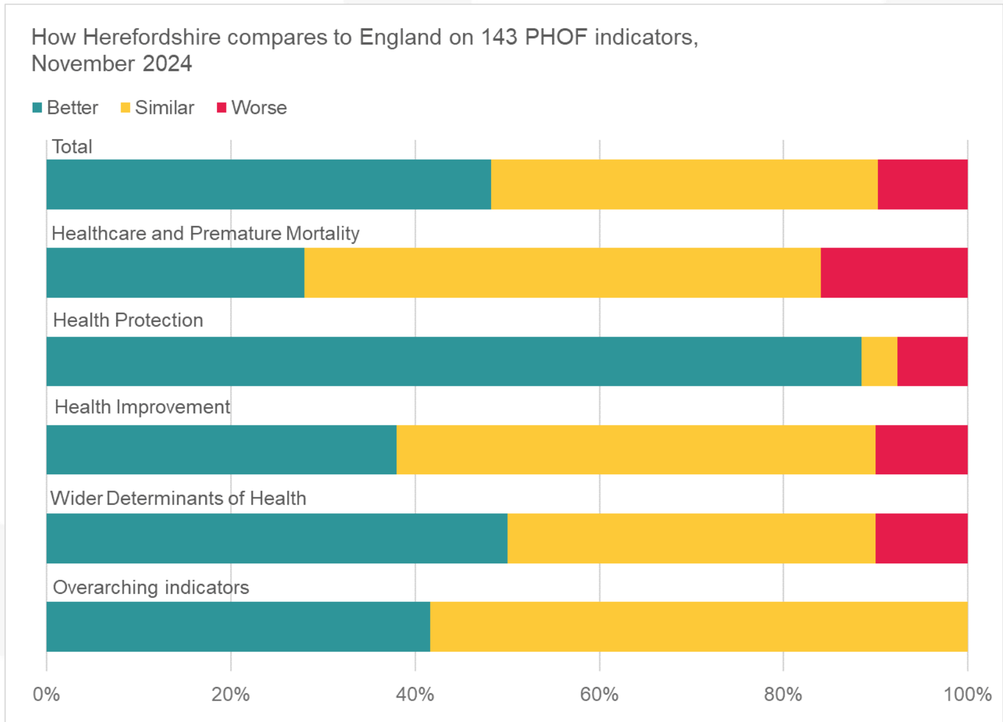
In November 2024, the PHOF comprised 160 indicators with data relating to dates after 2019 (see note). Herefordshire could be compared to England for 143 of these, and was:

- Better on 48%
- Similar on 42%
- Worse on 10%

The figure opposite illustrates how these are spread across the five domains.

It should be noted that because the PHOF relies on published data covering at least a whole year, there is often a lag compared to real-time insights from local operational data. This loss of timeliness is a common trade-off of having robust data to benchmark against other areas for strategic analysis.

Note: it also included seven indicators which had not been updated with data more recent than 2019, which have been excluded from this analysis, and ten indicators for which data was available for England but not Herefordshire.



Source: Herefordshire Council analysis of PHOF. Fingertips, Department of Health and Social Care (DHSC). Last accessed 18 November 2024.

Herefordshire outcomes that are better than England, or have an improving trend

This page and the next list the PHOF indicators where Herefordshire was performing well, or where the recent trend was improving, according to the data as of November 2024.

Of the 143 indicators comparable to England, Herefordshire was performing significantly better on 48% (69 out of 143).

Of the 79 indicators that had a recent trend calculated, 14 were showing improvement (either increasing or decreasing and getting better).

These indicators can be explored on the Department of Health and Social Care (DHSC) Fingertips website.

Note: three indicators (children in absolute poverty and screening coverage for breast and cervical cancer) were significantly better than England, but had a worsening recent trend - so they also appear on the next page.

Overarching indicators	Recent Trend
Life expectancy at birth (male and female)	-
Life expectancy at 65 (male and female)	-
Disability-free life expectancy at 65 (female)	-
Wider determinants of health	
Children in low-income families (all dependent children under 20)	➡
Children in absolute low-income families (under-16s)	⬆
School readiness: children achieving the following at the end of Reception: - A good level of development at the end of Reception - At least the expected level in communication and language skills at the end of Reception - At least the expected level of development in communication, language and literacy skills at the end of Reception	-
16 to 17 year-olds not in education, employment or training (NEET) or whose activity is not known	⬇
Gap in the employment rate between those with a physical or mental long-term health condition (aged 16 to 64) and the overall employment rate	-
Population with a physical or mental long-term health condition in employment (aged 16 to 64)	-
Percentage of people in employment	➡
Sickness absence: employees who had at least one day off in the previous week, - working days lost due to sickness absence	-
Killed and seriously injured (KSI) casualties on England's roads	➡
Violent crime: hospital admissions for violence (including sexual violence)	-
Rate of complaints about noise	➡
Homelessness: households in temporary accommodation	-
Social isolation: adult social care users who have as much social contact as they would like (18+)	-

Key for PHOF indicators section:

- Trend could not be calculated ➡ No significant change ⬆/⬇ Increasing/decreasing and getting better ⬆/⬇ Increasing/decreasing and getting worse

Health Improvement	Recent Trend
Baby's first feed breastmilk	-
Breastfeeding prevalence at 6 to 8 weeks	➡
Proportion of New Birth Visits (NBVs) completed within 14 days	➡
Emergency hospital admissions for intentional self-harm	⬇
Adults meeting the 'five-a-day' fruit and vegetable consumption recommendations (new method)	-
Proportion of the population meeting the recommended 'five-a-day' on a 'usual day' (adults) (old method)	-
Admission episodes for alcohol-related conditions (narrow) (male and female)	⬇
Cancers diagnosed at stages 1 and 2	➡
Cancer screening coverage: breast cancer, cervical cancer (ages 25 to 49)	⬇
Cancer screening coverage: bowel cancer	⬆
Abdominal aortic aneurysm screening coverage	➡
New-born hearing screening coverage	➡
New-born and infant physical examination screening coverage	-
Eligible population aged 40 to 74 offered an NHS Health Check	-
Emergency hospital admissions due to falls in people aged 65 and over, 65 to 79, 80 plus	➡
Health Protection	
New sexually-transmitted infection (STI) diagnoses (excluding chlamydia aged under 25) per 100,000	➡
Population vaccination coverage: PCV childhood vaccine against pneumonia and meningitis, HPV vaccination against some cancers including cervical cancer, two doses (13 to 14 yr-olds, female)	⬆
Population vaccination coverage: Infants (under 2 yrs) - Dtap IPV Hib HepB (1 yr), MenB (1 yr), Rotavirus (1 yr) Pre-schoolers (2 to 5 yrs) - Dtap IPV Hib HepB (2 yrs), MenB booster (2 yrs), MMR for one dose (2 yrs), PCV booster, Flu (2-3 yrs), Hib and MenC booster (2 yrs), DTaP and IPV booster (5 yrs), MMR for one dose (5 yrs), MMR for two doses (5 yrs) School-going children - Flu (primary school), HPV vaccination coverage for one dose (12 to 13 year-olds, female), Meningococcal ACWY conjugate vaccine (14 to 15 year-olds) Adults and at-risk groups - Flu (at risk individuals), Flu (aged 65 and over)	➡
Population vaccination coverage: HPV vaccination against some cancers including cervical cancer: one dose (12 to 13 year-olds, male) and two doses (13 to 14 year-olds, male)	-
Adjusted antibiotic prescribing in primary care by the NHS	-
Healthcare and premature mortality	
Under-75 mortality rate from: causes considered preventable, cancer, cancer considered preventable, liver disease, liver disease considered preventable	-
Premature mortality in adults with severe mental illness (SMI)	-
Excess under-75 mortality rate in adults with severe mental illness (SMI)	-

Herefordshire outcomes that perform worse than England, or have a worsening trend

The page lists the 15% of PHOF indicators (22 of 143) where Herefordshire performs worse than England according to the data as of November 2024, along with those performing similar or better but showing a worsening trend. It identifies areas for targeted public health efforts.

Note that for some of these indicators more recent published data indicate an improvement (for example homeless households and Health Checks), which is covered in the detail of the JSNA.

These indicators can be explored on the Department of Health and Social Care (DHSC) Fingertips website.

Note: three indicators (children in absolute poverty and screening coverage for breast and cervical cancer) were significantly better than England, but had a worsening recent trend - so they also appear on the previous page.

Indicator	Recent Trend	Period	Count	Rate	Spine Chart
Adults with a learning disability who live in stable and appropriate accommodation	-	2022/23	347	72.3%	
Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate	-	2020/21		72.6	
Households owed a duty under the Homelessness Reduction Act	-	2022/23	1,328	15.4	
% of children achieving the expected level in communication skills at 2 to 2½ years	↓	2023/24	1,148	81.8%	
% of children achieving the expected level in personal social skills at 2 to 2½ years	↓	2023/24		87.8%	
Hospital admissions caused by unintentional and deliberate injuries in children (under-15s)	↓	2022/23	245	87.0	
Eligible population aged 40 to 74 offered an NHS Health Check who received one	-	2019/24	13,779	32.8%	
Eligible population aged 40 to 74 who received an NHS Health Check	-	2019/24	13,779	24.1%	
Population vaccination coverage: PPV (pneumonia and meningitis for 65 years and older)	↑	2022/23	33,233	69.3%	
Population vaccination coverage: shingles (71 years)	→	2022/23	1,066	44.4%	
Percentage of five-year-olds with experience of visually obvious dental decay	-	2021/22		38.7%	
Emergency readmissions within 30 days of discharge from hospital	-	2022/23	3,620	17.7%	
Preventable sight loss: sight loss certifications	→	2022/23	116	61.5	
Estimated dementia diagnosis rate (aged 65 and older)	→	2024	1,880	56.9	
School readiness: children achieving the expected level in the phonics screening check (Yr 1)	↓	2022/23	1,469	78.6%	
Pupil absence	↑	2022/23	534,874	7.0%	
Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	↓	2023	14,741	75.0%	
Children in relative low-income families (under-16s)	↑	2022/23	5,938	19.7%	
Percentage of children achieving a good level of development at 2 to 2½ years	↓	2023/24	1,155	82.3%	
Children in absolute low-income families (under-16s)	↑	2022/23	4,512	15.0%	
Cancer screening coverage: breast cancer	↓	2023	17,797	67.7%	
Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	↓	2023	18,352	67.4%	

Herefordshire outcomes that have recently changed, or fluctuate in category

This page shows the 25 indicators for Herefordshire that have recently changed, or have fluctuated between categories of better, similar, or worse compared to England.

These indicators are those of temporary, rather than stable change, and or values that regularly border two categories.

A detailed list of these indicators is available on the DHSC Fingertips website.

Overarching Indicators	Reasons to Monitor Indicator
Healthy life expectancy at birth (male)	Was better than England before 2015/17
Wider Determinants of Health	
School readiness: Children with free school meal status achieving the expected level in the phonics screening check in Year 1	Worse than England before 206/17
First time entrants to the youth justice system	Worse than England until two years ago
Adults in contact with secondary mental health services who live in stable and appropriate accommodation	Fluctuating between better and worse
Gap in the employment rate between those who are in receipt of long-term support for a learning disability (aged 18 to 64) and the overall employment rate	Fluctuating between worse and similar
Adult carers who have as much social contact as they would like (18+ years)	Worse than England before 2020/21
Health Improvement	
Smoking status at the time of delivery	Worse than England before 2022/23
Proportion of New Birth Visits (NBVs) completed within 14 days	Worse than England before 2022/23
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years)	Fluctuating between better, similar, and worse in the last four years
Physically inactive adults (19+)	Fluctuating between better and similar
Successful completion of drug treatment: opiate users, non-opiate users	Fluctuating between similar and worse
Adults with substance misuse treatment need who successfully engage in community based structured treatment after release from prison	Fluctuating between similar and worse
Eligible population aged 40 to 74 offered an NHS Health Check	Fluctuating between better and worse
Percentage reporting a long-term musculoskeletal (MSK) problem	Fluctuating between similar and worse
Health Protection	
Chlamydia detection rate per 100,000 aged (15 to 24) (male and female)	Lower than England since 2021, but not possible to determine whether this is a good thing or a bad thing (see p.46 for discussion)
Population vaccination coverage: Meningitis B booster (2 yrs), Flu (above 65 yrs)	Worse than England before 2020/21
Healthcare and Premature Mortality	
Infant mortality rate	Fluctuating between similar and worse
Under-75 mortality rate from: liver disease, respiratory disease, respiratory disease considered preventable	Fluctuating between better and similar
Preventable sight loss: age related macular generation (AMD), diabetic eye disease	Fluctuating between similar and worse

Section 3: Population

Current and future demographics shape demand for all public services. With an increasingly older population, this is particularly relevant for health and social care services.

This section covers the profile of Herefordshire's population and the drivers of recent change. It also considers what is likely to happen in the near future, taking account of recent trends and planned levels of house building.

Current population (2023):

- 189,900 residents
- 194,500 registered GP patients

Recent population growth:

1,300 a year (2020 to 2023). Driven by migration.

Ethnicity:

91% white British. Of the 16,600 (9%) of a different ethnicity, 9,500 are 'white: other' (5% of total) (2021).

43% live in the **most rural** 'village and dispersed' areas (2022).

Age profile (2023):

- 16% under 16 (30,200)
- 57% 16 to 64 (109,000)
- 27% 65+ (50,700)

Future population growth:

Projections (based on long-term demographic trends, not including housing targets) suggest a 3% increase between 2023 and 2031 (average of 600 people per year).

Total population

189,900 residents in 2023 live across 2,180 square kilometres

Official population estimates from the Office for National Statistics (ONS) put Herefordshire as one of the 25% smallest local authorities in England. On the other hand, it is one of the biggest geographical areas. With 87 persons per square kilometre, it has the fourth lowest population density of all English upper-tier local authorities. Only Westmorland and Furness (60), Northumberland (65) and North Yorkshire (78) are less densely populated.

Neither population density, nor the proportion living in rural areas (53%), adequately illustrates quite how scattered the population is. No other English county has a greater proportion of its population living in areas with fewer than 50 people per square kilometre (described as 'very sparse'). This presents particular challenges for service delivery in the county.

Population growth was slower in the last ten years than both nationally and the previous decade. Between 2013 and 2023, the total population grew by 3% (from 184,700) compared to 7% across England and Wales as a whole. Between 2003 and 2013 it had grown by 5%. This was due to factors such as a declining birth rate, an ageing population, and lower levels of net migration (see p.17).

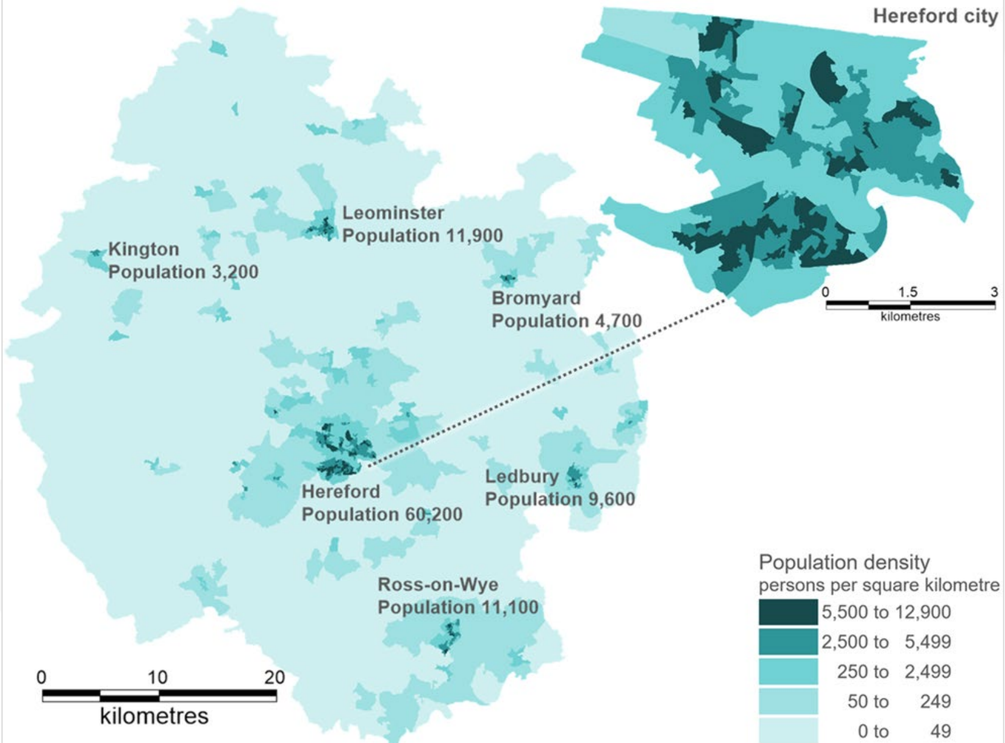
The difference between resident and registered population

Official population estimates are based on a definition of 'usual residence', with people counted at their main family home. The exception is students, who are counted at their term-time address. People are counted as a migrant to the UK if they intend to stay for a year or more, so short-term seasonal workers are not included in the resident population.

However, many health statistics, for example disease prevalence, are based on patients who are registered with a GP surgery in the county, which for various reasons can be different. In 2023 the Herefordshire registered population was 194,500, compared to the resident population of 189,900.

Population density across Herefordshire

Population density by square kilometre of Lower Super Output Areas (LSOAs) in Herefordshire, mid-2022



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ONS LSOA boundaries are reproduced with the permission of HMSO

Data source: Mid-2022 population estimates for small areas, Office for National Statistics. Last accessed 19 March 2024.

Population growth and drivers of change

Growth is entirely dependent on migration, and has been unpredictable in recent years

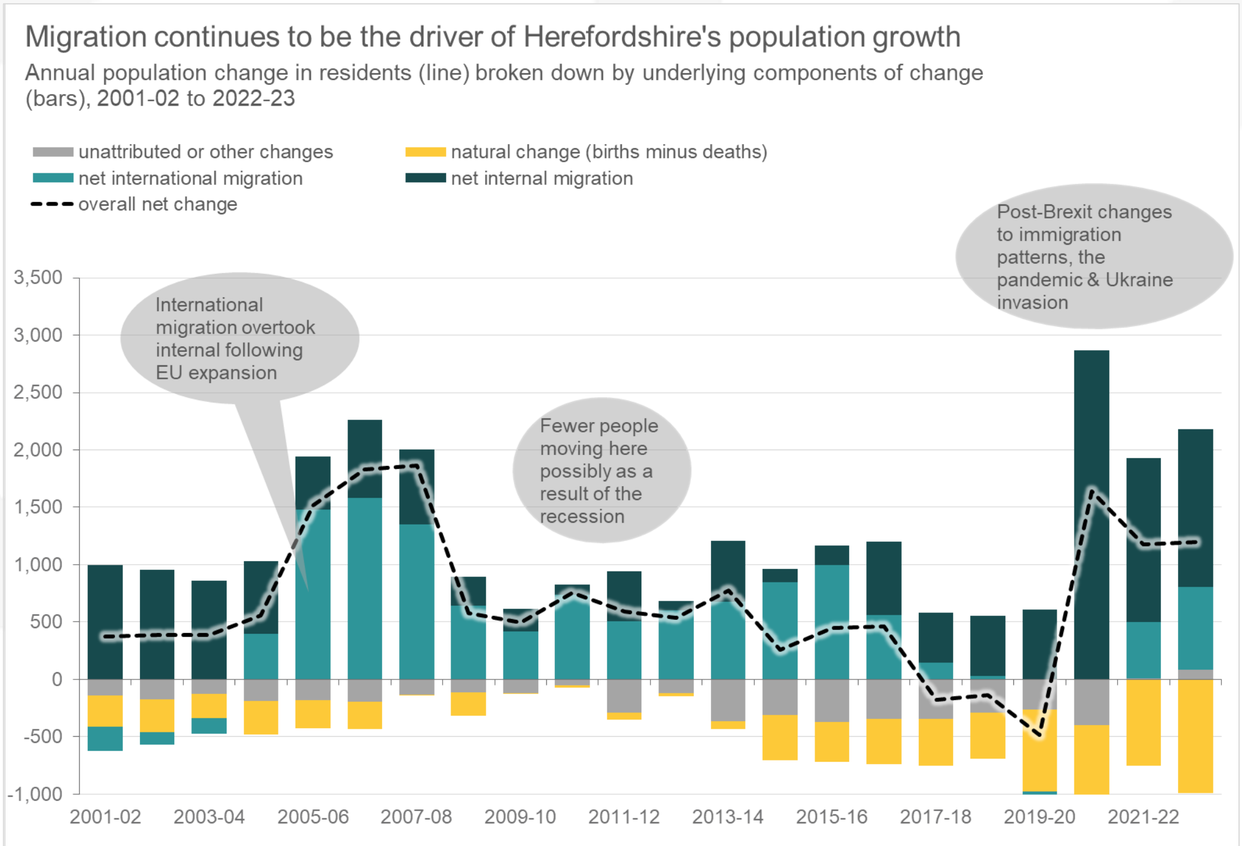
There are consistently fewer births than deaths in Herefordshire each year; in the latest year (2022-23) there were 1,500 births compared to 2,500 deaths. This means that without net migration into the county the total population would fall.

Births have been falling since 2018 (when there were 1,900), reflecting the continued decline in fertility rates seen nationally. However, the ageing population structure means that numbers of deaths have been rising since 2014-15; prior to this they averaged around 1,900 per year.

Migration is the hardest component of population change to measure. It has been particularly difficult in recent years due to several major events which have affected migration patterns across the whole of England and Wales. These include Britain leaving the European Union (EU) and subsequent changes to immigration policy, the COVID-19 pandemic and the war in Ukraine.

This has meant that Herefordshire's population change has been unpredictable, which also has implications for trying to understand what might happen in the future. For example, the 2021 Census found that growth since 2012 had been overestimated, meaning that there were around 8,000 fewer residents in 2021 than originally thought, mainly due to overestimates in international migration.

Even once this had been taken into account, population change has fluctuated since 2016. New official estimates suggest that total residents fell by 800 between mid-2017 and mid-2020, but since then has increased at its fastest rate for twenty years, with an average of 1,300 additional residents each year from mid-2020 to mid-2023.



Data source: Mid-2023 resident population estimates, Office for National Statistics. Last accessed 15 July 2024.

Ageing population

Herefordshire's age structure remains older than nationally, and numbers of older people will continue to grow

- In 2023, 27% of Herefordshire's population (50,700 people) were aged 65 and over, compared to 19% across England and Wales.
- Numbers in this age group grew by 21% between 2013 and 2023, a disproportionately higher rate compared to both nationally (16%) and the overall growth (3%).
- 6,900 residents are aged 85 and over, also reflecting a 21% increase from 2013.
- The natural ageing of the population structure means that these trends will continue for at least the next twenty years (see p.21).

Numbers of children have fallen

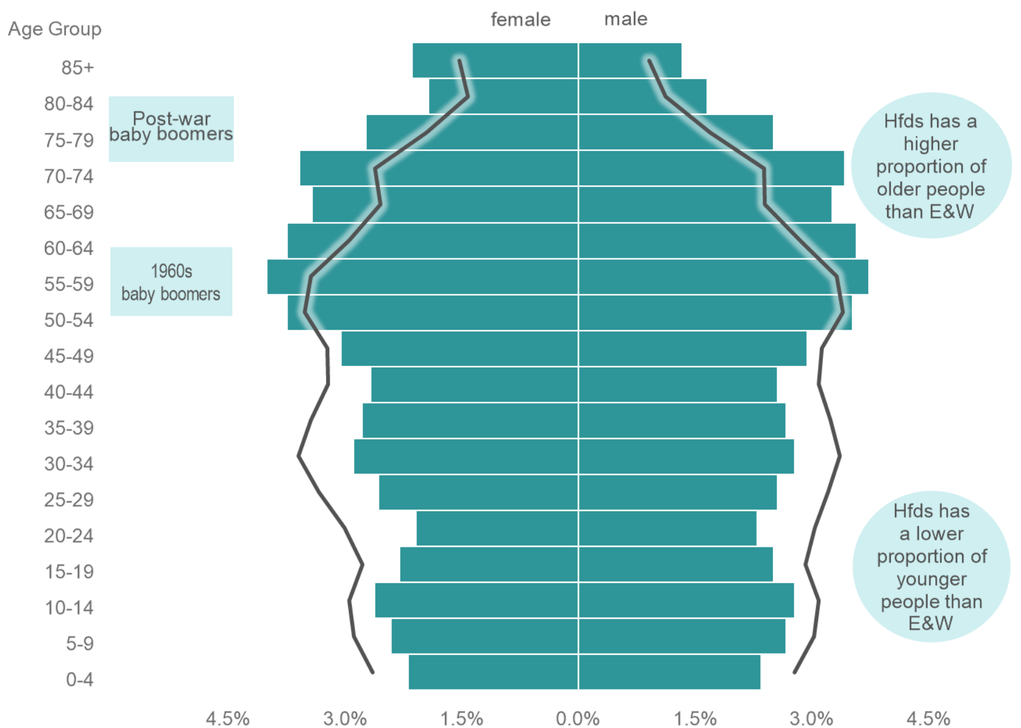
- In 2023, 16% of the population (30,200 people) were aged under 16, compared to 19% in England and Wales.
- This represents a fall of 4% since 2013, contrasting with a 4% national increase.

Lower proportion of working age adults than nationally

- In 2023, 57% (109,000 people) were aged 16 to 64, compared to 63% nationally.
- While net migration added approximately 1,000 people to this age group in the past three years, the overall working age population remains 4,000 fewer than in 2008.
- Changes to this age group are hardest to predict because of uncertainty over future migration patterns, as young working age adults are the most likely to migrate.

Herefordshire has higher proportions of residents in their early fifties and above than nationally and generally lower relative proportions of young people

Percentage of the mid-2023 population estimates in age band
Herefordshire (bars) and England & Wales (lines)



Data source: Mid-2023 population estimates for the UK, Office for National Statistics. Last accessed 15 July 2024.

Changing population: ethnicity

A very different ethnic profile to nationally

In the 2021 Census, the majority of Herefordshire residents identified themselves as being ‘white: British’ (91%). A total of 16,600 identified themselves as being of other ethnicities, an increase of 44% from 2011, and almost four times as many as in 2001. This change largely reflects the impact of the expansion of the EU in 2004 on a county which had historically seen very little international migration. However, at 9% of the total population, it was still very low compared to England and Wales (26%).

People of ‘white: other’ origin (not including British; Irish; Gypsy or Irish Traveller) made up the largest single minority group in the county: 9,500 people, 5% of the population, compared to 6% nationally. This is in contrast to the national picture, where ‘Asian or Asian British’ was the biggest group (9% compared to 1% locally).

Changes driven by migration from Eastern Europe

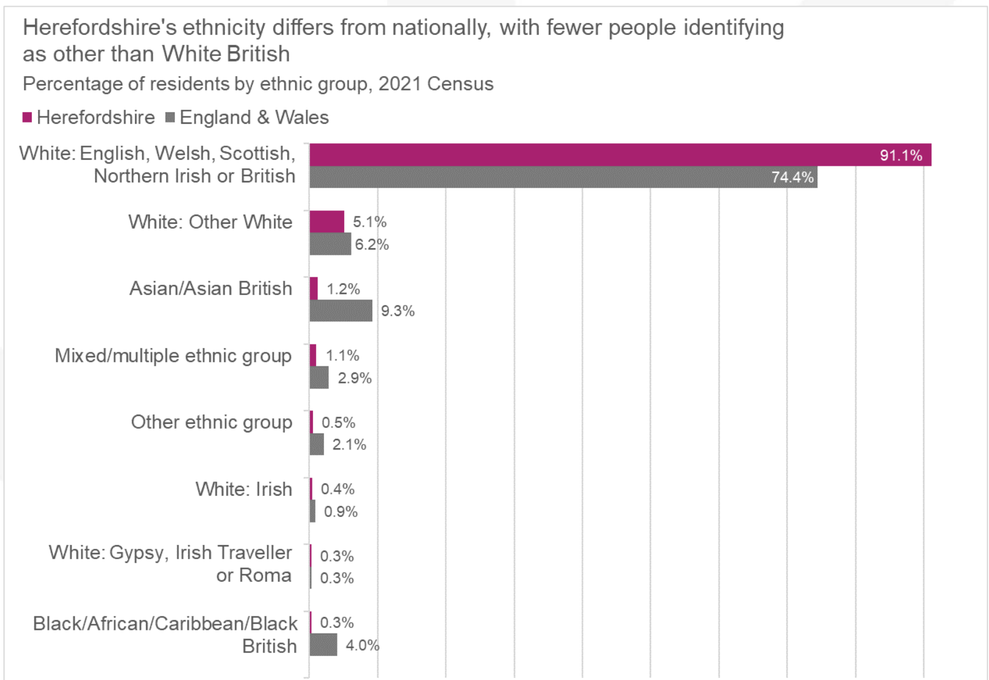
In 2021, around 7,300 residents (4%) were born in countries that joined the EU in 2004 and 2007; just under half in Poland and a quarter in Romania. Unsurprisingly, Polish was the most common main language spoken after English, used by 3,000 people; followed by Romanian (1,500). Others included South and East Asian languages (almost 1,000); Lithuanian (570), Bulgarian (470), Hungarian, Portuguese (each around 300), other European languages (800), and Russian (200).

Almost 2,400 households (3%) had no occupants whose main language was English, and in another 630 only children did. This does not mean that they were unable to speak English, just that it was not their preferred language. Crucially, around 1,800 residents (1% of people) could not speak English well, 280 of them not at all.

Gypsy and Irish Travellers are an important minority

Historically, the Gypsy, Roma and Traveller community has been one of the most significant minority groups in Herefordshire. On a national level, this community experiences poorer health outcomes and shorter life expectancy. Official counts have only been available since the 2011 Census and reliability is dependent on people feeling able to self-identify.

Although relatively small in number, with 430 people in 2021, ‘Gypsy or Irish Traveller’ was the only minority ethnic group over-represented locally (0.2%) compared to England and Wales (0.1%). A further 160 people (0.1%) identified as ‘Roma’, which was a smaller proportion than the 0.2% nationally.



Data source: 2021 Census: Ethnic group. Office for National Statistics. Last accessed 29 November 2022.

Population around the county

Age profile varies across the county

Over half of Herefordshire's residents (100,800; 53%) live in rural areas, with the majority (81,400 people; 43% of the total) living in the most rural 'village and dispersed' areas. A third live in Hereford city (61,900 people), and a fifth in one of the five market towns: Leominster (11,900), Ross-on-Wye (11,100), Ledbury (9,600), Bromyard (4,700) and Kington (3,200).

The most rural areas of Herefordshire have higher proportions of older working and early retirement age residents. Hereford city has a much younger profile than the county as a whole, with relatively high proportions of young adults and young children. The market towns and larger villages, like Colwall and Credenhill, have an age profile more in line with the county overall, but with higher proportions of the very elderly.

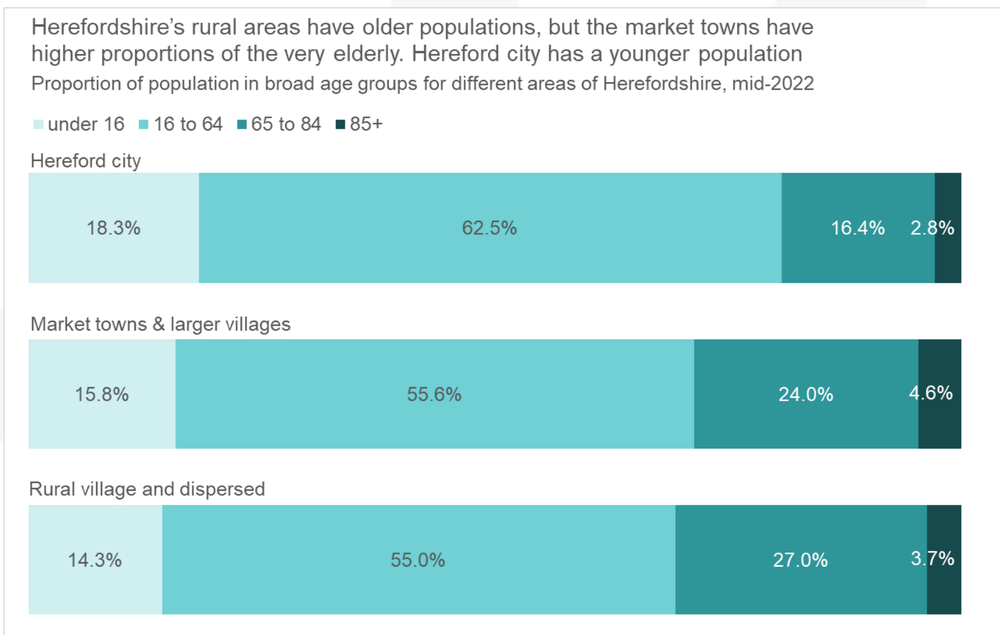
Variation in population growth is closely linked to the location of housing development

Over the period 2011 and 2021, the population of both built-up and rural areas grew by a total of 2%. Hereford City and the market towns of Ross-on-Wye and Leominster saw the largest absolute population increases: of 800, 400, and 300 people, respectively. However, Bromyard market town recorded the fastest growth rate at 5%, which is more than double the county average of 2%.

Population growth aligns closely with housing development patterns. The Local Authority Monitoring Report provides data on housing completions across Housing Market Areas (HMAs - see note). Between 2011 and 2022, around 6,300 new homes were built in the county. Nearly half (47%) were in Hereford HMA, followed by Ross-on-Wye (22%), Leominster (11%), Ledbury (8%), Bromyard (6%), Kington (4%) and Golden Valley (2%).

Note: For housing development purposes, Herefordshire is divided into seven Housing Market Areas (HMAs) - six are centred on the main settlements of Hereford City, Bromyard, Kington, Ledbury, Leominster, and Ross-on-Wye, including their surrounding rural hinterlands. The seventh area covers the broader Golden Valley region. See Housing Market Area Needs Assessment. Iceni Projects Limited on behalf of Herefordshire Council, July 2021.

Planned future housing growth around the county is outlined in the published Local Plan Core Strategy 2011-31. Allocations were designed to 'build upon the existing settlement pattern…, with a focus on Hereford as the county's administrative centre and on other sustainable market towns. However, almost a third [were allocated] to the rural areas to help to sustain local services, generate new ones and support local housing provision for local communities.' (Vision, Objectives and the Spatial Strategy). All areas will see increased allocations under new housing targets, to be developed in the new Core Strategy for 2021-41 (see p.21).



Data source: Mid-2022 population estimates for small areas, Office for National Statistics. Last accessed 19 March 2024.

Future population

It is currently very difficult to predict the future population of Herefordshire. Fluctuations in recent growth (see p.17) make it hard to determine appropriate trends on which to base assumptions. New housing targets will strongly influence migration levels, but their impact is not yet known.

Projections based only on recent trends in births, deaths, and migration would see a growth of around 600 people a year

Reflecting the uncertainty, the ONS has yet to publish official population projections for local areas based on the 2021 Census. These are currently scheduled for early 2025. In the meantime, unofficial interim projections predict that Herefordshire's population will grow by 3% over the ten years from when they were based, in 2021, (to reach 193,600 in 2031), a slower rate than the 6% growth predicted for England overall.

Within this overall growth, the number of older adults (65+) is projected to increase by 22% (to 59,400), while the numbers of children and working-age individuals (16 to 64) are expected to decline by 10% and 1% respectively (to 26,900 and 107,400).

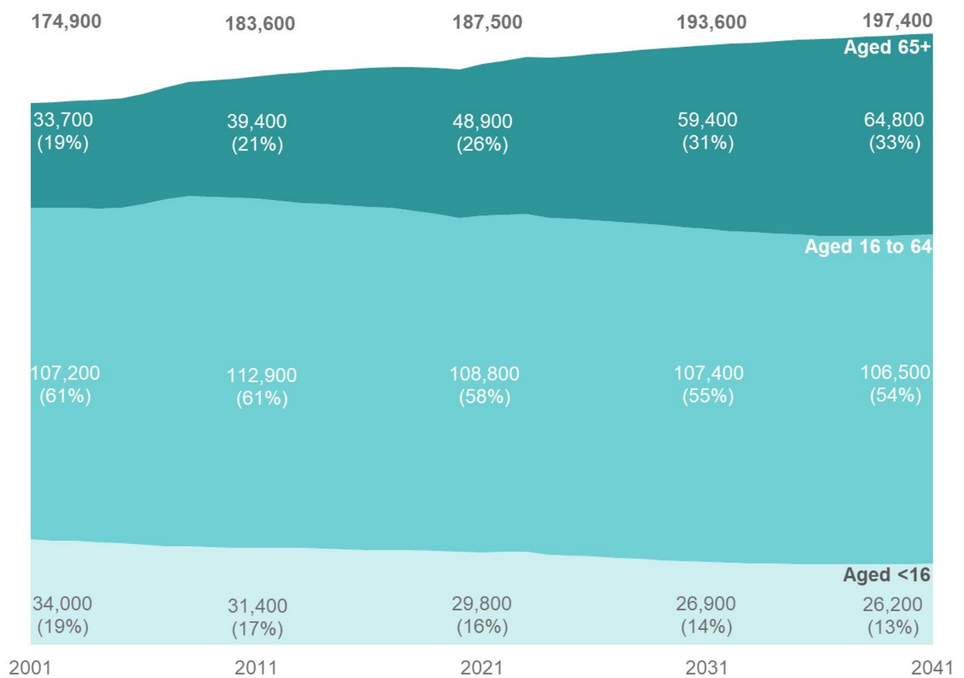
New housing development targets mean that future population growth is currently unknown

Housing growth targets are set out in the Local Plan Core Strategy 2011-2031, which is currently being updated to 2041. The existing strategy includes a requirement for the delivery of at least 16,500 homes (825 per annum) in Herefordshire between 2011 and 2031 to meet market and affordable housing need. Basic modelling which assumes that average household size remains constant and all new housing results in population growth (which may not always be the case), indicates that this could add as many as an extra 800 residents on average per year, on top of the 600 described above.

However, in December 2024, the UK government implemented reforms to the planning system which will see Herefordshire's housing target increase to 27,260 new dwellings between 2021 and 2041 (1,363 per annum). The likely impact of this on population growth has yet to be modelled.

Herefordshire's population of older adults (65+) will rise, while the proportion of children (<16) and working-age individuals (16–64) will fall

Resident population estimates, mid-2001 to mid-2023 & projections



Data sources: Mid-2023 population estimates for the UK, Office for National Statistics. Last accessed 15 July 2024. Trend-based population projections, Greater London Authority. Published July 2023.

Section 4: Population health

This section summarises the overall health of the population, including the overarching measures of life expectancy and healthy life expectancy.

It also considers the main long-term conditions (LTCs) which affect how long someone might expect to live and their quality of life, and the risk factors contributing to ill-health and mortality.

Overall **life expectancy** is better than England, but healthy life expectancy is not.

Average years lived in poor health (2021-23)

- Females: 19.7
- Males: 16.2

Biggest **health risk factors** are high blood pressure, smoking, and excess weight.

- Diagnosed hypertension: 18% (35,700) of GP patients (2023-24)
- Smokers: 10% (15,700) adults (2023)
- Overweight: 67% of adults (2022-23)

5% (9,800) in self-reported bad or very **bad health** (2021).

19% (34,800) have a self-reported **disability** (2021).

Diagnoses of ICS priority **long-term conditions** (diabetes, heart failure, asthma and COPD) could increase by at least 3,000 (7%) between 2023 and 2031 just from population ageing.

Life expectancy and healthy life expectancy

Life expectancy at birth is the average number of years a baby born in a given year would be expected to live if age-specific mortality rates stayed the same throughout their lifetime. Healthy life expectancy adds a 'quality of life' dimension; the number of years they would live in self-reported good general health if mortality levels and the level of good health at each age remained the same. (DHSC)

On average, people born in Herefordshire can expect to live longer than in England overall: in 2021-23, life expectancy at birth was 83.6 for females compared to 83.1, and 80.0 for males compared to 79.1. Female life expectancy has been consistently higher than male.

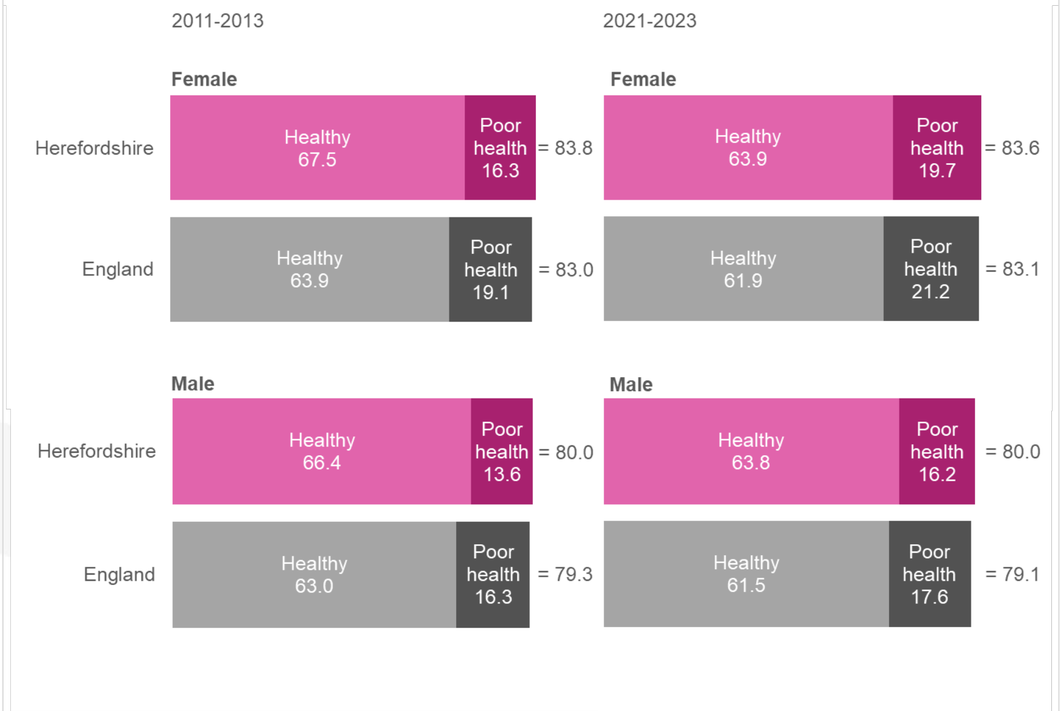
There are long-term inequalities in life expectancy for people in the most deprived areas. Locally the gap is smaller than nationally, with no change since the measure was first calculated in 2010. Nevertheless, in 2018-20 females born in the most deprived areas could expect to live 4.0 years fewer than those in the least deprived, while for males, the gap was 5.4 years. For England these gaps were 7.9 and 9.7 years respectively. The main conditions contributing to this gap in Herefordshire are circulatory diseases, cancers and respiratory diseases, accounting for 54% in females and 59% of the gap in males.

People born in Herefordshire could previously expect to live more of their lives in good health than nationally. However, latest estimates suggest that there is no longer a statistically significant difference: since 2017-19 for males and since 2020-22 for females. In 2021-23, healthy life expectancy for females was 63.9 compared to England's 61.9, whilst for males was 63.8 compared to 61.5.

Although life expectancy has increased over recent decades, both nationally and locally, healthy life expectancy has not. This means that more people are spending more years of their lives in poor health, with 2021-23 estimates suggesting 19.7 years for females and 16.2 for males in Herefordshire. Furthermore, there is no significant difference in healthy life expectancy between females and males. The longer overall life expectancy for females therefore means that on average they live a greater proportion of their life in poor health: 24% compared to 20% for males.

People born in Herefordshire have a longer life expectancy than nationally, but the number of years likely to be lived in poor health has increased. Females spend more years in poor health than males

Life expectancy and healthy life expectancy at birth, Herefordshire and England, 2011-13 and 2021-23



Data sources: Life expectancy for local areas of Great Britain and Health state life expectancy, Office for National Statistics. Last accessed 8 January 2025.

Population health and disability

The most comprehensive view of the general health and disability of the population comes from the national Census. In 2021, residents were asked to assess their general health. A separate question asked if they had any physical or mental health conditions, or illnesses lasting or expected to last 12 months or more. If so, to identify disability, they were asked whether their day-to-day activities were limited by this condition.

The majority of people (81%) said that their health was good or very good, the same as in 2011 and, despite the older age profile, similar to the proportion in England and Wales (82%). Conversely, 9,800 people (5%) reported being in bad health, 2,200 (1.2%) of them in very bad health.

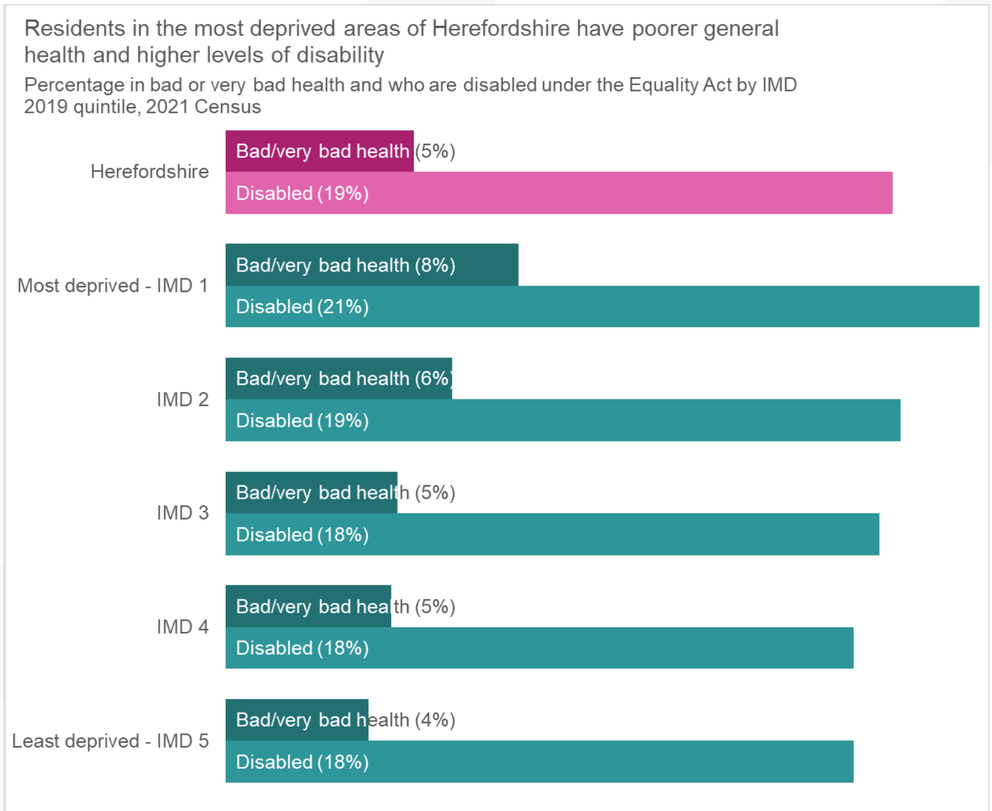
In total, 34,800 people (19%) said that they had a long-term condition (LTC) which limits their day-to-day activities, a similar proportion to nationally (18%). This would qualify as being disabled under the Equality Act 2010.

Being disabled does not necessarily mean being in poor health; around one-third (32%) of people with a disability said they were in good general health.

People who live in Herefordshire's most deprived areas were twice as likely to say they were in bad health as those in the least deprived (8% compared to 4%). A higher proportion also had a disability which limited their day-to-day activities a lot (10% compared to 7%).

The likelihood of being in bad health and/or having a disability both increase with age, especially for those aged 75 and over. In this group, 13% reported bad health, and 42% reported having a disability, both more than double the rates seen in the total population. Typically, the most deprived areas have younger age profiles. If the different age profiles were taken into account, the disparity in health and disability levels between the most and least deprived areas would be even more pronounced.

See 2021 Census health, disability and unpaid care headline results for Herefordshire.



Data sources: 2021 Census: General health, Disability. Office for National Statistics. Last accessed 30 January 2023
English Indices of Deprivation, 2019. Ministry of Housing, Communities and Local Government. Last accessed 9 December 2024.

Long-term health conditions

Long-term conditions (LTCs) or chronic diseases are conditions for which there is currently no cure that are managed with drugs and other treatment. People living with multiple long-term conditions are at greater risk of poorer outcomes such as increased mortality, lower quality of life, and greater use of health and social care services, including unplanned [hospital] admissions. (Director of Public Health Annual Report 2023)

Although the general self-reported health of Herefordshire's population is similar to nationally (see p.24), a large number of people are living with diagnosed LTCs such as diabetes, arthritis, high blood pressure (hypertension), epilepsy, asthma and some mental health conditions.

The H&W ICS Strategy: Living well with Long-Term Conditions (2024) determined that its initial priorities would be cardiovascular diseases (including diabetes and heart failure) and respiratory diseases (including asthma and chronic obstructive pulmonary disease (COPD)). In 2023, 43% of people attending secondary care across the two counties had a diagnosis at least one of these priority conditions, with 17% of attendances having three or more.

Highlighting the link between physical and mental health, 38% of those with a priority LTC also had a mental health diagnosis.

The prevalence of diagnosed LTCs is based on GP registers. The table shows the number of Herefordshire patients with a diagnosis of the priority conditions in 2023-24. The numbers of patients with diabetes and heart failure have been increasing in recent years and the proportions with heart failure and COPD are above the national rates, although this would be expected as the rates do not take account of the older age profile locally.

The table also includes other LTCs, some of which are more common in Herefordshire, for example 20,300 adults (13%) with diagnosed depression and 8,200 (5%) with chronic kidney disease (CKD). 35,700 patients (18%) have hypertension, a major risk factor for other diseases and mortality (see p.27).

Diagnosed condition	Number of patients in 2023-24	Proportion of population (not age-standardised)	Recent trend
ICS priority conditions			
Diabetes (17+ years)	12,208	7.5%	↑
Heart failure (all ages)	2,554	1.3%	↑
Asthma (6+ years) (note only includes those using prescribed medication during past year, which is only half those recorded as having asthma on GP systems: 22,700 April 2023)	12,843	6.9%	-
COPD (all ages)	4,758	2.4%	→
Other long-term conditions			
Hypertension (all ages)	35,691	18.3%	↑
Depression (18+ years) (Note 2022-23 data as indicator has been retired)	20,335	12.8%	↑
Chronic kidney disease (CKD) (18+ years)	8,228	5.1%	↑
Coronary heart disease (CHD) (all ages)	6,926	3.6%	→
Atrial fibrillation (all ages)	6,012	3.1%	↑
Stroke	4,993	2.6%	→
Osteoporosis (50+ years)	1,228	1.3%	↑
Schizophrenia, bipolar affective disorder and other psychoses (all ages)	1,594	0.8%	→
Rheumatoid arthritis (16+ years)	1,818	1.1%	→

Source: Quality Outcome Framework (QOF) data DHSC Fingertips. Last accessed 20 November 2024.

Long-term health conditions: the future and inequalities

Numbers are likely to continue to rise with the ageing population

The likelihood of having one or more LTC increases with age. In February 2024, around 50% of 60-year-olds registered with a Herefordshire GP had one LTC, whilst at 80, 50% had at least two. Therefore, as the population of older people increases (see p.18), it should be expected that the number of people with LTCs will continue to rise.

Projections of the priority LTCs to inform the H&W ICS Strategy estimated that the ageing of the population structure alone, without any changes to health or lifestyles, would lead to 3,000 (7%) more diagnoses of those conditions in Herefordshire in the next decade: from 41,700 in 2023 to 44,700 in 2033. Note that these numbers include 10,000 more people with recorded asthma, but who have not been prescribed medication in the last year, than are included in the published indicator.

A significant number of younger people also have LTCs, with 25% of 35-year-olds having at least one in 2024. In particular, prevalence of Type 2 diabetes amongst 15 to 19 and 40 to 49-year-olds in Herefordshire and Worcestershire has been increasing since 2013, doubling their risk of heart disease or stroke.

LTCs are not an inevitable consequence of ageing however. The strategy emphasises the importance of an all-age approach with a focus on prevention and addressing lifestyle issues such as smoking, diet, and alcohol consumption, as well as early diagnosis and support, the engagement of education settings, and alignment to the council's 'best start in life' priority (see p.6).

Inequalities

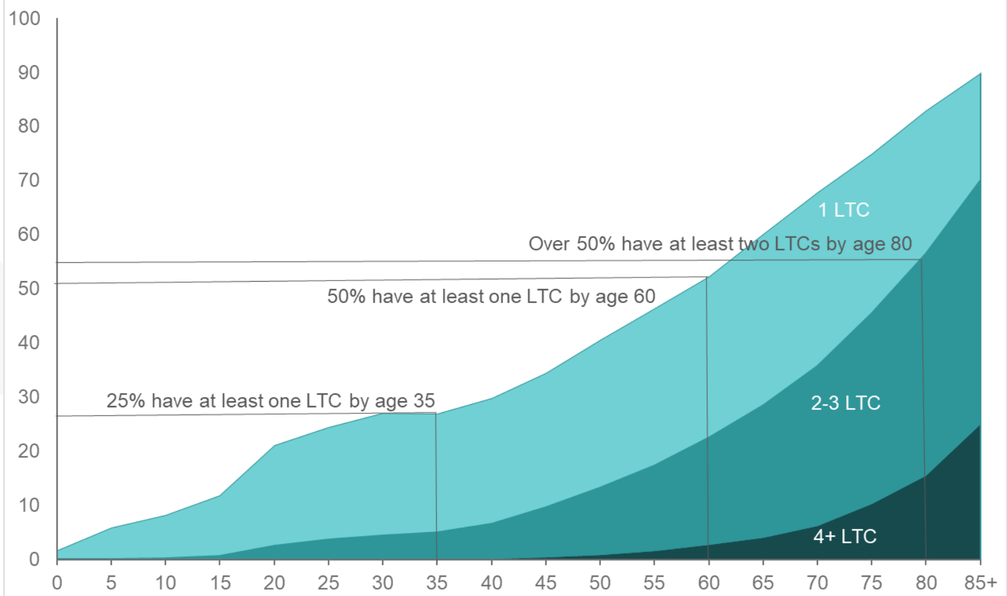
As well as being preventable, many LTCs are affected by the social and economic environments that people live in. In Herefordshire, we know that people born in the most deprived areas have a shorter life expectancy (see p.31) and are more likely to report poor general health (see p.24).

The strategy cites national research that people living in the most deprived communities are likely to be living with two or more LTCs around ten years earlier than people in the least deprived, and recommends 'targeted work to address the underlying causes of these un-just and unwarranted poorer health outcomes'.

Inequalities also exist among groups with protected characteristics, for example people aged 65 to 74 with learning disabilities are twice as likely to have Type 2 diabetes as those without (24% compared to 12%).

Long-term conditions (LTCs) increase with age: 50% of 60 year-olds have at least one and 50% of 80 year-olds have at least two

Percentage of Herefordshire GP patients with number of LTCs by age, February 2024



Source: Director of Public Health Annual Report 2023

Risk factors for ill-health and mortality

'Smoking, poor diet, physical inactivity and harmful alcohol use are leading risk factors driving the UK's high burden of preventable ill-health and premature mortality. All are socioeconomically patterned and contribute significantly to widening health inequalities. People's ability to adopt healthy behaviours is strongly shaped by the circumstances in which they live.' (Addressing the leading risk factors for ill health, Everest, G. *et al*, The Health Foundation, 2022)

Obesity (high body-mass index), smoking and high blood sugar levels (fasting plasma glucose) have been the biggest risk factors for disability in Herefordshire since 1990, according to the Global Burden of Disease tool (GBD, see diagram). They are also three of the four biggest risks for mortality, behind high blood pressure (hypertension).

In 2023-24, 18% (35,700) of patients registered with Herefordshire GPs had a diagnosis of hypertension, similar to statistical comparator areas but up from 16% in 2020-21 and most of the preceding decade.

Smoking rates have fallen from around 17% between 2011 and 2015 to 10% in 2023, but this still means an estimated 15,700 people are current smokers. See p.44 for more.

There are limited data on excess weight in adults, with the only published indicator suggesting that 67% people aged 18+ were overweight in 2022-23, similar to England. Excess weight in childhood is covered on p.38.

Whilst the causes of excess weight and high blood sugar can be multifaceted, there is a strong link to physical inactivity and poor diet. In 2022-23, 21% of adults were physically inactive (doing less than 30 minutes of moderate physical activity per week) and only 39% were eating the recommended five fruit and vegetables a day.

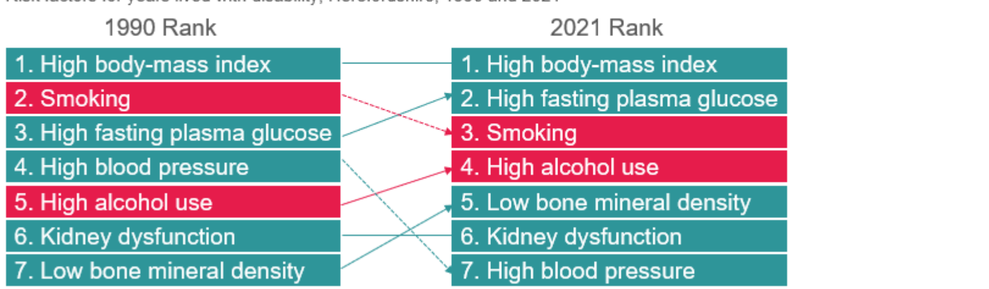
These risk factors can apply to anyone, but national evidence shows links between prevalence of them and high levels of deprivation, lower levels of education, and lower socioeconomic group. Locally, for example, there are higher rates of obesity among children in the most deprived areas, and people working in routine and manual jobs are twice as likely to smoke.

NHS Health Check is a screening programme available every five years to those aged 40 to 74. It is designed for early detection of the risks of heart disease, stroke, kidney disease and diabetes, in order to offer interventions to prevent or delay their onset and maximise health as people grow older. Over the latest five-year period (2019-20 to 2023-24), as measured in the PHOF, Herefordshire has performed poorly on both offers and receipt of Health Checks for the eligible population (see p.13). However, more recent data suggest improvement, with both significantly better than nationally in 2023-24. During 2023-24, 22,600 Herefordshire patients were invited for a NHS Health Check, more than 20% of the total eligible population, meaning that if this continues everyone will receive an invitation over a five-year period. Almost 6,500 received a Health Check. Work continues to further improve coverage, for example by offering checks at workplaces where employees are more likely to be smokers.

Identification of hypertension (case finding) and smoking cessation are also clinical priority areas in the NHS approach to reducing inequalities (see p.8).

The top seven risk factors for disability in Herefordshire has not changed in the past 30 years, with high body-mass index continuing to be the leading risk factor

Risk factors for years lived with disability, Herefordshire, 1990 and 2021



Source: Institute for Health Metrics and Evaluation GBD Compare 2021 © 2024 University of Washington

Section 5: Mortality

The age at which people die and what causes their death is not pre-determined and can be influenced by a variety of personal, social and environmental factors.

This section looks at overall mortality and the impact of an ageing population, and then at causes of death and inequalities due to deprivation. It also considers the factors contributing to avoidable deaths, including deaths by suicide.

A more detailed analysis can be found in the Herefordshire Annual Mortality Report.

Overall deaths:

2,420 deaths registered in 2023. Gradual increase over last decade due to ageing population structure (from 1,900 to 2,000 a year prior to 2014).

Cancer and circulatory disease are the two biggest **causes of death**, accounting for 50% of all deaths.

Since 2001, around one fifth of all deaths have been either **preventable or treatable**. Around two-thirds of preventable deaths have been among males.

Mortality rate is 30% higher in the **most deprived** areas than in the least deprived. These differences are driven by deaths from respiratory and circulatory diseases.

Average of 18 deaths by **suicide** per year (2001 to 2023), ranging from 12 to 27. Suicide mortality rate in line with England's and stable over this period.

Total deaths

A total of 2,420 deaths of Herefordshire residents were registered in 2023. This number has increased gradually over the last decade. Before this, between 1996 and 2014, annual deaths averaged between 1,900 and 2,000.

Numbers of deaths are closely linked to the age structure of a population: the more elderly people living in an area, the more naturally occurring deaths would be expected. Between 2013 and 2023, the number of people aged 85+ living in Herefordshire increased by 21%, from 5,700 to 6,900 (see p.18).

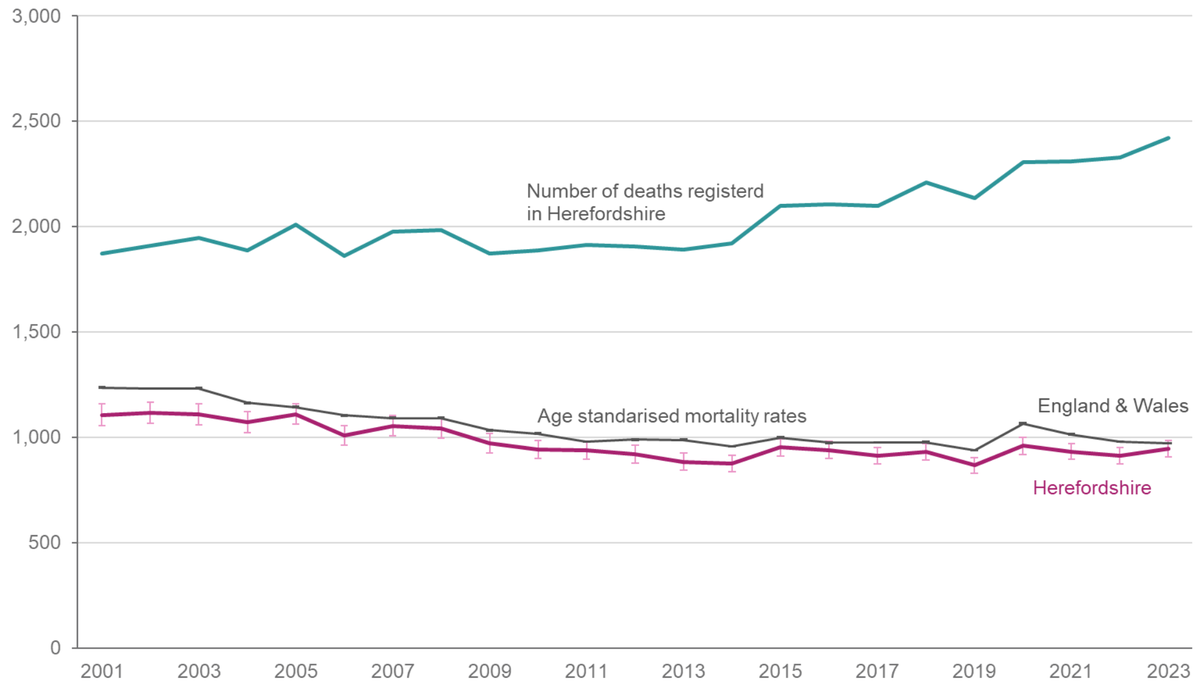
Age-standardised mortality rates (ASMRs) take account of the population size and age structure of an area. Despite the absolute numbers of deaths in Herefordshire increasing, the ASMR has fallen since 2001, and has been statistically lower than the rate for England and Wales for most of that time.

Since 2011, the number of male and female residents dying each year has been roughly equal. On average, ASMRs for males are higher than females, and males die younger than females. Since 2011, the median age of death for Herefordshire females has been around 85 compared to 80 for men.

Based only on the natural ageing of the current population structure, i.e. not taking account of any future net migration into the county, we could expect to see the number of deaths continue to increase by around twenty a year for at least the next fifteen years.

Although absolute numbers of death have increased since 2014, age-standardised rates have not

Total number of deaths registered in Herefordshire and age-standardised mortality rate per 100,000 people for Herefordshire and England and Wales, 2001-2023



Data source: Deaths registered in England and Wales, Office for National Statistics. Last accessed 14 January 2025.

Causes of death

As in the rest of UK, cancer and circulatory diseases have been the two biggest causes of death for at least the last thirty years. Between them they have accounted for at least half of all deaths in Herefordshire since 1990. (Global Burden of Disease Tool)

The chart shows how the main causes of death in the county have changed as a proportion of all deaths since 2001. Of the top two causes, cancer deaths remained relatively stable at 25%, whilst deaths from circulatory diseases fell from 45% of all deaths in 2001 to 25% in 2023.

Although the proportion of deaths from cancer remained stable, the absolute number rose from 480 in 2001 to 610 in 2023. The absolute number of deaths from circulatory diseases fell from 850 in 2001 to 600 in 2023.

Although accounting for a notably smaller proportion (12% in 2023), respiratory diseases were the third biggest cause of death (290 deaths in 2023). These diseases also had the widest inequality in mortality rates (see p.31).

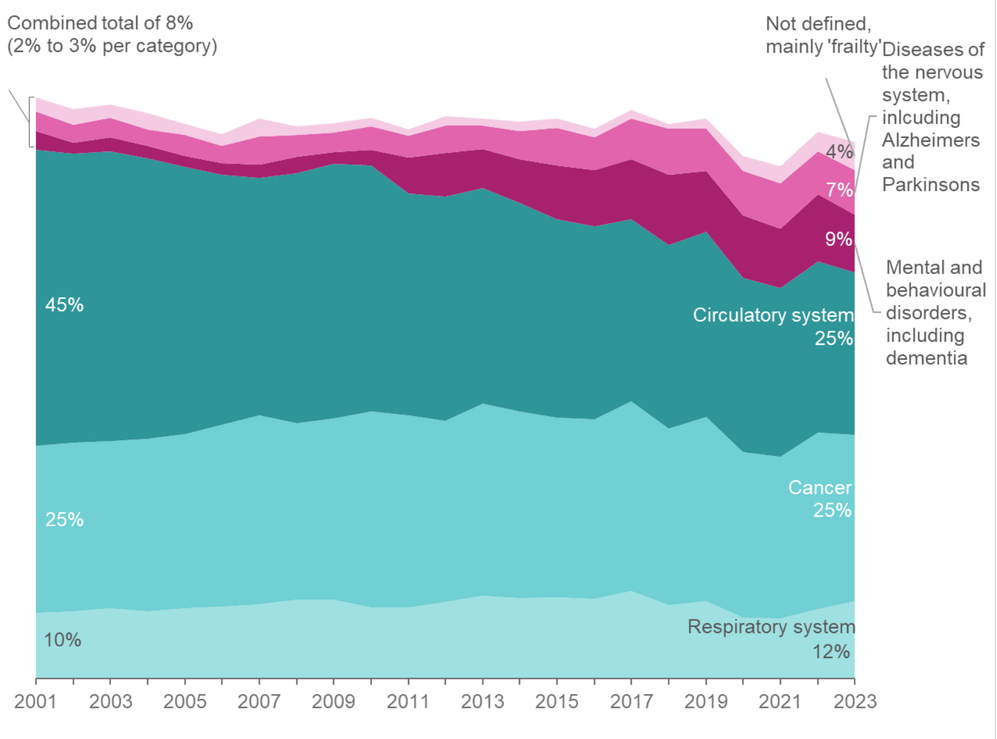
The three categories at the top of the chart (in pink) are those which have seen the biggest proportional increase over the period (see note). In 2001 they collectively made up 8% of deaths, but this had grown to 20% by 2023. Analysis of the detailed causes within these broad categories shows that this has been driven by diseases such as Alzheimer's, Parkinson's, dementia and frailty, suggesting a link with Herefordshire's ageing population. This analysis is not available nationally, but we know from joint work that this trend has not been seen in Worcestershire.

Taking the age structure into account, published profiles show that mortality rates were equal to or better than England for all but three measures in 2021-23; all of which related to stroke (overall, female, and for over 75 years old). Although mortality from stroke had more than halved since 2001, rates were still significantly higher than in England. There were 437 deaths from stroke in Herefordshire between 2021 and 2023.

Note: As shown in the chart, these are the broad ICD-10 categories of 'mental and behavioural disorders', 'neurological disorders' and 'not defined'. The ICD-10 is the World Health Organisation's International Classification of Disease, which groups specific diseases into 22 broad categories. Cause of death, as recorded on UK death certificates, is coded into ICD-10 categories by ONS.

The proportion of deaths from circulatory disease has fallen since 2001, whilst the proportion of deaths related to old age have risen during this period

Cause of death by main six ICD-10 categories in Herefordshire from 2001 to 2023



Data source: Primary Care Mortality Database, NHS Digital. Downloaded March 2024.

Mortality: deprivation

‘People who live in deprived areas and those in long-term unemployment have an increased likelihood of dying from a range of health conditions…’ (British Medical Journal, 2023)

Once differences in age profile were accounted for, mortality rates had been consistently higher in the 20% most deprived areas of Herefordshire than in the rest of county, and the latest (2023) data suggest that this disparity had widened (see chart). People living in the most deprived quintile (IMD 1) experienced a 40% higher mortality rate from all causes of death than those in the least deprived quintile (IMD 5).

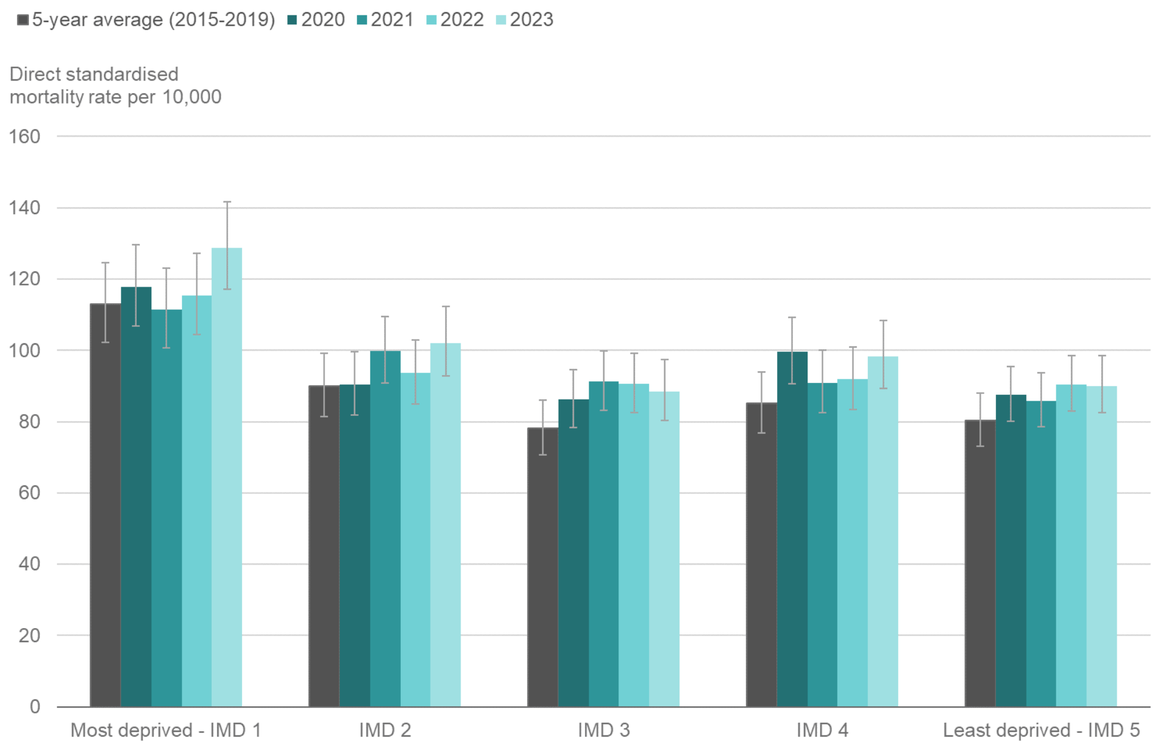
This pattern is different to that seen nationally and in neighbouring Worcestershire, where mortality rates gradually increase with increasing levels of deprivation. Whereas in Herefordshire, all quintiles have fairly similar rates, apart from the most deprived, which is notably worse.

Considering the broad causes of deaths, in Herefordshire these inequalities have been most apparent in deaths from respiratory and circulatory diseases during recent years. Pooling five years’ worth of data for robustness, but excluding 2020 due to the unusual number of deaths from COVID-19, the mortality rate for respiratory disease was twice as high in the most deprived areas as in the least deprived, whilst for circulatory disease it was 45% higher.

There was little difference in the total number of deaths between the most and least deprived quintiles, which means that the disparity in rates was driven by people dying at younger ages in the most deprived areas. Over the same pooled period there were 560 deaths from circulatory disease in the most deprived quintile compared to 700 in the least, whilst for respiratory disease the numbers were 300 and 270 respectively.

Mortality rates for the most deprived areas are significantly higher than the rest of the county

Age standardised mortality rates per 10,000 for all deaths, Herefordshire IMD quintiles, each year 2020 to 2023 and 5-year average for the period 2015 to 2019



Data source: Primary Care Mortality Database, NHS Digital. Downloaded March 2024.

Avoidable (preventable and treatable) mortality

Avoidable mortality relates to deaths of people aged under 75 where the cause of death is considered either preventable (through effective public health and primary prevention interventions) and/or treatable (through timely and effective healthcare interventions), based on an internationally agreed classification.

Avoidable mortality is lower than nationally

The ONS publish avoidable, treatable and preventable mortality data at local authority level. However, these are not broken down by cause.

These data show that once the age profile is taken into account, in general Herefordshire has had lower rates of avoidable deaths than nationally since 2001. This is driven by lower than national rates of preventable deaths, since treatable deaths are similar to national levels. Until 2012-14 there was a fairly consistent gradual fall in the overall avoidable mortality rate. However, since then the rate has remained stable.

Consistently, since 2001, around one fifth of all deaths in Herefordshire have been either preventable or treatable. Of the 7,000 deaths registered between 2020 and 2022, 800 (12%) were preventable and 500 (7%) were treatable.

Causes of preventable deaths

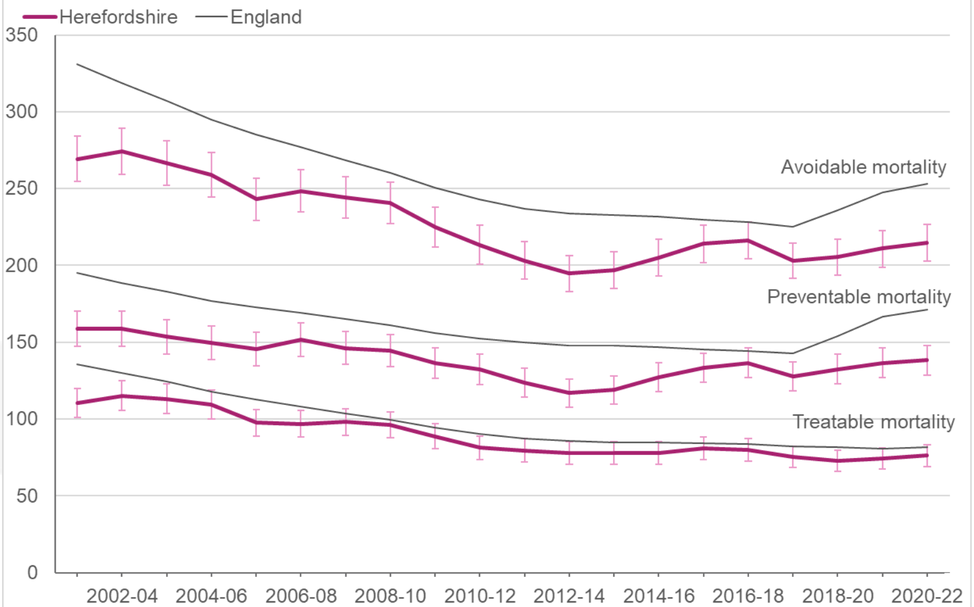
The DHSC publish more detailed information about preventable mortality specifically. The latest data (for 2021 to 2023) showed that although overall, preventable mortality from all causes was significantly lower than England, there was some variation. Cancer rates for both males and females, and the male rate for liver disease, were significantly lower than nationally, while for cardiovascular disease (CVD) and respiratory disease they were similar.

Of the 800 preventable deaths, two-thirds were due to the three biggest overall causes of death: cancer (247), CVD (181) or respiratory disease (96), representing 10 to 14% of all deaths from each of these diseases. Although a relatively small absolute number, 59% (81) of the 137 deaths from liver disease were considered preventable.

Males are consistently more likely to die of preventable causes than females: since 2001 around two-thirds of preventable deaths in Herefordshire have been among males. The disparity is consistently widest for deaths from cancer and CVD.

Herefordshire has had lower rates of avoidable deaths than England since 2001, driven by lower rates of preventable deaths

Age-standardised mortality rates (per 100,000 population) for avoidable, preventable and treatable deaths, 2001-2003 to 2020-2022



Data source: Avoidable mortality by local authority in England and Wales, Office for National Statistics. Last accessed 10 December 2024.

Suicide

‘There is no single reason for why people die by suicide. Social, psychological and cultural factors can contribute to a person being at greater risk of suicide.’ However, in many cases poor mental wellbeing can be an important factor. (Mental Health UK)

The overall suicide rate for Herefordshire has shown no significant trend since 2001 and is not statistically different to England’s. Because numbers are small, fluctuating year-on-year, the rate over a three-year rolling period is used as a more robust indicator of trends and for comparison. 54 suicides were registered in Herefordshire during 2021-23, equal to the annual average of 18 a year since 2001. Absolute numbers registered each year fluctuated between 12 and 27 during the period 2001 to 2023.

The age and sex profile of deaths from suicide has also consistently been the same as nationally over the last two decades:

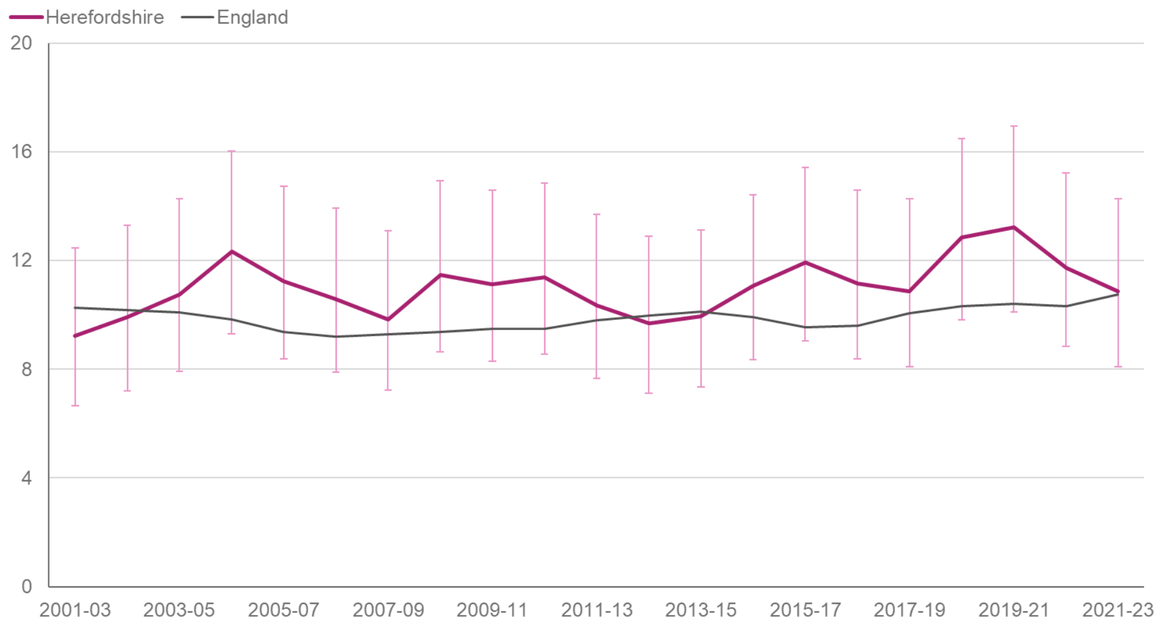
- Males are three times more likely to die by suicide than females, accounting for 75% of all suicides.
- Whilst deaths by suicide occur from teenage years to over 90, the highest suicide rates are seen in those aged 45 to 64. The average age that someone dies from suicide is 50.
- However, suicide is also one of the biggest killers of men aged under 35, accounting for 1 in 4 deaths.

There can be an association between suicide and mental ill-health; see p.43 for more information on mental health.

Herefordshire has an established multi-agency Suicide Prevention Working Group and recently set up a Suicide Audit Group to ensure a data-driven, collaborative approach to suicide prevention and bereavement support. A new Prevention Strategy and Action Plan in 2025 will align with the national Suicide Prevention Strategy while addressing specific local needs based on analysis and engagement work.

The suicide rate in Herefordshire has been unchanged and consistently in line with England over the past 20 years

Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population in Herefordshire and England, 2001-2003



Data source: Age-standardised suicide rates, Office for National Statistics. Last accessed 9 December 2024.

The ONS publish national analysis of suicide data, and the DHSC Fingertips public health profiles enable comparisons with other areas and change over time.

Section 6: Children and young people

‘The early years of a child’s life have a huge impact on their future development and physical and mental wellbeing. The foundations for virtually every aspect of human development start from preconception and what happens from this point forward has lifelong effects on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational achievement and economic status.’ Marmot Review 2010

This section looks at the factors that can help determine whether a child has the best start in life, focusing on the main challenges locally. It reflects the ambitions of the JHWBS, and the findings of Herefordshire Council’s 2022 assessment of the Health and Wellbeing Needs of Children and Young People (CYP).

An important source of evidence was the 2021 CYP Quality of Life (QoL) Survey of 5,000 students at local schools and colleges. The survey was repeated in 2024, and, once published, results will inform the continuous JSNA process.

Risks in pregnancy:

Increasing risks from maternal obesity and diabetes. Smoking in pregnancy has fallen; 8% of women were smokers at the time of delivery in 2023-24.

10% of Reception and 21% of Year 6 pupils were classified as **obese** in 2023-24.

39% of five year-olds had experience of visually obvious **dental decay** in 2021-22 - the 8th worst rate in England.

Early years **child development** has fallen: 82% of 2 to 2½ year-olds had a 'good' level in 2023-24 compared to 88% in 2021-22.

Only 24% of primary and 13% of older pupils had a high level of **resilience** in 2021.

Numbers with the highest level of **special educational needs** rose by 40% in the last five years: in 2023-24 1,150 pupils had an Education, Health and Care Plan (EHCP).

Overall demand for **Children's Services** and rates of looked after children remain relatively high but show signs of improvement.

~400 Children in Care in 2023-24

Pregnancy and birth

One of the four 'best start in life' ambitions of the JHWBS is that 'parents are well supported during pregnancy and birth'. All of the indicators discussed on this page are included in the DHSC Child and Maternal Health Fingertips profile.

The majority of the 1,600 births in Herefordshire each year have good outcomes. Over 90% are full-term and few of these (2 to 3%) are underweight. Early access to maternity care is similar to England overall, with 63% of women having an initial 'booking-in' appointment with a midwife by their tenth week of pregnancy in 2023-24 (although until 2021-22 the proportion was better than nationally, at 71%). Over half of babies are breastfed at 6 to 8 weeks of age (55% in 2022-23 compared to 49% for England), providing health benefits for both mother and infant.

Nevertheless, the 2022 Health and Wellbeing Needs of CYP concluded that some aspects of maternal health were of concern. It drew particular attention to the risk factors of smoking and excess weight in pregnancy; premature births; and infant mortality. These were also reflected in the 2023 H&W ICS Local Maternity and Neonatal System (LMNS) Strategy.

Risk factors in pregnancy: smoking has fallen

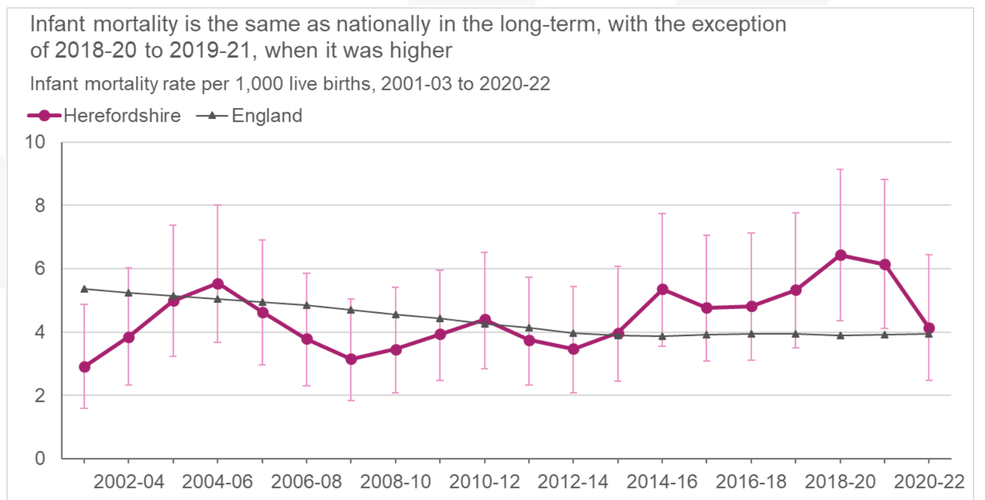
The LMNS Strategy noted that, as nationally, maternal obesity has increased 'over the past 10 years', along with gestational and pre-existing diabetes. 'These changing risks will impact new-born and maternal outcomes'. The latest published figure estimated that in 2023-24 26% of women were obese in early pregnancy, in line with England and statistical comparators but still representing one in four pregnancies.

'Smoking in pregnancy results in poorer outcomes…, and is associated with deprivation and [is] a cause of health inequality'. The proportion of Herefordshire mothers who were smokers at the birth of their baby had been around 14% for much of the last decade, and since 2016-17, had been consistently higher than England's, which had fallen steadily from 14% in 2010-11. However, it has shown signs of improvement since 2019-20 and in 2023-24 was 8%, similar to the England figure (7%).

Infant mortality: no longer significantly higher than England

Infant mortality (deaths under a year of age) is an indicator of general population health. Small numbers can mean wide annual fluctuations, so rates are published for three year rolling periods. The England rate has been 3.9 per 1,000 live births since 2013-15. It was slightly higher locally, and in 2018-20 and 2019-21 the difference was big enough to be statistically significant (6 per 1,000) - equating to an average of 10 deaths a year compared to fewer than 8 in earlier years. However, the latest published rate was almost the same as England's: 4.1 in 2020-22.

A local review of infant mortality in 2021-22 reported that the most common risk factors were prematurity, smoking, neonatal care and families with complex social factors. In 2019-21, 93.2 per 1,000 births were premature, reflecting a rise from 2015-17 and a higher than national rate since 2017-19 (around 80 per 1,000).



Data source: Infant mortality rate. Fingertips, DHSC. Last accessed 9 December 2024.

Child development and educational outcomes

‘The first 1,000 days of life, from conception to age two, is a critical phase during which the foundations of a child's development are laid. If a child's body and brain develop well then their life chances are improved…. Clear inequalities [are] evident by socio-economic position from an early age. By the time children get to school, there are already big differences in their levels of development which persist and amplify over time.’ (House of Commons Health and Social Care Committee, 2019)

The above is recognised in the JHWBS ambition that ‘children are able to achieve their early developmental milestones’ under the ‘best start in life’ priority. The 2022 Health and Wellbeing Needs of CYP noted that although overall early years’ development in Herefordshire was good, there was a clear inequality for disadvantaged children by the time they start school. It was also too early to see any impacts of the pandemic.

Insights come from universal checks on whether children are achieving expected levels of development for their age, covering aspects of learning such as personal, social and emotional; communication; physical ability; as well as educational. If they are, across all skill areas, they are considered to have a ‘good level of development’ (GLD).

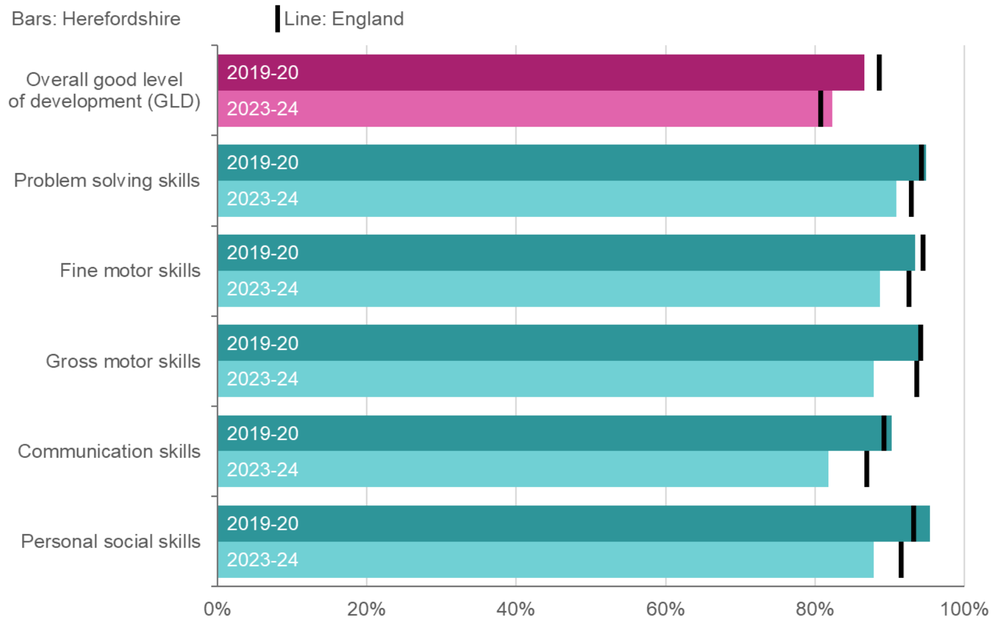
The first of these checks take place at age 2 to 2½, where most children do achieve a GLD: 82% in Herefordshire in 2023-24. However, the latest data show signs of a local deterioration, with lower proportions achieving overall GLD and expected levels on each of the skill areas in 2023-24 than in 2019-20 (when overall GLD was 87%). Rates are now worse than England on each of the five skill areas and in line with the national rate for overall GLD (80%). Many similar authorities remain better than nationally, although most have also seen a declining trend.

The second development check is at the end of the Early Years Foundation Stage (EYFS), usually around age five when finishing Reception year in school. Generally, a lower proportion of children meet the expected levels across all aspects of these age-appropriate skills than at 2 to 2½. In 2022-23, 70% of Herefordshire children achieved a GLD at the end of Reception, higher than the 67% for England.

This is the first point at which inequalities are measured, and as nationally, there is a clear gap between children eligible for free school meals (a common proxy for disadvantage) and their peers. In 2023 only 55% of these pupils had achieved a GLD, statistically similar to England (51%).

Fewer Herefordshire 2 to 2½ year-olds achieving expected levels of development in 2023/24 than in 2019/20, and lower rates than England on individual skill areas

% meeting expected levels at universal health visitor checks



Data source: Early Years indicators, Child and Maternal Health Profile. Fingertips, DHSC. Last accessed 9 December 2024

Special educational needs and disabilities (SEND)

A child or young person (up to the age of 25) has SEND if they have a learning difficulty or disability which calls for special provision to be made for them where they learn. The needs of most children with SEND can be met with some support to access education (SEN support), but a small number of children need more specialist help and, following statutory assessment, may require an education, health and care plan (EHCP).

The 2024 SEND needs assessment (not yet published) provides a single up-to-date evidence base to inform the Herefordshire SEND and Alternative Provision Partnership's work improving services and outcomes for children and young people, as set out in its 2023-26 strategy.

Numbers with the highest need continue to rise

Herefordshire has consistently had a relatively high rate of school pupils identified as having SEND. The 5,200 in 2023-24 represented 21%, compared to England's 18%. Most (4,050) had SEN support, 600 more than in 2018-19 – a 17% increase. At the same time, 1,150 pupils had an EHCP, which in line with the rest of England had increased by 40% since 2018-19: from 2.6% of pupils to 4.6%. The majority (56%) were educated in mainstream state-funded schools, and a disproportionate number (30%) lived in the most deprived quintile of the county.

The profile of SEND needs remained broadly similar to England. In 2023-24, the most common was 'social, emotional and mental health' (21%) and 'speech, language and communication' (19%) needs. The proportion identified as 'Autistic Spectrum Disorder' needs increased from 5% in 2018 to 9%, but remained much lower than in England (15%). The H&W ICS All-Age Autism Strategy stated that this likely reflects the length of waiting for a diagnosis of autism.

Strengths

The EHCP assessment process appeared to be working well locally. Although still lower than before the pandemic, 77% of new EHCPs were developed within the twenty-week national requirement in 2023, notably higher than the 50% nationally.

Herefordshire's coproduction charter enables parent carers to have their say and influence change in the delivery of services. Recent actions included improved engagement and the joint development of better information materials.

The evidence of need gathered from QoL surveys in both mainstream and special schools informed priorities for health and wellbeing improvements. Parent carers of a third of special school pupils said in 2022 that tooth brushing was inconsistent, so those schools now support supervised tooth brushing.

Opportunities for improvement

There were clear inequalities. In the 2021 QoL survey there were significant unfavourable differences between pupils in mainstream secondary schools who said they had a disability and their peers. Themes included mental wellbeing, resilience and coping strategies, bullying and physical attacks, and sense of belonging. For example, 48% were afraid of going to school because of bullying at least 'sometimes' compared to 29% of pupils without SEND.

Historically, Herefordshire children with SEN support had generally done better than their peers nationally in the early key stages of education, but there had been persistent gaps in attainment for those with EHCPs. Changes to the education system limit long-term trend analysis, and small numbers mean that results can fluctuate as different groups pass each stage (the cohort effect). However the needs assessment noted signs that this picture was changing. In 2024, only 26% of children with SEN support achieved a GLD at the end of Reception, similar to the national rate and lower than the 37% in 2022. Conversely, recent EHCP cohorts did better than both their peers nationally and previous cohorts locally at the end of primary school.

The needs assessment concluded that although referrals to services had risen, recording systems did not enable a holistic view of the needs of children with SEND across the whole partnership. It recommended that a comprehensive tracking system across all services would support an understanding of need and tracking of outcomes for children and young people.

Children and young people's physical health: excess weight

One of the four 'Best Start in Life' ambitions of the JHWBS is that 'children enjoy good health and wellbeing'. The desired outcomes related to physical health focus on two of the biggest long-term physical health challenges: excess weight and oral health, as well as improving vaccination coverage.

Excess weight patterns are broadly in line with England

The DHSC states that 'tackling obesity is one of the greatest long-term health challenges currently faced in England', and the latest data indicate that Herefordshire is no different. The National Child Measurement Programme weighs children at school in Reception (age 4 to 5) and Year 6 (age 10 to 11).

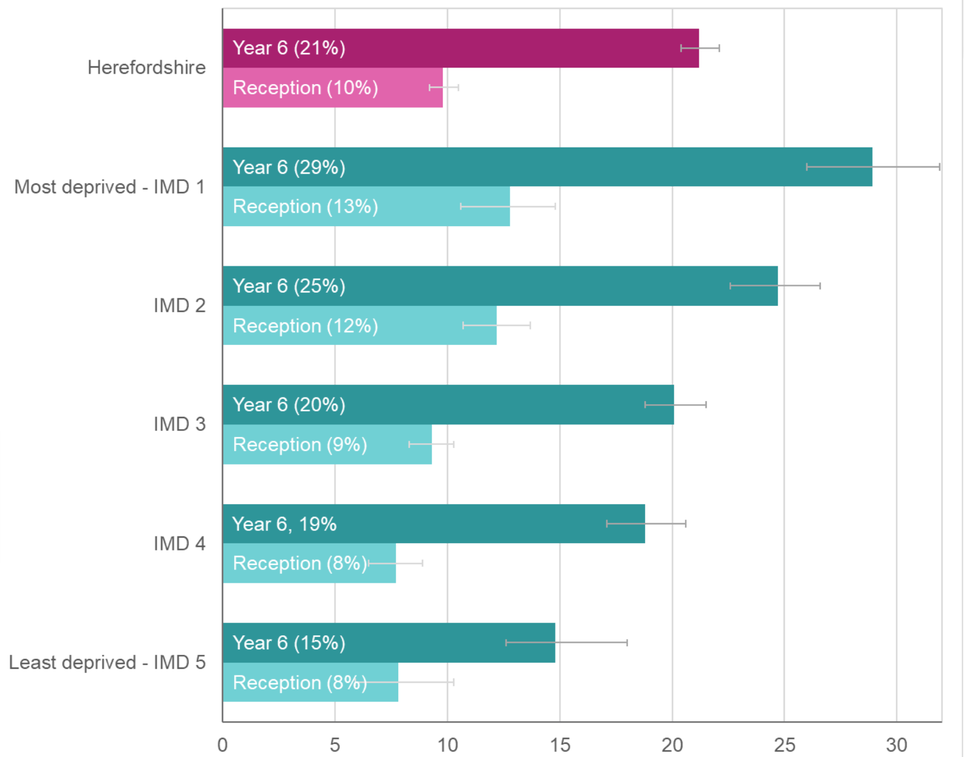
In 2023-24, 22% of Reception children were overweight (including obese), rising to 35% of Year 6. There were signs of improvement for the youngest age group, with fewer children overweight when starting school in the last two years than previously: in the three years 2019 to 2021 the rate was 26%, which was significantly higher than England overall.

Considering obesity specifically, there has been a long-standing pattern of rates doubling during primary school. In 2023-24, 10% of Reception and 21% of Year 6 were classified as obese. Reflecting the national pattern, children living in more deprived areas have had consistently higher rates of obesity, with a significant difference locally between the two most deprived quintiles and the two least deprived (see chart). For example, 29% of Year 6 children in the most deprived quintile (IMD 1) compared to 15% in the least deprived quintile (IMD 5). The chart also shows that the difference in obesity rates between Reception and Year 6 has been widest in the most deprived areas: a difference of 16 percentage points in IMD 1 compared to 7 in IMD 5.

Obesity in childhood is a strong indicator of obesity in adulthood, which is one of the major risk factors for disease (see p.27). Explore long-term trends and geographical variation in DHSC's Obesity Profile.

Children in more deprived areas are more likely to be obese than those in less deprived areas

% of children in Herefordshire in Reception class and Year 6 who are obese by Index of Multiple Deprivation (IMD) 2019 quintile, 5 years pooled 2019/20 to 2023/24



Data source: Obesity Profile. Fingertips, DHSC. Last accessed 9 December 2024.

Children and young people's physical health: other aspects

Significantly higher rates of dental decay than most of England

In 2021-22, 39% of Herefordshire five-year-olds had experience of visually obvious dental decay, based on a sample selected under the National Dental Epidemiology Programme. This was the eighth worst rate in the country on this key indicator of dental health, and significantly above that of England (24%) and all statistical comparators (all either the same or lower than England). The local rate has not changed significantly since the measure was first recorded in 2007-08, whilst England's has fallen from 31%.

Local access to NHS dentists is a commonly cited problem – see for example the 2022 Healthwatch Herefordshire Dental Engagement report. Half of CYP who took part in the 2021 QoL survey said they had seen a dentist in the 2020-21 academic year, although routine access may have been impacted by the COVID-19 pandemic. Two new NHS practices will have opened in Hereford by the end of 2024. Preventative efforts are focused on working in partnership with nursery and education settings to encourage healthy oral care habits such as supervised tooth brushing.

Vaccination coverage below target

Historically, Herefordshire has had better coverage of childhood vaccinations than nationally, and this remains the case in the latest data (2023-24). However, levels remain significantly below the national target of 95% population coverage at age five for the pre-school vaccinations of:

- 4-in-1 booster against pertussis (whooping cough), diphtheria, tetanus and polio offered at three years four months (also called Dtap/IPV): 89%.
- Full two doses of the MMR vaccine against measles, mumps and rubella: 90%.

This is despite uptake initial uptake of first doses of both of these vaccines being closer to or above target: 96% for Dtap/IPV/Hib/Hep B and 93% for MMR. Both are priorities for improvement under the JHWBS.

Having been below the national rate for a year in 2022, vaccination coverage of children in care was better in 2023 (87% compared to England's 82%), but remains lower than the 97% achieved locally in 2018.

Hospital admissions

Hospital admission indicators are published to benchmark the use of acute healthcare services, with rates per 100,000 population enabling comparison between different sized areas. However, such indicators may be influenced by local variation in referral and admission practices, as well as variation in incidence or prevalence.

A child is recorded as being admitted to hospital in Herefordshire if they are seen on the children's ward. Admissions can be planned via an appointment or unplanned (emergency), for example via attendance at A&E.

The rate of child A&E attendances has been lower than nationally, although the absolute number of visits rose from 13,000 under-18s in 2021-22 to 14,150 in 2022-23. Conversely, the overall rate of emergency admissions for children has been significantly higher than England's since 2010-11 (except during the pandemic). There were 3,300 admissions of under-18s in 2022-23, 58% of which were under-fives.

Four specific admission reasons had rates significantly higher than England in 2022-23:

- Unintentional and deliberate injuries to children aged under 15 (particularly 5 to 15), although the recent trend was improving: 245 in 2022-23 compared to 345 in 2019-20.
- Epilepsy amongst under-19s: consistently higher than England, and the highest in the country in 2022-23. Having averaged around 40 per year since 2013-14, there were 70 admissions in 2022-23.
- Lower respiratory tract infections: 2022-23 saw 235 admissions of under-fives, 75% of which were under one year old.
- Gastrointestinal infections amongst under-twos, although small absolute numbers (55 admissions in 2022-23) mean that the confidence intervals around these rates are very wide.

Although these indicators give a sense of the demand for emergency healthcare, they should be interpreted with caution. Several local analyses have suggested that over half of recorded child admissions are discharged the same day.

Children and young people's mental health

'Mental health is as important to a child's safety and wellbeing as their physical health. It can impact on all aspects of their life, including their physical wellbeing, relationships and educational attainment. Mental health can also change over time, to varying degrees of seriousness, and for different reasons.' (NSPCC, 2024)

Mental wellbeing and resilience

Nationally, an estimated one in five children and young people had a probable mental disorder in 2023 (NHS England). Locally, the 2021 QoL survey provided new insight into the emotional health and wellbeing of almost 5,000 children and young people at school and college in Herefordshire. It revealed that the majority were happy with their life: 75% of primary pupils and between 50 and 60% of older CYP. However, large minorities had low mental wellbeing scores: 25% of primary pupils and 48% of older students.

The most common worries across all ages were about their future, the way they look, and, especially for teenagers, their own mental health. Even at primary age, 28% of boys worried about their future, and 34% of girls worried about the way they look. 33% across all ages were afraid to go to school at least sometimes because of bullying.

Building resilience (the ability to cope with adversity and adapt to change) in children and young people can have life-long protective benefits. Only 24% of primary and 13% of older pupils had a high resilience score (based on answers to what they do if something goes wrong or if they don't succeed).

Across multiple indicators emotional wellbeing and resilience was generally lower amongst teenagers and girls in particular; for example 28% of girls from Year 7 onwards weren't happy with life, compared to 10 to 13% of boys of all ages.

Inequalities were also noted amongst disabled and economically disadvantaged pupils, and these children were also most likely to say that they or their family had sought help for their mental health: 40% of secondary pupils with a disability compared to 25% without, and 20% of those eligible for free school meals compared to 12% who were not.

Mental ill-health

Mental health risk factors are often inter-related and compounding, and mental ill-health of parents is a significant risk for children's wellbeing. Mental health support for a family member is one of the most common reasons for needing Early Help in Herefordshire (identified in 73% of new cases in 2020-21), and parental mental ill-health is observed in many social care assessments (29% in 2020-21).

Depression was the second most common LTC for children and young people registered with a Herefordshire GP in 2024 (behind asthma). Currently (October 2024), 13% (275) of children and young people aged 10 to 19 years have a diagnosis of depression. Depression is particularly prevalent among teenagers with 96% of these cases amongst those aged 15 to 19 years.

The CLD Trust provides specialist mental health services for children and young people in Herefordshire. According to its Annual Report for 2023-2024, the number of referrals it had received increased by 30% during the year. From April 2023 to March 2024, overall 1,660 children and young people were referred to the CLD Trust for emotional health and wellbeing support, 7% directly from Child and Adolescent Mental Health Services (CAMHS), which provide services for CYP with persistent and complex issues.

Published data suggest that Herefordshire had the highest rate in England for under-18s being admitted to hospital for mental health conditions in 2022-23. However, such indicators may be influenced by local variation in referral and admission practices as well as variation in incidence or prevalence. Nevertheless, the local rate was significantly higher in the last two years than before 2019-20, with 120 admissions in 2022-23 compared to fewer than 70 a year.

More detail on children and young people's mental health will be available once the Mental Health Needs Assessment undertaken in 2024 is published (see p.43).

Safeguarding children

The UK government's Working Together statutory guidance (2023) requires that local arrangements are in place to safeguard and promote the welfare of children, and to work together to identify and respond to the needs of children in the area. Locally, this is the Herefordshire Safeguarding Children Partnership (HSCP), made up of the statutory partners of the council, police and NHS Integrated Care Board. Its strategic priorities are aligned to the Children's Services Improvement Plan, put in place following the 2022 'inadequate' Ofsted rating.

The rate of children with experience of the social care system in Herefordshire is consistently amongst the highest in England. Latest published comparisons showed that there were 412 Children in Care in 2022-23, which represented a rate of 121 per 10,000 children; the 17th highest of all upper-tier local authorities in England, and significantly higher than in all statistical comparators except Shropshire. This was the highest it had been for five years, and had increased by 100 children since 2019-20.

The HSCP's Yearly Review of Effectiveness Report 2023-24 set out evidence of the impact of the partnership's activities for the year. It recognised sustained high demand for Children's Services, indicating required continuation of work to ensure appropriate application of thresholds of need (see diagram).

However, the 2023-24 data showed signs of emerging improvements in dealing more appropriately with need, for example through prevention or early intervention:

- Although numbers of safeguarding contacts received by the Multi-Agency Safeguarding Hub (MASH) remained high, fewer progressed to referral: 20% compared to 28% in 2022-23.
- The rate of Children in Need fell to 88 per 100,000 from 105 in 2022-23, more in line with other local authorities in the West Midlands.
- There was an increase in Early Help activity (almost 5,000 Children's' Help and Advice Team contacts, 34% more than the year before).
- 204 children were on a Child Protection Plan (CPP) in March 2024. This was lower than in March 2023, but had been increasing since June 2023. The rate remained relatively high.
- Although the rate remained high, the absolute number of looked after children fell: 98 children were taken into care in 2023-24 whilst 119 left.

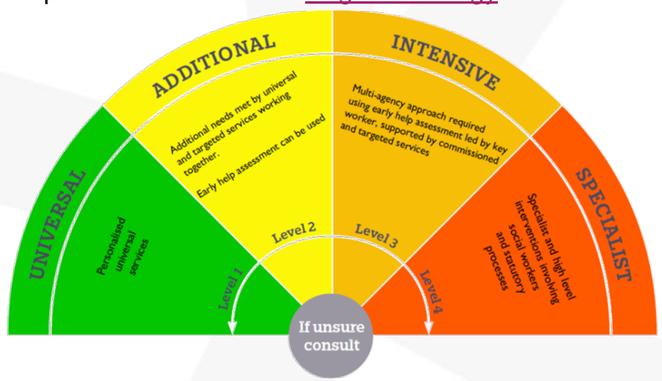
Emotional abuse was the most common reason for children being subject to a CPP, followed by child neglect. A small proportion were due to sexual or physical abuse.

Almost all (94%) of Herefordshire's care experienced young people aged 19 to 21 lived in suitable accommodation. The Corporate Parenting Service has regular oversight of those who do not.

As in other similar authorities, the proportion of care experienced children in education, employment or training (EET) was low (54% for those aged 19 to 21). The HSCP note that it should be improved by maximising apprenticeships, work experience and employment opportunities with the local authority and partners.

The report also describes findings and recommendations of three themed audits facilitated by the HSCP in respect of safeguarding and child protection: strategy meetings, child on child abuse and child sexual abuse.

The HSCP also implemented a reviewed Neglect Strategy for 2024 to 2027.



Source: Right Help Right Time Levels of Need, HSCP (2020)

Section 7: Adults - factors affecting health

‘Smoking, poor diet, physical inactivity and harmful alcohol use are leading risk factors driving the UK’s high burden of preventable ill health and premature mortality. All are socioeconomically patterned and contribute significantly to widening health inequalities.’
The Health Foundation

This section includes summaries of needs assessments relating to adult health which have been completed in the last three years.

The adults’ mental health page reflects the ‘good mental wellbeing throughout life’ priority of the JHWBS.

The others reflect the Public Health commissioning cycle:

- Smoking (2023)
- Substance misuse (2023)
- Sexual health (2023)

Mixed picture for **mental wellbeing** (2023):

- 'good' for 37% of adults
- 24% reported high levels of anxiety.

Substance misuse:

Lower prevalence of drug and alcohol misuse than nationally.

Smoking:

10% of adults smoke (2023). Overall rate similar to England but worse for certain groups.

Sexually transmitted infection (STI) testing rates have remained significantly below England since 2012. Diagnosis rates remain low since.

Adults' mental health

Having good mental health makes life easier. It helps us to calm and comfort ourselves when we're upset, to cope with the losses, changes, fears and uncertainties in life, to make and keep good relationships with other people and to learn.' (Mental Health Foundation)

'Good mental wellbeing throughout life' is one of the two priorities of the JHWBS; four ambitions relate to people feeling:

- Satisfied with life and having a positive sense of personal wellbeing.
- Able to access appropriate mental health information and services.
- Safe from harm in their community.
- Connected to their community.

The last two are covered in the wider determinants section - see p.67 (community safety) and p.66 (friends, family and community). See p.40 for children and young people's mental health.

Mental wellbeing

Levels of personal wellbeing are generally similar to nationally; in 2022-23 the ONS Annual Population Survey (APS) suggested that relatively few people had scores indicative of low life satisfaction (6%), happiness (8%), or feeling worthwhile (6%).

More detailed insights come from the 2021 and 2023 Herefordshire Community Wellbeing Surveys (CWS). The Warwick and Edinburgh Mental Wellbeing Scale is a composite measure of overall mental wellbeing. In 2023, 37% of adults (aged 18+) had good mental wellbeing, while 8% had poor. Overall levels of mental wellbeing were similar to 2021, but there were significant inequalities, with lower levels for example amongst people living with a disability, those in deprived areas and social renters.

The APS and CWS suggest that somewhere between a fifth and a quarter of Herefordshire adults had high levels of self-reported anxiety in 2022-23, similar to England overall. In the 2023 CWS, 24% had high levels, down from 28% in 2021.

Similarly to overall mental wellbeing, those living in the most deprived areas were much more likely to have high anxiety levels (38%). In addition, inequalities were also noted in some other groups, such as minority ethnic communities (37%) and those receiving care (34%). Significantly, 45% of those who 'often' or 'sometimes' felt lonely also had high anxiety.

Mental ill-health

Levels of mental ill-health (prevalence) are based on GP registers. In 2022-23, 20,350 adults aged 18+ (13%) had a diagnosis of depression, and over the past five years there have been an average of around 2,000 new diagnoses a year. In 2023-24, 1,500 people of any age (0.8%) had a diagnosis of schizophrenia, bipolar affective disorder, or other psychoses. These rates are amongst the lowest 40% in England.

The number of emergency admissions to hospital due to intentional self-harm across people of all ages has fallen in the last four years from around 300 a year to 170 in 2022-23, and the age-standardised rate is now significantly below England's.

There can be an association between suicide and mental ill-health. The suicide rate has been similar to England since at least 2001, and has not changed significantly over this period (see p.34).

A Mental Health Needs Assessment (not yet published) was undertaken in 2024 to support the mental health ambitions set out in the JHWBS. It noted two areas of service provision for adults which are currently significantly worse than in England, related to attending contacts with community and outpatient mental health services and support for those entering drug treatment who also need help with their mental health.

It also notes that based on the age profile of the county and estimated age-specific prevalence of mental ill-health, we would expect to see more older people accessing mental health services than currently are. There are also a lack of local mental health and wellbeing data for several high-risk groups and in some cases it is not currently possible to even determine numbers at risk, for example sex workers.

Lifestyle factors: smoking needs assessment

Smoking is the leading cause of preventable illness and premature deaths in the UK. It also plays a major role in health inequalities, accounting for half of the life expectancy gap between the most and least deprived communities in England. While smoking prevalence continues to decline, the gap in prevalence between the most and least deprived has increased. (DHSC).

In 2017, the UK government set a target for England to become 'smoke free' by 2030, aiming for a smoking prevalence of 5% or less. (Towards a Smoke free Generation: A Tobacco Control Plan for England, DHSC, 2017). A cross-sector Herefordshire Tobacco Control Alliance, established in 2024, is developing a Tobacco Control Plan which will set out local actions to achieve this ambition.

Smoking and vaping research, 2022

In 2022, the Public Health teams at Herefordshire and Worcestershire councils commissioned research to gain insight into attitudes and behaviours related to smoking and vaping to inform needs assessments for community tobacco control services.

At the time, smoking rates in Herefordshire were similar to England overall (11.7% of adults in 2020) and had been falling in line with national trends over the previous five years. Smoking rates for certain groups, such as those in routine/manual jobs, adults with mental health conditions, and pregnant women, were worse than the national average and/or worse than 50% or more of its statistical comparators.

575 adults across both counties took part in the research; primarily smokers (57%), ex-smokers (24%) and vapers (21%). The main findings were:

- Reasons for smoking included social aspects, stress relief, and enjoyment, with most smokers starting in their teens. About half of smokers wanted to quit, and 90% of them had tried and failed.
- Health concerns, cost, and existing health issues were top motivators to quit. Support from a GP and a pharmacy, willpower, online and local support were the most frequently stated resources that would help respondents quit smoking.
- The main motivations for vaping were as an alternative to smoking, stress relief, boredom, and socialising with friends who vape. The main reasons for not quitting vaping were a lack of motivation, its role in helping reduce or quit smoking, and nicotine addiction.

The latest data suggest

- The overall smoking rate was still in line with the England average, with 10% of adults saying they were current smokers in 2023. Consistent with the national trend, this rate has fallen from around 17% between 2011 and 2015. 60% of adults said they had never smoked.
- Smoking during pregnancy (at time of delivery) improved to 8% in 2023-24, down from 14% in 2017-18 and similar to the national rate of 7%. Additional cessation support had been implemented in maternity services.
- Smoking among routine and manual workers was in line with the national rate, but remained twice as high as for adults overall. The estimated rate in 2023 was 21%, down from 31% in 2022, although this change is not statistically significant due to the small sample used to calculate the rate.
- In 2022-23, 28% of adults with long-term mental health conditions smoked, more than double the overall rate. While this rate was similar to the national, Herefordshire ranked second worst among its statistical neighbours.
- Local analysis of GP records shows that smoking rates also vary significantly between the most and least deprived areas of the county. In 2024, the most deprived areas had a smoking rate of 18%, while the least deprived had a rate of just 9%.
- To further reduce smoking rates in the county, local stop-smoking services received a UK government grant in 2024 to expand and enhance their programs.

Find the latest data, trends and comparisons in the DHSC Fingertips Tobacco Control profiles. The Herefordshire health inequalities dashboard managed by Taurus Healthcare provides more detail about smoking amongst GP patients.

Lifestyle factors: substance misuse needs assessment

Drug misuse contributes to physical and mental health issues, such as lung damage, cardiovascular disease, depression, and anxiety. It can also result in unemployment, homelessness, family breakdown, and increased criminal activity.
(Department for Levelling Up, Housing and Communities, 2022)

Although substance misuse is estimated to be lower in Herefordshire than elsewhere in England, there is room for improvement. Herefordshire Council conducted a needs assessment in 2023 to consider how to reduce the harm caused by substance misuse in the county, aligned with the 2022 government 'From Harm to Hope' 10-year drugs strategy.

The main facts summarised in the needs assessment were:

- Lower prevalence of opiate use than nationally: 5.1 per 100,000 compared to 7.3
- 921 adults and 17 young people (aged under 18) engaged with substance misuse services in 2021-22.
- Opiates were the most commonly cited substance of drug misuse for adults, whilst for CYP it was cannabis.
- People in Herefordshire were in treatment longer than elsewhere, with 23% remaining for over four years compared to 19% nationally.
- Less successful treatment for misuse of non-opiates (such as cannabis, crack or ecstasy) than elsewhere: in 2021-22 the success rate for completing treatment was 49%, lower than England (55%).
- Treatment success for opiate users was less (3.6%) than England (5%) in 2021.
- Lower rates of testing for some blood-borne viruses (BBV) than elsewhere (examples of BBVs include Hepatitis and HIV).

Areas of good practice highlighted were:

- Below national rate of hospital admissions for drug poisoning: 24 per 100,000, compared to 43 per 100,000 in 2021-22.
- Increasing numbers of people in treatment: between 2020 and 2022, new drug treatment presentations rose by 6%, and new alcohol treatment clients by over 50%.
- Positive feedback from service users about treatment.
- Increasing engagement of former treatment service users as peer mentors.

The following areas were identified for improvement:

- Number of drug-related deaths: there had been 24 drug-related deaths in the three years 2018 to 2020, a similar mortality rate to nationally (5 per 100,000), but showing an increasing trend.
- Numbers of people engaged with services.
- Length of time in treatment and treatment outcomes.
- Transition from prison to community-based services: engagement with community treatment services among adults released from prison was lower locally (26%) than nationally (37%) in 2021-22.
- Early identification and help at every stage of life.

The needs assessment concluded that both treatment and prevention interventions should be strengthened and that a whole-system approach across the life course would be needed in order to secure a drug free Herefordshire. It also noted that many of the risk factors that draw people into substance misuse, such as poverty, domestic abuse, or adverse childhood experiences, were increasing and that it is important to effectively mitigate these risks to avoid a worsening future pattern of substance misuse.

A new treatment provider has been in place since 2021, and more recent local data suggest some notable improvements since the needs assessment was completed:

- Provider data show that successful completion of treatment for opiate users had steadily increased from as low as 3% in early 2021 to 9% by mid-2024.
- An important milestone towards the NHS target of eliminating Hepatitis C by 2025 was achieved with the micro-elimination of Hepatitis C confirmed in June 2024.

Find the latest published data, trends and comparisons in the Fingertips public health profiles.

Note: a previous version of this report stated that the number of drug-related deaths had reduced since 2018-20. This related to the number of deaths of people in treatment. The total number of deaths from drug misuse in the latest published period (2021-23) was 37, which equated to a rate of 7.6 per 100,000 – not significantly different to England's 5.5. Although higher than the 24 in 2018-20, the difference is not statistically significant.

Lifestyle factors: sexual health needs assessment

The World Health Organization defines sexual health as the physical, emotional, mental, and social wellbeing related to sexuality. While needs vary by age, gender, and orientation, core needs include access to high-quality information, education, services, and treatment. Poor sexual health can have serious consequences, including unplanned pregnancies, HIV transmission, and psychological harm. (DHSC, 2022)

Sexual health needs assessment, 2023

A sexual health needs assessment was completed in 2023 to provide an overview of sexual health services and outcomes for the population. Its main findings were:

- Outcomes were mixed, with some indicators above and others below national averages.
- Sexually transmitted infection (STI) testing rates were rising but remained below the national average.
- Low proportions of STI tests were positive (called 'test positivity rates'), which may have indicated lower prevalence but only if there was fair and equitable access and uptake of testing, particularly for high-risk groups.
- Treatments have improved prognosis for individuals living with HIV nationally. However, Herefordshire had low HIV testing rates and a higher percentage of late diagnoses (see note).
- Rurality poses challenges in accessing sexual health services, especially for young and high-risk groups. Equitable healthcare access remains a priority.
- Evidence-based primary preventative interventions should be prioritised to help improve sexual behaviours and sexual health outcomes across all ages.
- Multi-agency collaboration through the sexual health forum is essential for addressing local needs effectively.

Note: The HIV data presented in this section may have been affected by coding limitations, which could have impacted the accuracy of the data. Caution should be exercised when interpreting these figures, as they may not fully reflect the true prevalence or trends of HIV in the population.

What the latest data say

In the context of sexual health indicators, 'good' performance generally implies high testing rates coupled with low test positivity. However, diagnosis rates are closely tied to testing frequency and coverage.

Since the needs assessment, the routine indicators of sexual health have been reviewed in the Health Protection Assurance Forum Annual Report 2024. The latest data indicate there have not been any notable changes since the needs assessment. The main messages from the annual report were:

- In 2023, the STI diagnoses (excluding chlamydia) remained significantly below England and the second lowest amongst statistical comparators. STI testing rates have also remained significantly below England since 2012. This means it is unclear if the low STI diagnosis rates are accurate, or due to low testing.
- Gonorrhoea diagnosis rate remained significantly better than England's, ranking fourth lowest nationally and second lowest among comparators.
- Cervical screening coverage for 25 to 49-year-olds remained significantly better than England, while coverage for the 50 to 64 age group was similar to England. However, screening coverages for both age groups had been declining. For the younger age group, coverage had dropped from 77% in 2010 to 67% in 2023, while for the older age group, it had fallen from 82% to 75% over the same period.
- The percentage of late HIV diagnoses in the county remained similar to the national average. However, when compared to the recommended targets, the county performed poorly and exceeded the threshold for late HIV diagnoses.
- Of those tested, chlamydia detection rates in Herefordshire have remained below national levels since 2014 for both females and males. Chlamydia was the most prevalent STI locally.
- The screening coverage for chlamydia testing in females aged 15 to 24 declined from 2021 to 2023, with rates being significantly worse than England in 2023.

Section 8: Adults - vulnerable groups

Some people are more vulnerable to poor health and wellbeing outcomes, either because of a characteristic they have, or due to circumstances they are in at a particular time.

This section summarises needs assessments or other pieces of work with a focus on a specific characteristic or circumstance which have been completed in the last three years.

It is not intended to cover all vulnerable groups.

- Social care users (2022-23)
- Adult safeguarding (2023-24)
- Domestic abuse (2024)
- Carers (2024)
- Armed forces and veterans (2023)

Social care: 2,200 adults accessing long-term support, 60% aged 65+ (2022-23).

Safeguarding: most incidents occur in the victim's home (47%), with financial and material, and psychological /emotional abuse the most common (2023-24).

Carers: 4,800 people aged 5+ provide 50 hours or more of unpaid care a week (2021).

Estimated 8,000 people affected by **domestic abuse** each year; 68% female.

Armed Forces: 1,750 serving personnel (2023), plus 9,600 veterans (2021).

Social care

‘Local authority budgets have failed to keep pace with rising costs and the increase in the number of people needing care.’ (Care Quality Commission, October 2023)

Reflecting the county’s ageing population, at the end of 2022-23, 60% of the 2,200 adults receiving long-term support in Herefordshire were aged 65 and over.

Herefordshire performs well across most Adult Social Care Outcomes Framework (ASCOF) measures**,** particularly in service user quality of life (see chart). For instance, the county is ranked highest nationally for the proportion of service users reporting that they had as much social contact as they would like. However, in June 2023 a West Midlands ADASS (Association of Directors of Adult Social Services) Benchmarking Report identified several areas of concern:

Workforce issues: Challenges in recruiting and retaining staff, with a high reliance on agency workers.

Rising demand: An increase in service requests that lead onto a service.

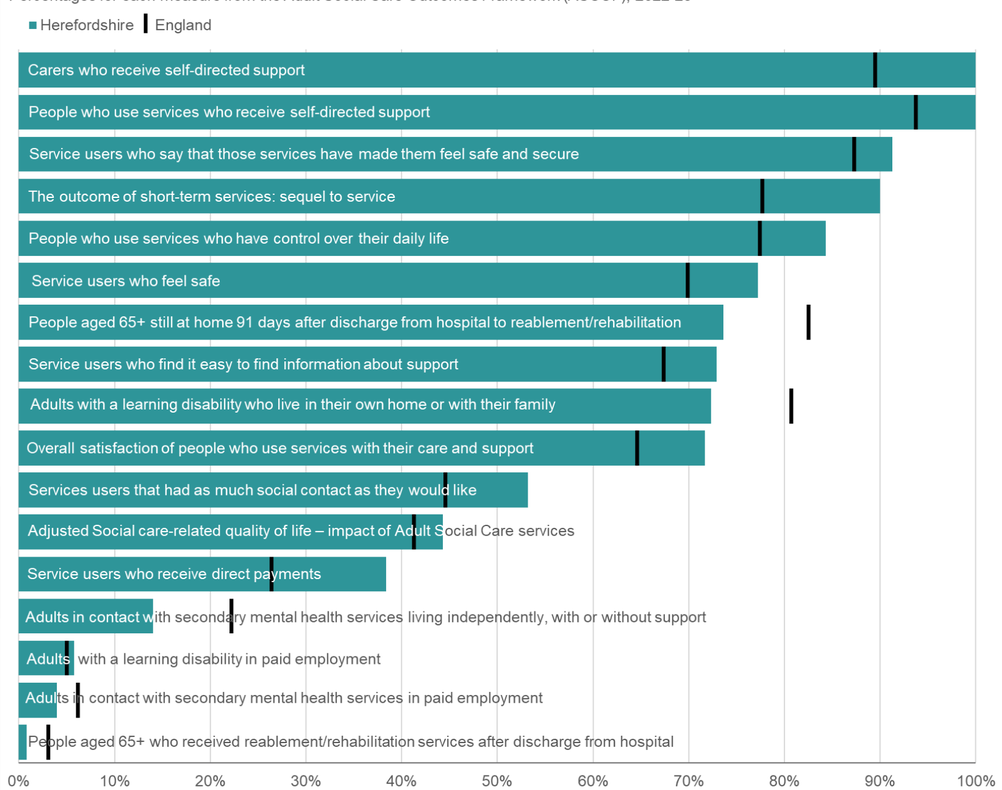
Accommodation gaps: Limited specialist in-county facilities for working-age adults with complex needs.

Service imbalances: Over-reliance on residential and nursing care due to issues with domiciliary care and ‘discharge to assess’ services, resulting in less spending on community-based solutions.

The Market Position Statement (MPS) 2020-2025 (refresh due 2025) recognises pressures such as rising costs, market fragility, uncertainty around demand, and choices available to those who are self-funding their care. It outlines commissioning intentions to address these areas, emphasising a strengths-based social work model that focusses on clients' personal capabilities and ways of empowering them to manage their own needs and making full use of community resources. The MPS also promotes collaboration between health and social care services and community health services, to deliver joined-up, accessible care, emphasising prevention and proactive, upstream interventions, to minimise reliance on intensive, long-term care.

Despite challenges facing the provision of social care in Herefordshire, performance is better than nationally on most outcomes for adult social care service users

Percentages for each measure from the Adult Social Care Outcomes Framework (ASCOF), 2022-23



Data source: Measures from the Adult Social Care Outcomes Framework, England, 2022-23. Information from NHS England, licenced under the current version of the Open Government Licence. Last accessed 9 December 2024.

Safeguarding adults

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. The Herefordshire Safeguarding Adults Board (HSAB) exists to ensure that adequate local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance. It acts in accordance with the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership, and accountability and transparency.

The following is summarised from the HSAB Annual Report 2023-2024.

The current priorities for the HSAB are:

- **Self-neglect**: improving the response to understanding and managing self-neglect needs, making sure all agencies understand and respond to self-neglect.
- **Exploitation**: addressing the safeguarding issues and challenges arising from criminal exploitation including 'cuckooing', sexual exploitation, modern slavery, county lines, human trafficking and financial exploitation.
- **Prevention**: supporting initiatives and activities which prevent or reduce abuse and neglect and keep people safe.
- **Neglect and omission**: understanding the profile of neglect and omission occurrences within the county and identifying approaches and resources to mitigate the impact.
- **Board effectiveness**: ensuring the board fulfils its statutory duties and is effective in its role of assurance of the safeguarding system.

The HSAB has also decided to focus on:

- Transitions for those moving from a child to an adult service, service to service, or service to discharge, in a safe and positive way.
- Following the Safeguarding Adults Review on adults with multiple and complex needs the Board, monitoring provision for those 'rough sleeping' in Herefordshire.

Characteristics of those affected by safeguarding concerns

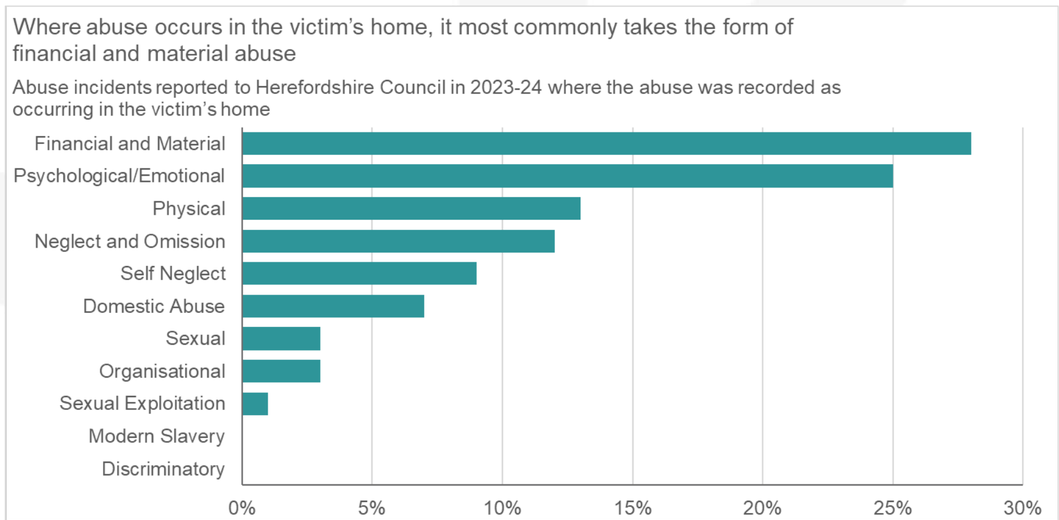
1,300 safeguarding concerns were received by Herefordshire Council in 2023-24, and 120 safeguarding enquiries were opened. Due to a change in practice, the number of concerns being referred to the safeguarding team reduced substantially from the previous year (2,250).

In 2023-24, 34% of all concerns involved people aged 18 to 64, while 24% were 85 or over.

Almost half of incidents involve those in their own home (47%), with 'financial and material' and 'psychological/emotional' the most commonly reported types of abuse, each mentioned in 25% or more of incidents.

The 'source of risk' was personally known to the individual in 48% of concluded enquiries and providing a service to the person in 23% of concluded enquiries.

In 30 completed enquiries the person at risk lacked mental capacity. Where the person was assessed as not having capacity in 2022-23, 33% were provided with either formal or informal advocacy but in 2023-24, this proportion fell to 25%. The HSAB is reviewing these data to understand why more advocacy is not taken up or provided.



Data source: Herefordshire Safeguarding Adults Board Annual Report 2023-2024

Domestic abuse needs assessment

'Domestic abuse [DA] has a huge impact on society and is one of the most pervasive of all social problems. It causes pain and suffering for those affected and their family, and has a significant cost to public services and the local community. It is often a hidden crime, with people experiencing domestic abuse reluctant to report their situation and friends, neighbours or family hesitant to get involved.' (Herefordshire's strategy for addressing domestic abuse, 2021-24)

Under the Domestic Abuse Act 2021, local authorities are required to regularly assess the need for accommodation-based domestic abuse support in their area. The 2024 needs assessment will inform the new DA strategy, to be published in 2025.

The Act defines DA as 'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'.

An estimated 8,000 people experience domestic abuse each year

There are currently no official estimates of trends in the extent (prevalence) of domestic abuse. SafeLives, a leading charity, estimate that around 8,000 people a year in Herefordshire experience it: 5,500 (68%) females and 2,500 (32%) males.

Reflecting the hidden nature of domestic abuse, it was estimated that of these victims, only 34% of females and 24% of males accessed services. It is therefore unlikely that numbers recorded by services will ever give a complete picture.

Domestic abuse crime is highest in the most deprived areas

West Mercia Police recorded 2,100 DA offences (recorded crimes) in Herefordshire in 2022-23; slightly lower than the 2020-21 peak of 2,200 but still much higher than the 1,400 in 2017-18. Whilst this may suggest an increase in offences being committed, it may also be linked to better recording, recognition and reporting of DA.

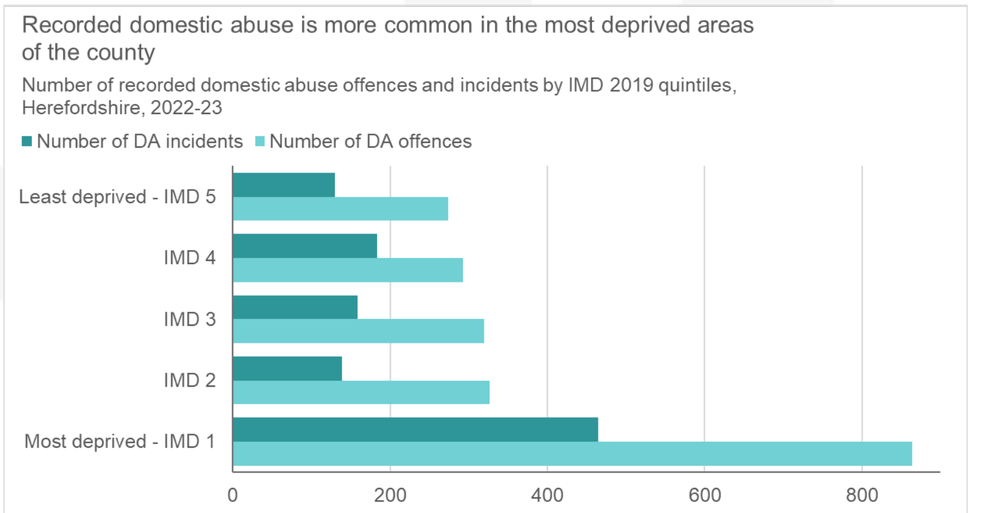
The gender profile of victims is similar to the estimated prevalence. There is a clear link with deprivation, with over 40% of both offences and incidents (when police attend but no crime is recorded) occurring in the most deprived quintile (IMD 1) of the county.

Fewer than 10% of offences in 2022-23 proceeded to a criminal charge or summons; with the most common reasons being the victim not supporting police action (57%) or difficulties with evidence (25%).

Accommodation needs

Based on population size, the Council of Europe recommends 19 units of safe accommodation in Herefordshire. In 2022-23 this level was provided, with a further four commissioned for future use.

However, despite this adequate provision of immediate refuge, feedback from people with lived experience of DA suggests a need for sustained housing options upon leaving safe spaces and improving in-home security arrangements to allow survivors to remain in their homes.



Data source: Domestic abuse crime and incident data supplied by West Mercia Police

Carers

'Unpaid carers play a pivotal role in our communities, contributing dedication and compassion to support their loved ones. It is crucial to recognise that the experience of caregiving is not a one size-fits-all journey, but rather a nuanced and dynamic process shaped by the unique needs and circumstances of those involved.' (Herefordshire All-Age Carers Strategy 2024-2029)

An assessment of the numbers of unpaid carers and their health and wellbeing outcomes was completed in 2024, to inform the Herefordshire All-Age Carers Strategy.

Numbers of carers

Estimates vary as to the number of unpaid carers. 2021 Census data suggested that around 16,000 people (9%) aged five and over provided at least an hour of care a week, similar to England and Wales. However, this may be an underestimate and the 2023 CWS (of Herefordshire adults only) indicated that 21% (32,500) were providing some level of unpaid care.

Similarly, for young carers, the CYP QoL survey suggests that in 2021 around 1,500 pupils in school years 6 and above were caring for someone at home but the 2021 Census only identified 360 young carers aged between 5 and 17.

A relatively small proportion of adult carers are entitled to claim Carers Allowance and even fewer are known to social care services (in 2023 around 2,100 and 170 respectively). Fewer than 200 young carers were known to local services in January 2024.

Characteristics of carers

2021 Census data indicated that around 8,800 people in Herefordshire provided 19 hours or less of unpaid care each week. However, nearly a third (29% or 4,800 people) provided 50 or more hours.

The majority of carers were female (60% overall), although the likelihood of being a carer varied by age and gender. Females were more likely to provide any unpaid care (at least one hour a week) than males in all age groups. In particular, the likelihood of providing unpaid care was highest amongst females aged 50 to 64: 19%, compared to 12% of males of the same age and 12% of females aged 35 to 49, and less than 11% for other age-sex groups. Males and females aged 65+ were the most likely to be providing the highest levels of care (4.5% provided 50+ hours a week).

7% of carers aged five and over (1,200) were in poor or very poor health, and 28% (4,600) were disabled under the Equality Act.

Of those carers who were in poor or very poor health or who disabled, nearly a half provide care for 50 or more hours per week, despite their own significant health challenges.

Impacts of caring: children and young people

National research has found that young carers miss more school days and perform worse in GCSEs than peers without a caring role. Locally there is evidence that with regard to some aspects of quality of life, for example risky behaviours, feeling of safety and anxiety, young carers also fare worse.

Impacts of caring: adults

Carers' UK research in 2019 found that carers were seven times more likely to experience loneliness than the general population.

The Caring for Others survey of adult carers known to Herefordshire Council in 2021-22 found that at least 40% suffered from poor mental wellbeing (e.g. tiredness, disturbed sleep, depression) and only 28% had as much social contact as they desired. Almost all said they had little or no control over their daily life (91%), or did not have the time to do things they value or enjoy (94%).

The 2023 CWS found that adults who said they provide some level of unpaid care were more likely to say their anxiety level increased since last year (28% compared to 22% of all adults).

Armed forces and veterans

Our armed forces make a unique and important contribution to national life. Herefordshire has a proud military heritage and is home to a significant population of serving personnel and their families, as well as armed forces veterans.

Those who serve in the armed forces and their families face different challenges to the civilian population and although most service leavers and families adapt well to civilian life, almost all will experience some kind of hardship when adapting to their new lives. Recognising this, the Armed Forces Covenant Partnership works to ensure that no member of our local armed forces community faces disadvantage. Herefordshire has a good range of support from military charities and other organisations, including the Herefordshire Veteran Support Centre, which provides a safe, confidential one-stop shop for the whole armed forces community.

Serving military personnel and their families

There were 1,750 members of the regular armed forces (the majority being army personnel) and 320 civilian Ministry of Defence personnel stationed in Herefordshire in April 2023. The total number of their dependents living in the county is unknown but in autumn 2023 944 children in Herefordshire schools attracted the Service Pupil Premium.

Veterans

A larger proportion of the adult population of Herefordshire are veterans than nationally and regionally. In the 2021 Census, 9,600 residents aged 16 and over had served in either the UK armed forces, UK reserve armed forces or both; 6% of the 16+ population, compared to 4% in England and Wales. 11% of households (9,000) contained at least one veteran, a greater proportion than the England and Wales figure of 7%. Partly, this may be due to Herefordshire having an older population than the UK as a whole (see p.18), as a majority of veterans are aged 65 and over. However, other local authorities that contain military establishments also had above average numbers of veterans, which suggests veterans tend to stay in the same areas after they have left service. There were higher concentrations around the active military base at Credenhill, as well as nearby Hereford city, Weobley and Wellington areas.

Veterans' characteristics

Some of the particular characteristics of veterans in Herefordshire in 2021 were:

- Veterans were much more likely to be older and male than the general population. Herefordshire's veteran community had a similar age profile to the rest of the country with 52% (5,000) aged 65 and over, compared to 53% nationally. 86% (8,300) of Herefordshire veterans were male, again similar to nationally.
- When the non-veteran population was adjusted to account for age and sex, Herefordshire veterans reported better general health than their non-veteran peers (69% compared to 63%).
- 29% of veterans in Herefordshire had a disability as defined under the Equality Act, compared to 30% of the non-veteran population and a lower proportion than that for England and Wales (32%).
- Herefordshire veterans of working age (aged 16 to 64) were less likely to be economically active than the non-veteran population (45% compared to 60%). However, a greater proportion were economically active than in England as a whole (42%). Retirement was the main reason for economic inactivity (91%), which is unsurprising given that normal retirement age for military pensions is earlier than state pension age.
- 78% of Herefordshire veterans were homeowners compared to 66% of non-veterans. Again, this is to be expected, as home ownership increases with age and a higher proportion of veterans were in older age groups than non-veterans.
- Over 50% (5,000) of veteran households in Herefordshire were deprived in at least one domain. However, when looking across three or more dimensions of deprivation, veteran households were actually marginally less likely to be deprived than non-veterans.

More information on numbers of veterans is available in the UK armed forces veterans 2021 Census report. A new Armed Forces Needs Assessment is planned for 2025.

Section 9: Adults - ageing well

People are more likely to experience ill-health as they get older, but many long-term health conditions are preventable and are affected by the social and economic environments we live in.

Ageing well was the focus of the Director of Public Health Annual Report 2023, and this section summarises the main messages in terms of the health challenges facing older people specifically, as well as the risk and preventative factors which influence the likelihood of healthy ageing. It also summarises a falls prevention needs assessment completed in 2024.

Of 53,000 GP-registered patients aged 65+, 72% have at least one **long-term condition** (2024).

Falls: Average of 770 emergency hospital admissions a year for people aged 65+.

65% of GP patients aged 65+ (over 33,000) are **overweight or obese** (2023).

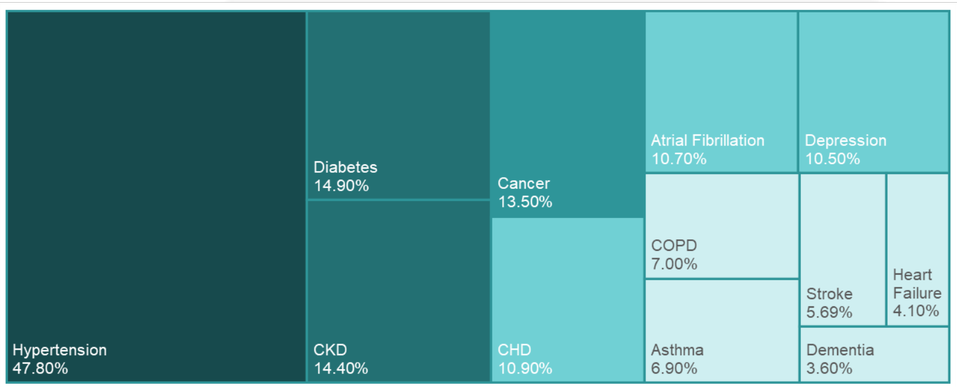
Health challenges for older people

‘People experience more ill-health as they get older, [including]…an increasing likelihood of an accumulation of chronic diseases, sometimes called multi-morbidity… These conditions increase mortality, lower the quality of life, and increase demand for health and social care services.’ (Director of Public Health (DPH) Annual Report 2023)

The 2023 DPH report considered in detail the specific health challenges facing the older population, these are summarised below.

Long-term health conditions (LTCs)

As discussed on p.35, the likelihood of having one or more LTC increases with age. In February 2024, of 53,000 people aged over 65 registered with a Herefordshire GP, 38,000 (72%) had one or more LTC. The most common conditions are shown in the chart, with nearly half (48%) being for hypertension (high blood pressure). By 2040, 29% more people over 65 in the county are expected to have hypertension.



Current prevalence of long-term conditions in over 65s registered with a Herefordshire GP. Source: Director of Public Health Annual Report 2023.

Dementia

Dementia is a group of symptoms affecting brain function. It affects a relatively small proportion of the population (3% in the UK) and, although more common in older people, should not be considered an inevitable part of ageing. Nevertheless, as the number of older people increases, the number of people in Herefordshire affected is likely to rise: from an estimated 3,200 people aged over 65 in 2017 to over 5,500 by 2040.

Improving dementia diagnosis is important to ensure people get the care and support they need. The estimated diagnosis rate in Herefordshire is consistently significantly below both the national target of 68% and England’s overall rate. In 2024, it was 57% compared to England’s 65% and was the 17th lowest of all upper-tier local authority areas in the country. It is therefore very likely that the true prevalence of this disease is underestimated.

Frailty and falls

Having an ageing population means that more people are at risk of frailty, falls and fractures. A detailed falls prevention needs assessment was completed in 2024 (see next page).

Health and social care

People aged 65 or over are more likely to use GP services, with an average of 11 contacts per year compared to 5 for those under 65. 44,000 people aged over 65 (83%) had 12 or more GP contacts last year. This demand is expected to increase as the older population grows.

Older people are the heaviest users of adult social care services. The rise in the older population is expected to lead to increased demand for care home places (from 1,150 in 2018 to 2,650 by 2038) and input from unpaid carers is likely to become greater. See also p.48 and p.51.

Falls prevention needs assessment

One of the supporting priorities of the JHWBS is to enable people to live and age well. National research indicates that falls are the main reason older people are admitted to hospital in an emergency. They have a significant impact on long-term health, often resulting in people having to leave their homes and move into nursing or residential care. (DHSC)

A Herefordshire Falls Prevention Task and Finish Group was set up in 2022, and a Frailty Strategy was produced by the H&W ICS in 2023. This page summarises a 2024 epidemiological falls prevention needs assessment.

Summary of main falls statistics for Herefordshire

- Institute of Public Care projections suggest that the number of people aged 65+ who have a fall could increase from an estimated 36,700 in 2020 to 45,300 in 2030 and 52,500 in 2040 (23% and 43% increases respectively).
- Not all falls result in injury, but on average each year they lead to 770 emergency hospital admissions of people aged 65+ (average for 2017-18 to 2022-23). About one in three people who are admitted with a fall are diagnosed with a hip fracture.
- Unlike in some statistical comparator areas, residents aged 65+ are less likely to be admitted to hospital because of a fall than in England overall.
- Frailty is a complex concept, beginning with loss of muscle strength and increased fatigue, and reducing ability to recover from illness. Those living with frailty are at increased risk of falls, admission to hospital, and the need for long-term care. In 2022 around 8% of over-50s were estimated to have frailty.

The importance of exercise

Achieving the best level of fitness, even in the presence of a chronic illness, will reduce the risk of loss of function and independence, and even less than ideal levels of activity can reduce the risk and impact of falls.

Nationally, in 2022 only 62% of over-55s and 41% of over-75s were meeting the recommended 150 minutes minimum of moderate activity a week; and only 44% of all adults the recommended 2+ sessions of muscle strengthening (resistance) exercise.

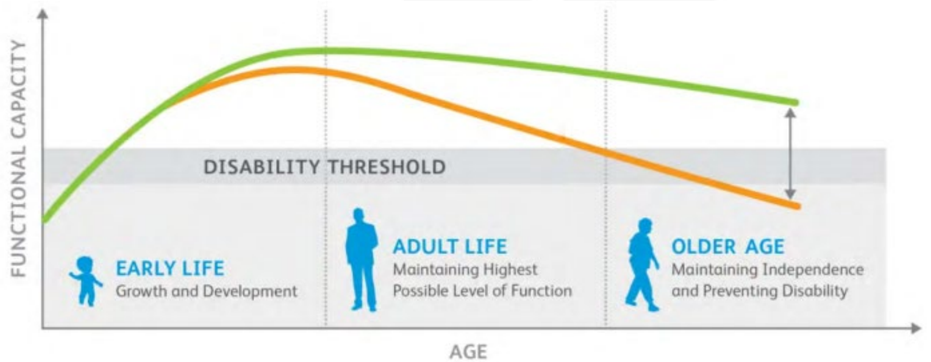
Implications and recommendations

The main priority should be prevention through exercise: for those in their 40s to 60s to stay fit and maintain functional capacity for as long as possible to avoid future health and care system failures, and for those at more immediate risk in recognition that at least one-third of frailty can be reversed.

This should be achieved through education of both individuals and health and social care professionals, and improving exercise opportunities. Reconditioning should be emphasised at all appropriate opportunities, for example as part of standard clinical management for long-term conditions, as well as recovery from acute illness or injury.

Home assessments/adaptations and expedited cataract surgery are cost-effective ways of preventing falls happening, although they do not improve an individual's functional resilience should they fall. The cost-effectiveness of other interventions are less clear, with reviews recommended of assistive technology and the local physiotherapy offer; and also of how medicines individuals are regularly taking are reviewed.

Functional capacity change with age in physically active (top) and sedentary (bottom) individuals



Source: Adopted from A Global Strategy for Healthy Ageing, A. Kalache & I Kiekbusch. World Health, 1997

Factors affecting ageing well

The development of health conditions associated with older age is not inevitable. There are many straightforward actions that can be taken by individuals and society to delay or prevent the onset of disease and maximise healthy life expectancy. This page highlights the factors associated with ageing well, as discussed in the Director of Public Health Annual Report 2023: Ageing Well in Herefordshire.

Healthy behaviours

Health behaviours play a key role in how well people age. Being physically active, eating a healthy, balanced diet, not smoking and moderating alcohol consumption can make a big difference to health in later life, increasing the proportion of life spent in good health. There is a great deal of evidence about how making healthy choices can enhance health and wellbeing in older age and that it is never too late to adopt healthy behaviours and add years to life and life to years.

For example, maintaining a healthy diet as people age is important. However, in 2023 nearly 65% (33,035) of over-65s registered with Herefordshire GPs were overweight or obese. The promotion of healthy diets early on in life, as well as supporting older people to achieve a healthy weight, is therefore essential for maintaining good population health.

Social connections

Being socially connected is vital for health and happiness in later life. Positive relationships with family, friends, and communities foster a sense of belonging and improve physical and mental health. Being socially active may also reduce the risk of developing dementia. Loneliness and isolation can have negative impacts in the same way as chronic long-term conditions like diabetes and hypertension. The 2021 Census showed that 31% of Herefordshire households were people living alone and half of these were over 65, equating to 28% of all those of this age group.

Older adults are particularly vulnerable to loneliness due to changing social networks after retirement, caregiving, or bereavement. In 2021-22, only 32% of carers over 65 known to Herefordshire Council reported having sufficient social contact, although this was higher than England (29%). See p.51 for more on unpaid care.

Social connectedness also varies depending on financial resources, which can create health inequalities. Poverty increases loneliness, with older adults often struggling to afford transport for social activities or visits with loved ones. Social connections are enhanced by a wide range of community assets that include good transport links, green spaces, community groups, and learning, employment and volunteering opportunities.

The internet has transformed work, communication and access to information, playing an essential role in fostering social connections and community engagement. However, many older adults face barriers to accessing and using online resources, which can lead to feelings of loneliness and difficulties in accessing health services. While 88% of adults in Herefordshire used the internet regularly in 2023, 25% of those over 65 did not. Other work has highlighted that 49% of Telecare service users (a group largely comprising elderly people) did not use the internet in 2022. See p.66 for more on digital exclusion.

Environment

In order for older people to maintain their independence and quality of life they need a suitable environment in which to live. The built environment can promote physical and mental health in older adults by providing opportunities for exercise and safe active travel, and by making social activities more accessible to people with some degree of disability.

Older adults spend more time at home and are more likely to live in cold homes during winter. Hence, suitable housing is also vital, as homes that are cold, damp, prone to overheating, unsafe, or unsuitable for the needs of older people, contribute to the development and exacerbation of many LTCs (p.54). See p.62 for more on cold homes. Home aids and adaptations can improve quality of life for older people who are losing mobility (see p.55).

Section 10: Wider determinants of health and wellbeing

‘Our health is a precious asset. Good health and wellbeing enable us to live happy, fulfilling lives and free us up to achieve our potential. Building a healthy society is like constructing a sturdy building. To succeed, we need all the right building blocks in place.’

‘When we don’t have what we need to heat our homes or buy healthy food, for example, and are constantly worrying about making ends meet, it can lead to chronic stress, poor health and lives being cut short.’

‘But change is possible. By improving things like access to good-quality jobs, developing affordable homes, reducing poverty and making healthy food more accessible, we can… fix the gaps and build better health for all our communities.’

(The Health Foundation 2024)

Wider determinants: strengths and challenges

‘Good or bad health is not simply the result of individual behaviours, genetics and medical care. A substantial part of the difference in health outcomes is down to the social, economic and environmental factors that shape people’s lives. These factors are collectively described as the wider determinants of health.’
(Public Health England 2018.)

This section summarises the latest insights about the wider determinants, focusing particularly on those that have most direct impact on health, and which can be influenced by local organisations.

The information is drawn from a variety of sources, including the Herefordshire Economy and Cost-of-Living Compendium, the 2021 Census, the Community Wellbeing Survey (CWS) and the Community Safety Assessment.

A good place to live and visit, with nature-rich countryside but inequalities of access. However, the benefits of the natural environment are under threat.

11 ‘highly significant’ floods 2008 to 2022.

Average house price **9.7** times average earnings (2023).

Cold homes are the biggest housing-related risk to health.

14,300 homes with excess cold hazard (2019).

Employment is high, but productivity is low - leading to lower average earnings.

£539 weekly workplace-based median earnings (2023).

Most people have a positive view of their local community, but with some significant inequalities.

87% satisfied with local area as a place to live (2023).

Fuel poverty remains more common than nationally.

20% of households in fuel poverty (2022).

Access to services, lack of transport infrastructure and road-safety pose challenges.

62% of areas in most deprived quartile nationally for ‘geographical barriers to services’ (2019).

Number of NEETs has fallen and is significantly lower than nationally.

4.3% of 16-17 year-olds not in education, employment or training (NEET) or whose activity is not known (2022-23).

Unemployment low compared to England. More people not working due to ill-health or disability than unemployed and seeking work:

4,900 vs **3,500** 16-64s (2021).

Relatively low risk of being a victim of crime and most people feel safe in their local area.

73% of adults say they feel safe when outside after dark (2023).

Farming and food production is a big part of the economy and heritage but not enough people are benefiting from a healthy diet.

39% of adults eat the recommended five-a-day fruit and vegetables (2021-23).

Our surroundings: the environment

‘Evidence shows that a thriving, wildlife-rich environment benefits both physical and mental health. People with nature on their doorstep are more active, mentally resilient and have better all-round health’. (The Wildlife Trusts)

The natural environment is an asset for the economy and residents, although not everyone has equal access

Herefordshire has two National Landscapes (Wye Valley and Malvern Hills), 9% of land area is designated for nature conservation and it borders the Bannau Brycheiniog (Brecon Beacons) National Park. This offers a wealth of opportunities for residents and tourists to benefit from engaging with nature.

In 2023, tourism contributed almost £736 million to the local economy. Over 5.8 million visitors spent significant time in the area, supporting over 8,000 jobs.

Shaped by the natural environment, agriculture is a cornerstone of Herefordshire’s economy, heritage and communities. In 2023, 10,000 jobs were in farming: 11% compared to just 1% across England.

However, access to green spaces is unequal. Although higher than the national average, Herefordshire does not meet the Fields in Trust Green Space Index 2023 minimum standard, and 31% of residents do not live within a ten-minute walk of accessible green space [note 1]. The 2021 CYP QoL survey found that more than a quarter of primary and secondary school pupils and nearly 40% of further education (FE) students had not visited parks or open spaces in the past four weeks.

Note 1: correction from previous version which stated that only 31% of residents lived within a ten-minute walk of accessible green space.

The many benefits of the natural environment are under threat

The climate crisis is also a health crisis as rising temperatures and extreme weather will disrupt care and impact the health of our communities (H&W ICS Green Plan).

Climate change is impacting land use and food production in Herefordshire, which has a large number of low-lying areas liable to flooding. Analysis to inform the Climate Change Adaptation Plan for Herefordshire 2023-2028 found that there had been 41 severe weather events in Herefordshire between 2008 and 2022, including 11 ‘highly significant’ floods.

In 2021, 30% of Herefordshire primary school pupils, 19% of secondary school pupils, and 23% of FE students, said they were worried about the environment and climate change.

As well as risks from climate change, widespread declines in biodiversity were recognised in the council’s declaration of a Climate and Ecological Emergency in 2019. Pollution means that the ecological health of the entire catchment of our two biggest rivers (the Wye and its tributary the Lugg) has been downgraded to ‘poor’ (‘unfavourable-declining’) by Natural England. This is mainly attributable to nutrient run-off from intensive poultry farms and discharges of raw sewage.

The Herefordshire Council Plan 2024-2028 explains how the council plans to address the environmental challenges facing the county. A Local Nature Recovery Strategy is currently being developed and a pioneering integrated constructed wetland project at Luston is attempting to mitigate local river pollution.

In addition, in 2023 Herefordshire Council was ranked as the top performing local authority in the West Midlands on sustainability action for the third year in a row, after completing Sustainability West Midlands benchmarking.

Transport: geography and infrastructure

‘Available, reliable and affordable transport supports the other building blocks of good health, such as connecting people to work and public services. Good transport options and infrastructure can enable exercise, employment and road safety.’
(The Health Foundation, May 2024)

Herefordshire’s geography shapes transport options and choices

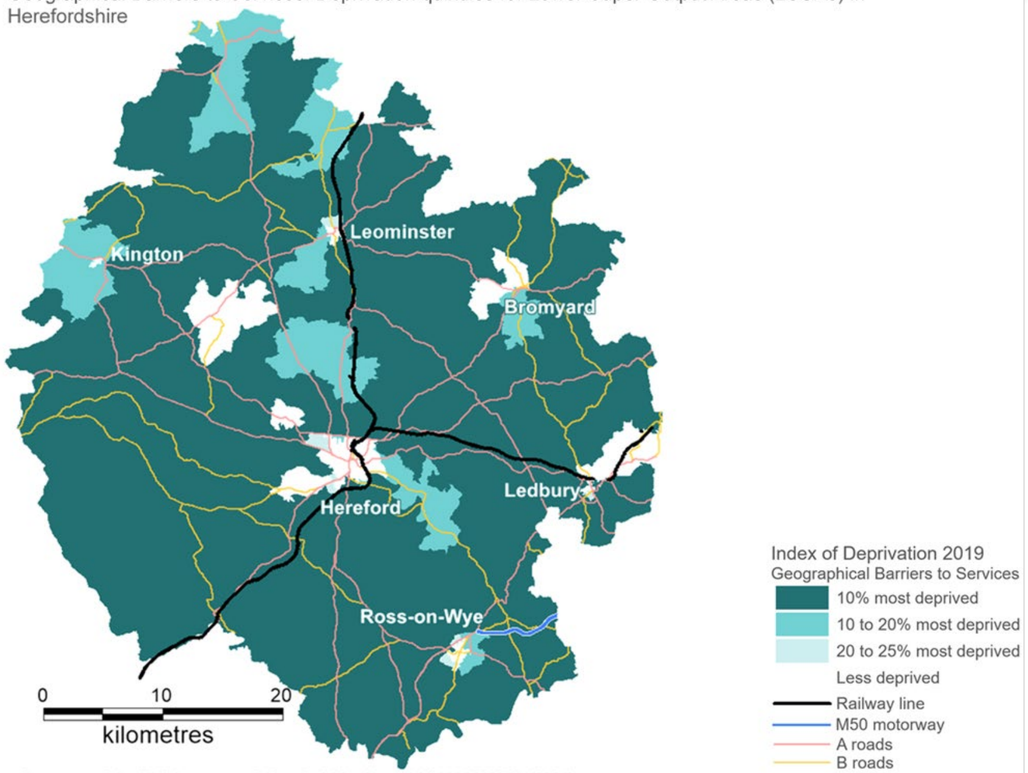
Services are concentrated in Hereford City and the five market towns (Herefordshire Local Plan – Core Strategy 2011-2031) and yet 43% of the county’s 189,900 residents live in areas classified as ‘rural village and dispersed’. ‘Geographical barriers to services’ is the most widespread type of deprivation affecting the county: 72 of the county’s 116 LSOAs (62%) were among the most deprived 25% in England in the 2019 Indices of Deprivation, with 53 of these in the most deprived 10%.

The rail network is limited, with only four stations on the two lines passing through the central and eastern parts of the county. The population is scattered across the entire 842 square miles, making commercially sustainable bus provision problematic (Herefordshire Local Transport Plan 2016-2031 Strategy). Combined with the distances involved, it is unsurprising that there is a heavy reliance on car travel. The 2021 Census recorded that 24% of the county’s working adults travelled over ten kilometres to get to work, compared to 19% across England. 58% of workers commuted by car, compared to 35% nationally.

High proportions of children travel to school by car (in 2021, 59% of primary school and 37% of secondary school pupils), and school transport services cost the council more than £8million in 2023-24. Over 400 of the 4,000 students receiving Home-to-School transport are eligible because some or all of their route to school is deemed hazardous (unsafe to walk alone or with an adult). These routes cost the council over £600,000 per year based on the average cost per student.

Most of Herefordshire outside of the city and market towns is amongst the most deprived in England in terms of geographical barriers to services

Geographical Barriers to Services: Deprivation quintiles for Lower Super Output Areas (LSOAs) in Herefordshire



Crown copyright. All rights reserved. Herefordshire Council AC0000850532. (2024)
ONS LSOA boundaries are reproduced with the permission of HMSO

Data source: English Indices of Deprivation, 2019. Ministry of Housing, Communities and Local Government. Last accessed 9 December 2024.

Transport: active travel and road safety

Active travel: a priority for improvement

Walking, wheeling, cycling and other alternatives to driving are better for individuals' health, as well as the environment, and they help reduce congestion in towns and cities. The county's only two Air Quality Management Areas (AQMAs - where air pollution levels are higher than the national objectives) are on busy road junctions in Hereford and Leominster.

Active travel will be one of the main ambitions of the council's new Local Transport Plan (LTP), due to be published in 2025. 90% of 630 respondents to a consultation in 2024 supported the plan enabling health behaviours and improving wellbeing. 29% said improving walking and wheeling options, such as making pedestrian environments more attractive and improving lighting/security, was a top priority.

Extensive evidence bases are in development to inform the LTP and related policies, such as the Local Cycling, Walking and Wheeling Infrastructure Plan (LCWWIP). Visit the Herefordshire Council website to find out more.

Road safety: risk to young adults in cars

In 2023, the rate of people killed or seriously injured on Herefordshire's roads was 67.9 per billion road miles, significantly better than England (91.9) for the first time since 2018.

However, the county stands out as consistently having a rate for young adults (aged 15 to 24) injured or killed as a result of being in a car that is almost double that of England. In the period from 2016 to 2020 it was the 9th highest in the country (58.9 per 100,000), although the rate was similar to other rural counties. Despite this high rate, absolute numbers are relatively small, equating to about 11 per year.

Equivalent measures for cyclists, motorcyclists and younger children in cars are routinely in line with the national figure. For pedestrians, they are significantly lower. The same patterns are seen in similar rural counties and population-based rates can be affected by the sparsity of population in large rural areas.

Explore the range of road safety indicators on DHSC Fingertips.

Housing

'We all need somewhere to call home – not just walls and a roof but a secure, stable, safe place to grow up and live in. Our homes influence our health in many ways, both physically and mentally. Good housing should be affordable to all, decent quality, and secure and stable.' (The Health Foundation, May 2024)

Like many rural areas, Herefordshire has high proportions of older and larger homes. As of 2024, an estimated 26% of all dwellings were built before 1900, compared to 15% in England as a whole and 40% were detached, compared to 25% nationally.

67% of households are homeowners compared to 62% nationally. 'Outright' home ownership (without a mortgage) is more common in areas with older populations, as the 'baby boom' generation reaching retirement age are able to pay off their mortgages.

Housing affordability and homelessness

The high levels of home ownership mask a long-standing issue of affordability making it harder for local people to get on the property ladder. House prices are in line with the national average, but combined with relatively low wages, this means that the 'housing affordability ratio' (average price divided by average wages) is consistently one of the worst amongst statistically similar areas. In the year to September 2023, the average (median) house price of £290,000 was 9.7 times higher than the median earnings of people working in the county, a significantly bigger gap than the 8.2 for England overall.

Census data revealed that while outright homeownership rose from 39% in 2011 to 42% in 2021, the proportion of homeowners with a mortgage or loan decreased from 28% to 24%. Conversely, the proportion of households renting privately increased from 16% in 2011 to 19% in 2021, a similar increase to England as a whole, where the proportion increased from 16% to 20% during this period.

Reflecting the national trend, private rents have been increasing faster than overall inflation, but are lower than nationally: in October 2024 the average monthly rent was £766 compared to £1,348 in England, an increase of 8% from 2023.

Recently, Herefordshire saw a significant drop in households who are either homeless, or at risk of homelessness, from 1,328 in 2022-23 to 758 in 2023-24, reducing the rate from 16 to 9 per thousand, which is now below England's rate of 13. The recent implementation of several strategies that include early intervention, targeted support and enhanced collaboration between charities, outreach teams, and housing services, have effectively reversed previous trends driven by the cost-of-living crisis.

The number of people sleeping rough in Herefordshire fell from an average of 19 on any given night in 2022-23 to 12 in 2023-24. The Rough Sleeper Outreach Team has helped to reduce homelessness by providing support and securing stable housing.

Excess cold is the biggest housing-related risk to health

The nature of the housing stock means that Herefordshire homes are less likely to be well-insulated or connected to the gas network, making them harder and more expensive to heat. Only 54% of households had mains gas central heating in 2021, compared to 74% nationally.

The 2019 stock condition survey found that excess cold (threats to health from cold indoor temperatures) was the most common hazard, affecting 14,300 county homes: 17% compared to just 3% nationally. The proportion was higher amongst owner occupied dwellings (20%). National BRE research found people living in such properties are most at risk given their age and health. Energy inefficiency is also one element of fuel poverty - see 'money and resources' (p.68).

Local Housing Strategy

The provision of affordable and other types of housing to meet identified housing need, and improvements to the quality and energy efficiency of existing homes, are priorities under the Local Housing Strategy 2021-2026 published in 2022. Projections of future need formed part of the evidence base for the strategy, including an indication of a need for 422 rented and 175 owned affordable homes per year.

Education and skills

'Good education and skills provide a strong foundation for good health and a decent quality of life, throughout life…People with the highest levels of education can expect to live around 4 years longer than those with the lowest, and are less likely to live in poverty during their working age. As with the other building blocks, the relationship between education and skills and health is multidirectional and complex [which] can mean that both health and economic inequalities can persist – or escalate – throughout people's lives, as well as between generations.' (The Health Foundation, May 2024)

Educational attainment

Overall, primary school children at Herefordshire schools do as well as nationally. In 2024, 61% achieved expected standards in reading, writing and mathematics at the end of Key Stage 2 (primary school), compared to 60% in England. This had also been the case through secondary school, but the position has deteriorated over the last two years. 'Attainment 8' measures how well pupils do in eight key GCSE subjects, and in 2023, the average score for Herefordshire was 44.8, slightly below the 46.4 for England.

Furthermore, Herefordshire pupils are not progressing as well as their peers either nationally, or in statistically similar areas, throughout their time at secondary school. This is measured by the 'Progress 8' score, where in each of the last three years for which data are available (2019, 2022 and 2023), scores have fallen year-on-year and are notably lower than elsewhere. In 2023 average 'Progress 8' was -0.26, compared to -0.03 in England and down from -0.03 in 2018.

As noted on p.36, inequalities are already apparent when children start school and, as nationally, this gap is at its widest at GCSE stage. In 2023, only 19% of Herefordshire pupils eligible for free school meals (a common measure of disadvantage) achieved at least grade 5 in English and Maths GCSEs, compared to 46% of non-disadvantaged. This is also below attainment levels for disadvantaged pupils nationally (24%).

Leaving school

Research has found that young people who are not in education, employment of training (NEET) at age 16 to 17 remain educationally disadvantaged throughout life and are nearly three times as likely to be unemployed or economically inactive ten years later compared to non-NEET peers. In 2022-23, 160 Herefordshire young people were either NEET or their status was unknown, representing 4.3% of 16 to 17-year-olds, significantly below England (5.2%). Around a third of these lived in the most deprived areas of the county compared to around one in ten in the least deprived.

Young people in Herefordshire are also consistently much less likely to go on to higher education (HE) than their peers nationally: 39% in 2022 compared to 50% for England. Continuing the inequalities seen throughout their lives, the gap is even wider for disadvantaged young people: only 12% went on to HE compared to 29% nationally.

Qualification levels

Qualification levels amongst the whole population aged 16 and over were almost identical to nationally, according to the 2021 Census. 33% had higher qualifications of broadly degree level or above (level 4), but 28% did not have the equivalent of five grade A* to C GCSEs (level 2), including 18% with no formal qualifications.

The qualification levels of the local labour force influences an area's ability to attract, retain and train highly qualified workers. The ONS composite education score combines individual qualification levels amongst working people into a local authority average. Herefordshire ranks 201 out of 331 English and Welsh authorities, placing it just in the bottom 40%, in a similar position to neighbouring Powys. On this measure, 42% of the national workforce had level four qualifications, compared to only 37% of Herefordshire's. This is reflected to a certain extent in the type of work people do, with relatively fewer working residents in professional occupations than in England and Wales (16% compared to 20%). Conversely, more people work in skilled trades (15% compared to 10%).

Herefordshire's Big Economic Plan sets out the Herefordshire Sustainable Growth Strategy Board's ambition to create a highly skilled population and attract young people and families to the county by transforming Hereford into a thriving university-city and developing a strong offer across local colleges and training organisations.

People in work

‘Rewarding and fulfilling work supports good physical and mental wellbeing. It fairly rewards peoples’ efforts, enables them to earn a decent living wage and provides opportunity for personal development and financial security.’ (JHWBS)

The economic activity profile is different to nationally

In statistics about working, people are classified by their economic activity status. Those who are economically active are either working, or unemployed but looking for work. Being economically inactive means not being available for work, either due to retirement, commitments such as family or study, or ill-health and disability. 2021 Census data show that 57% of residents aged over 16 were economically active, compared to 61% nationally, driven by the greater proportion of people in retirement (28% compared to 22%), reflecting the older age structure of our population (see p.18).

Although most people work, productivity and earnings are low

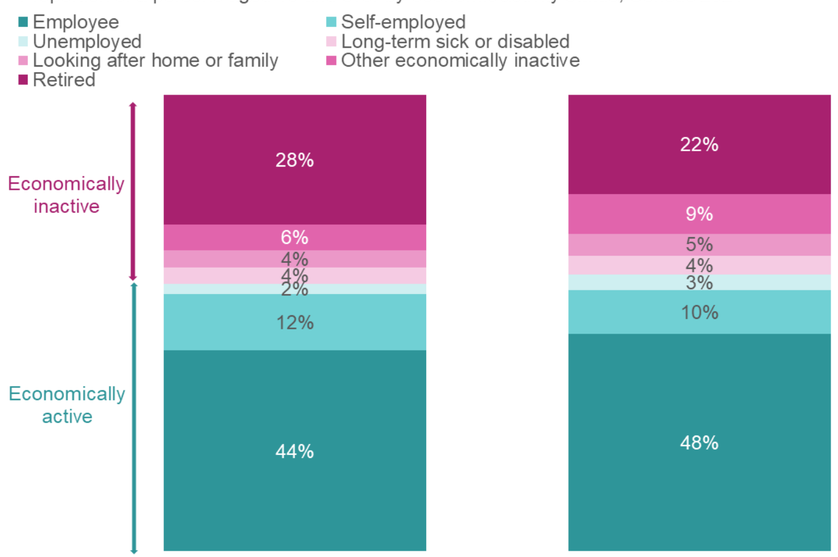
Data from the ONS APS show that in the period July 2023 to June 2024 the majority (81%) of Herefordshire’s working-age population (aged 16 to 64) were in employment, either as an employee of an organisation (69%), or through self-employment (13%).

ONS Business Register and Employments Survey (BRES) data for 2023 showed that the health sector accounted for the largest proportion of employment in Herefordshire (13%, the same proportion as nationally). However, a much higher proportion of jobs were in agriculture and manufacturing: 11% and 12%, compared to 1% and 7% respectively.

Labour productivity is an important determinant of living standards and is most commonly measured as gross value added (GVA) per hour worked (see note 1). Herefordshire consistently has one of the lowest levels of labour productivity of comparable economic areas (see note 2). In 2022, GVA per hour worked was £30, significantly below England (£40). This has an impact on earnings, which are also relatively low. In 2024, average (median) workplace-based earnings were £539 per week compared to England’s £620.

Relatively lower economic activity in Herefordshire due to a higher retiree population, compared to England and Wales

Proportion of a persons aged 16 and over by economic activity status, Census 2021



Data source: 2021 Census: Labour market and travel to work. Office for National Statistics. Last accessed 29 November 2022.

Note 1: Gross value added (GVA) is one way of measuring economic output [it] measures the contribution made to the economy by individual producers, industries, sectors or regions. The figure is a quantitative assessment of the value of goods and services produced minus the cost of inputs and materials used in the production process. What is Gross Value Added (GVA)? O’Farrell, L. University of Birmingham, May 2019. Last accessed 18 December 2024.

Note 2: International Territorial Level 3 (ITL3) areas: A geocode standard for referencing the subdivisions of the UK for statistical purposes, used by the ONS.

People not in work

'Unemployment has consistently been found to have a negative impact on a range of health outcomes, including mental health issues such as depression, anxiety and levels of self-esteem.' (The Health Foundation, July 2024)

'Once out of the workforce, people with a work-limiting health condition are nearly three times less likely to return to employment than those in good health' (The Health Foundation, October 2024)

Unemployment is low, but with significant inequalities

Historically, the unemployment rate in Herefordshire has been lower than nationally, and this remains the case. In the year to June 2024, the model-based estimate was 2.4% of economically active adults (16+), compared to 3.8% in England.

Those who want to work but cannot get a job can claim out-of-work benefits. Numbers of claimants increased dramatically at the start of the pandemic and haven't returned to pre-COVID-19 levels: in October 2024 there were around 3,250, 54% more than in March 2020.

There are significant inequalities within the county. Generally, areas that have the highest levels now already had more claimants before the pandemic. Rates in some of the most deprived areas of South Hereford and Leominster are around 5% compared to 3% for the county as a whole.

The age profile of claimants has also changed over time, with older people aged 50+ now accounting for a much bigger proportion of claimants than a decade ago (29% in 2024 compared to 23% in 2014).

Households where nobody is working (defined as 'workless') face a range of social and financial issues, for example increased risk of problem debt, homelessness and relationship distress. In 2023, 12% of Herefordshire households were workless, a similar proportion to England (14%).

More people not working due to ill-health and disability than are unemployed and seeking work, and numbers have risen

Nationally, 38% of people who were economically inactive in 2023 because of long-term sickness reported having five or more health conditions (up from 34% in 2019), suggesting that many have interlinked and complex health issues.

2021 Census data showed that more Herefordshire adults of working-age were not working due to ill-health or disability than were unemployed and seeking work: 4,900 (4.5%) compared to 3,500 (3.3%). This represented an increase from 3.9% and fall from 4.3% respectively since 2011.

As with unemployment, there was significant inequality within the county: 33% of these people lived the 20% most deprived areas of the county, compared to 13% in the least deprived.

National research indicates that the proportion of people who are long-term sick has been continuously rising since the pandemic. The fastest rises have been amongst under-25s, and a larger proportion have mental health conditions.

People with a LTC or disability who have difficulty doing certain tasks can claim Personal Independence Payment (PIP) to help with living costs. Although not directly comparable because people can still work whilst in receipt of PIP, it is a useful indication of more recent trends locally. Between January 2020 and July 2024, the number of claimants in Herefordshire increased by 52% to around 9,500 people, 37% of whom had some form of psychiatric disorder.

More information and data on these topics is in the latest Herefordshire Economy and Cost-of-Living Compendium and the 2021 Census labour market and travel to work headline results for Herefordshire, both available on the Understanding Herefordshire website.

Family, friends and communities

‘Family, friends and communities are the cornerstone of our everyday lives and play an important role in shaping our health and wellbeing. The nature of our social networks – the quality of our relationships, the support we have, whether we feel we belong where we live, whether we feel lonely – can influence our health and wellbeing in a range of ways.’ (The Health Foundation, May 2024)

The 2021 and 2023 CWS provided insights into Herefordshire residents’ perceptions of community wellbeing and their quality of life, and how these have changed over time. Unless otherwise stated these have informed the following findings.

Social contact and community resilience

Most adults in Herefordshire have a positive view of their local community. Although significantly down from around 90% in 2021, it was still the case in 2023 that over 80% were satisfied with, and felt they belonged to, their local area, and agreed that people from different backgrounds got on well together.

However, there were notable inequalities, with significant variation between different social groups and communities. For example, overall 87% were satisfied with their local area as a place to live but this was significantly lower amongst people living in the most deprived areas (80%), younger adults (aged 18 to 34) (82%), Housing Association/Trust renters (78%), lower socio-economic groups (82%), those who received care (81%), had a disability (83%) or were from a minority ethnic background (74%). Similarly, younger adults and those with a disability were much less likely to feel they belong (76% and 77% respectively compared to 82% overall).

Consistently, the majority (~60%) of Herefordshire adults said they had contact with family, friends or neighbours most days. This was the case even during the pandemic. However, an important minority of adults said they often or always feel lonely (6% in 2023), and this was a particular issue amongst vulnerable groups such as those with a disability (10%), or low levels of mental wellbeing (20%).

Studies have shown that volunteering can help combat stress, depression and anxiety. In 2023, the proportion of people volunteering had largely recovered from the disruption of the COVID-19 restrictions and was similar to 2018, with around a third of adults giving unpaid help to a group, club or organisation at least once a month.

Digital exclusion

National research has found that people who are digitally excluded (do not use the internet regularly) are less able to access services and have poorer health outcomes. Digital exclusion is also a barrier to social, educational and employment opportunities.

Overall, a relatively small proportion of people in Herefordshire are not regular internet users (12% in 2023), but non-use is much more common amongst certain groups. For example, 19% of people living in the most deprived areas, 25% of those aged 65+, and 41% of those with no formal educational qualifications. In a separate 2022 survey of Telecare service users (a group exclusively comprising vulnerable adults), 49% did not use the internet.

The 2023 CWS found that the most common reason for not using the internet was not needing it (44%), but 31% said they do not have the skills, rising to 48% amongst Housing Association tenants.

The proportion of people who expressed concern about more things being provided online increased by 13 percentage points between 2021 and 2023 to 35%. The proportion was even higher amongst non-internet users (54%) and a number of other vulnerable or otherwise disadvantaged groups, such as people with a disability, who receive care, or have no formal qualifications (43% in each case).

Community safety

'The level of crime in an area can influence how safe people feel, which can in turn affect mental health – along with impacting participation in activities which are good for our health' (The Health Foundation, May 2024)

The following has been mainly summarised from the Herefordshire Community Safety Partnership (HCSP) Community Safety Strategy 2024-2027 and Annual Report April 2023 to end of March 2024.

The risk of being a victim of crime in Herefordshire is relatively low, with no areas of the county falling within the 10% most deprived in England for crime according to the 2019 Indices of Multiple Deprivation, and people generally feel safe. Following a dip during the pandemic, recorded offences in Herefordshire are now similar to pre-COVID-19 levels. A total of 11,060 crimes were recorded from July 2020 to June 2023.

In 2023, most Herefordshire adults (73%) said they felt safe when outside after dark, which was in line with the national figure. Following an increase in feelings of safety during the pandemic (85% in 2021), figures had returned to 2012 levels.

In 2023 the HCSP undertook a strategic assessment of the available evidence to inform the priorities for the new Community Safety Strategy (2024 to 2027). The strategy identified four strategic priorities: domestic abuse, violence against women and girls (including sexual violence), misuse of drugs and neighbourhood crime. However, it was recognised that these individual crime types and priorities cannot be addressed in isolation. For example, substance misuse can be a factor in domestic violence, sexual violence and acquisitive crime. The strategy therefore also focused on four underpinning cross-cutting themes: serious violence, serious organised crime, prevention and community engagement.

Domestic Abuse: The HSCP reports that offences where domestic abuse was identified fell in the year to June 2023 (1,854 in total). However, it notes that the financial impact of the cost-of-living crisis is likely to have increased risks for victims and they are likely to put off leaving a dangerous partner due to the financial impact. For more detail on domestic abuse, see p.50.

Violence against women and girls (VAWG): Nationally, domestic abuse, sexual offences, stalking and harassment, and modern slavery and human trafficking have all seen recent increases. Domestic abuse is a key contributor to VAWG crime numbers.

Herefordshire data indicate that 'violence without injury' accounts for almost half of VAWG offences. Sexual assault and rape accounted for 13%, with 311 sexual offences and 107 rape offences recorded in the year to June 2023.

Misuse of drugs: Although recorded drug offences are decreasing, more people are accessing services and receiving treatment. Most drug offences in Herefordshire relate to possession of cannabis, with it being suggested that younger people are using it in preference to Class A opioids, which are on the decline and are now mostly used by older people. See also the substance misuse needs assessment (p.46)

Neighbourhood crime (including anti-social behaviour, acquisitive crime, and hate crime); the report states:

- Currently (2023-24) the number of incidents of anti-social behaviour in Herefordshire is high.
- Acquisitive crime includes shoplifting, burglary, theft, and robbery: overall, these offences increased in Herefordshire after 2021, a trend that continued into 2024. The majority involve theft, although shoplifting is an increasing category.
- Hate crime involves any criminal offence which is perceived to be motivated by hostility or prejudice based on a personal characteristic, disability, gender identity, race, religion or faith and sexual orientation. The relative incidence of hate crime in Herefordshire is low.

Money and resources

‘Secure financial circumstances lead to better material conditions, including adequate food and heating and reduce the likelihood of stress. Income also provides the resources to have a healthy diet and can provide the impetus to give up health-harming behaviours.’ (JHWBS)

Overall levels of income deprivation are relatively low, with twice as many areas amongst the 25% least deprived in England as in the most deprived (22 out of 116 areas compared to 10 according to the 2019 Indices of Deprivation). However, gross disposable household income is lower than in England: £22,726 per head in 2022 compared to £23,338.

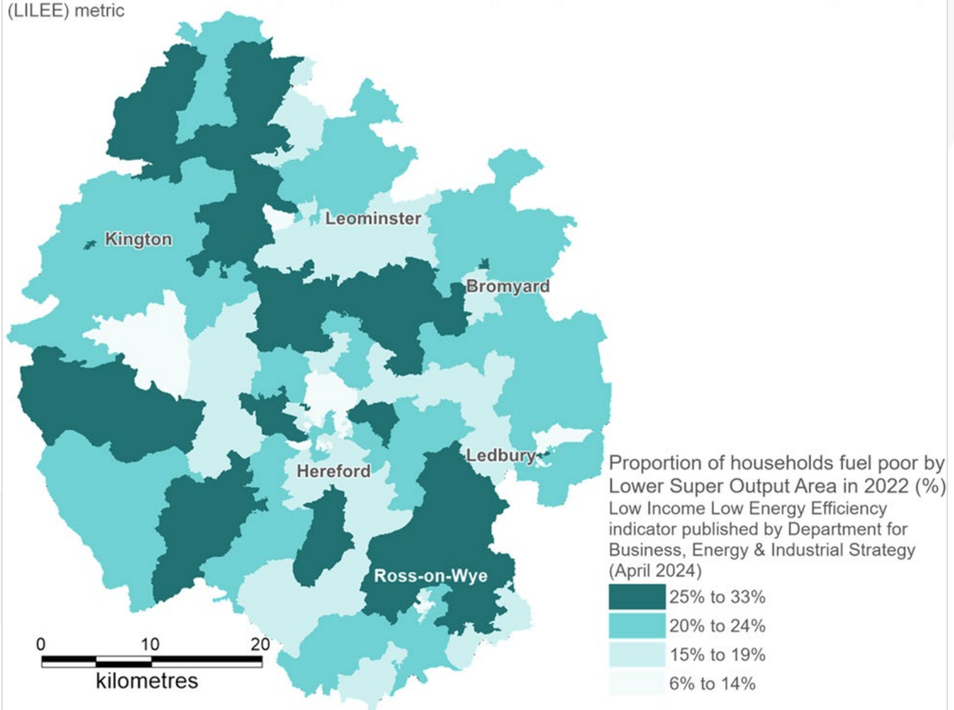
The number of households reliant on state benefits increased substantially during the pandemic and continued to rise during the cost-of-living crisis. Universal Credit is the main means-tested benefit in the UK: a monthly payment to help with living costs for those on a low income, out of work, or unable to work. There were 15,100 claimants in Herefordshire in October 2024, up from the pandemic peak of 12,400 in April 2021. This equated to 13% of working age adults, lower than in England (18%) but still more than double the pre-pandemic rate (5% in March 2020). Being on a fixed income, these households are amongst the most financially vulnerable.

Child poverty has increased in the last decade and after historically being lower than in England, the Herefordshire rate is now at a similar level. 20% of county children were living in relative poverty in 2022-23 compared to 14% in 2014-15. This amounted to around 5,900 children. However an alternative, unofficial, estimate accounting for housing costs, suggested the number may have been almost double this at 11,700.

Reflecting the rurality of the county, the rate of fuel poverty is higher than nationally: 20% in 2022 (16,900 households) compared to 13% in England. The measure takes account of both household income and energy efficiency of homes, so deprivation and housing age, type and location are all relevant factors. This is illustrated by the amount of variation in small area rates: from 6% in parts of Ledbury to 33% in parts of the rural north (see map).

Fuel poverty varies across Herefordshire, reflecting factors such as deprivation and housing age, type and location

Percentage of households in fuel poverty in Herefordshire by LSOA (based on Low Income Low Energy Efficiency (LILEE) metric



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ONS LSOA boundaries are reproduced with the permission of HMSO

Data source: Sub-regional fuel poverty data, 2022, Department for Energy Security and Net Zero. Last accessed 9 December 2024.

Find out more about these topics on the Understanding Herefordshire website.

The food we eat

‘Every year unhealthy diets cause a high number of deaths. A significant proportion of British people are struggling to afford a healthy diet and unhealthy diets are related to 6 of the top 10 risk factors for the global burden of disease.’ (Director of Public Health’s Annual Report 2022.)

Food production and security

Globally, the current food system is unsustainable, being the single biggest contributor to biodiversity loss, deforestation, drought, freshwater pollution and the collapse of aquatic wildlife. After the energy industry it is the biggest cause of climate change, responsible for 25 to 30% of global greenhouse gas emissions. A shift to plant-based diets, sustainable, seasonal and locally sourced foods, and a reduction of food waste, can greatly reduce carbon emissions from this sector.

Currently, the UK is roughly 60% food secure and although mostly self-sufficient in meat, dairy, eggs and grain, is heavily reliant on imported vegetables (50%) and fruit (84%).

To make matters worse, across the country around a third of all food is wasted. Annually, over seven million tonnes of food is thrown away by Herefordshire households, 70% of which is considered avoidable. Between 2019 and 2022, food waste per kilogram, per household, per week, increased among affluent rural communities and reduced across urban family groups, suggesting that more food tends to be wasted by those who can afford to do so.

However, farming is an essential part of rural life and of Herefordshire communities’ and prosperity, and Herefordshire makes a vital contribution to the UK’s food security. 77% of Herefordshire land is farmed and agriculture accounts for a much higher proportion of businesses and economic output than nationally: in 2022, 21% of businesses, compared to 4% in England and 9% of gross value added (GVA), compared to 1% in England (see note).

Note: Gross value added (GVA) measures the value generated in the production of goods and services. It is one measure of overall economic performance.

Eating well

Unhealthy diets often become established in early childhood and, combined with insufficient physical activity, mean that many children are overweight or obese even before they start school. There is a long-standing pattern of levels of obesity almost doubling during primary school (see p.38). Once people reach adulthood changing entrenched eating preferences and behaviours becomes very difficult.

Following a healthy diet has many benefits, including building strong bones, protecting the heart, preventing disease and boosting mood. Conversely, poor diet is one of the leading risk factors driving the UK’s high burden of preventable ill-health and premature death, contributing significantly to the population’s widening health inequalities. Poor diet is associated with developing chronic diseases, including cancer, Type 2 diabetes, coronary heart disease and stroke, with red and processed meats and sugar sweetened beverages associated with increased risks.

In 2022-23, 39% of Herefordshire adults were meeting the recommended five-a-day for fruit and vegetable consumption, more than in England (31%). In response to the 2023 CWS, 93% of adults said they were eating the same amount of, or more, nutritious food than a year ago, up from 84% in 2021.

However, price and affordability are major determinants of the food people choose to purchase, particularly for those on low incomes. Research has shown that the poorest fifth of UK households would need to spend 43% of their disposable income on food to meet the cost of the government-recommended healthy diet. Food insecurity has been greatly exacerbated by the cost-of-living crisis, with at the end of 2023, Citizen’s Advice data suggesting around 11,000 adults in Herefordshire being in a negative budget each month.

For more information see the Director of Public Health Annual Report 2022: A recipe for healthy and sustainable food.

Appendix: useful links and tools

The JSNA is a continuous process of analysis and review to ensure that commissioning and service planning decisions are informed by the latest available evidence relevant to a particular decision.

A growing number of self-serve tools are available to allow users to explore certain information: such as long-term trends, comparisons with other similar areas, or trying to better understand outcome variation within Herefordshire.

Fingertips Public Health Profiles (fingertips.phe.org.uk/profiles)

These profiles provide collections of indicators covering a range of public health topics, organised into themes like mental health, obesity, healthy ageing etc. They have been developed to show local area data alongside relevant comparators as well as:

- Trends over time.
- Within county variation showing significant differences for **residents** of middle super output areas (MSOAs) and wards compared to the rest of the county and nationally, plus variation by index of multiple deprivation quintile for some indicators.
- Profiles of **registered patients** by GP practice and Primary Care Network (benchmarks and trends).

Local tools to analyse GP registered patients

Dashboards developed with Taurus Healthcare, designed primarily to help Primary Care Networks understand their local populations. Accessible on request from herefordshire.analytics@nhs.net. Including:

- Herefordshire inequalities dashboard: focusing on key indicators within the CORE20Plus5 measures (see p.8), such as Health Checks and other screening programme uptake, as well as prevalence of conditions including hypertension. Compare differences between IMD quintile and other characteristics.
- Herefordshire Population Health Management tool: segmentation of patients based on long-term conditions in each GP practice in Herefordshire. Data can be sliced by ethnicity and IMD.

County-level benchmarking

ONS Local: Office for National Statistics experimental tool enabling comparison of 70 local indicators, including disposable household income, further education and life satisfaction. Note this is mainly to compare Herefordshire to other parts of the UK.

LG Inform: Local Government Association benchmarking tool allowing users to compare local authority areas and assess performance locally, regionally and nationally across a range of topics and indicators.

Data profiles of residents of areas within Herefordshire

Herefordshire area profiles: explore a wide range of census and deprivation statistics about the **resident population** of the county's 53 wards and the LSOAs within them (lower super output areas: statistical geographies of about 1,500 people)

Office for National Statistics 2021 Census tools:

- 2021 Census Maps: explore maps of key variables.
- Profiler tool: build your own areas to extract data.

AGENDA ITEM 8

NHS
Herefordshire
and Worcestershire

Title of report: NHS Five Year Joint Forward Plan update for 2025/26

Meeting: Health and Wellbeing Board

Meeting date: Monday 9 June 2025

Report by: David Mehaffey, Executive Director: Strategy, Health Inequalities and Integration - NHS Herefordshire and Worcestershire Integrated Care Board

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

Herefordshire's Health and Wellbeing Board reviewed and endorsed the first plan in the 2023 and issued an opinion that was published at the front of the document. The current refresh builds upon the previously endorsed plan.

NHS Herefordshire and Worcestershire Integrated Care Board endorsed this version of the refreshed Joint Forward Plan at its Public Board meeting on the 21 May 2025.

All NHS Trust partner boards, and representatives of general practice will also be asked to endorse this version of the JFP for publication through their governance cycles, reflecting the "joint" element of the plan.

Recommendation(s)

The Health and Wellbeing Board is asked to reconfirm its endorsement of the refreshed plan given the updates that have been included in 2025/26 iteration, and to agree any amended wording to its supporting opinion as necessary.

Alternative options

1. There are no alternative options. NHS partners (Integrated Care Boards (ICB) and all NHS Trusts in the ICB's geography) are required to produce a Five-Year Joint Forward Plan (JFP).

Key considerations

Introduction

2. JFP's were originally designed to have multiple purposes:

   i. To outline how NHS partners will contribute to the delivery of the Integrated Care System's strategy and the Joint Local Health and Wellbeing Strategies (JLHWS) that exist in the Integrated Care System area. For this ICS that means two JLHWS (Herefordshire and Worcestershire).

   ii. To outline how NHS partners plan to exercise their statutory duties and functions, meet mandatory national requirements in the NHS Long term plan and other operational priorities set out by NHS England.

3. The first Herefordshire and Worcestershire JFP was published in June 2023 and national guidance for planning stipulates that ICBs and trusts should carry out a limited refresh at the start of each financial year. This year's iteration is therefore the third version of the JFP.

Overview of the Joint Forward Plan

4. A full version of the JFP is attached as Appendix A.

5. The plan addresses all services within the scope of the Integrated Care Board's statutory duties and system priorities for NHS partners. This results in a broad ranging and comprehensive document. To make the plan easily navigable for readers, it has been structured in the following way:

Section	Pages	Focus
Main document	28	The main strategic focus of the plan outlines the NHS intention to drive a shift toward more focus on prevention and, when treatment/care is required, it is provided in the best value care setting. Best value care is defined within the plan as the setting that achieves the right balance between clinical need and optimal cost.
Appendix 1: Core areas of focus (services)	35	This outlines the detailed plans for individual NHS service areas such as urgent care, cancer services, stroke, primary care, mental health etc. Each section is split into five areas: 1) Overview of why the area is included 2) What has been delivered in 2023/24 and 2024/25 3) Priorities going forward 4) Action plan 5) Links where more detail can be found.
Appendix 2: Strategic enablers and cross cutting themes	21	This covers how enabling services (such as digital) and cross cutting themes (such as personalised care, prevention etc) impact on all NHS service areas.

		The section also addresses strategic developments such as place-based working and collaboration between NHS providers. This appendix is structured in the same way as appendix 1 in terms of the information outlined.
Appendix 3: Statutory requirements checklist	5	This covers a number of checklists to demonstrate how the JFP addresses specific areas. This includes a specific page cross referencing JFP actions to the priority areas set out in the JLWHS for Worcestershire.

Development of the 2025 draft JFP

6. A working group was established across NHS and Primary Care organisations to oversee the approach to developing the JFP for this refresh. It is important to remember that the Joint Forward Plan is the NHS contribution to the implementation of wider system strategies and as such, does focus in on specific areas of healthcare provision. The main changes between the original publication in June 2023 and this refresh are:

Main document

- Updates to leadership and of Worcestershire Health and Wellbeing Board.
- Updates to strategic priorities for 2025/26.
- Addition of 2025/26 Building a sustainable future programme.
- Update to 2024 Point Prevalence Audit results and medium term financial plans.
- Updated section on Population Health Management approach and governance.
- Finalised summary of overall delivery during 2024/25.
- Updates to 2025/26 performance trajectories in line with national operational planning guidance when published.

Appendix 1, 2 and 3:

- Summary of 2024/25 delivery added to each section.
- Priorities and actions updated to reflect the rolling 5-year period.
- Governance and ownership updated, including additional delegated services.

Community impact

7. The Joint Forward Plan supports delivery of the Joint Local Health and Wellbeing Strategy so the community impact of this plan is perceived to be positive.

Environmental impact

8. Implementing the Joint Forward Plan does not have any specific environmental impact risks associated with it. Section 13 of Appendix 2 identifies the priorities and progress set out in the NHS Greener Plan.

Equality duty

9. The Joint Forward Plan is governed by the NHS Equality Duties and these have been factored into the production of the document and the various Impact Assessments that are undertaken relating to any decisions that would be made under the remit of the plan.

Resource implications

10. The resource implications of the Joint Forward Plan are set out in the Financial Section (page 18 of the main document). There are no specific financial implications associated with the endorsement of this plan for the Health and Wellbeing Board.

Legal implications

11. There are no specific legal implications associated with endorsing the Joint Forward Plan.

Risk management

12. There are no specific risks to highlight in relation to endorsing the Joint Forward Plan.

Consultees

13. Patient and stakeholder engagement was undertaken as part of the process to produce the original Joint Forward Plan in 2023/24. Further engagement beyond taking the Joint Forward Plan through public governance processes is not required for this refresh.

Appendices

Appendix A NHS Five Year Joint Forward Plan 2025/26 – 2029/30, Version: 2025 Refresh, May 2025

Background papers

None identified.

Herefordshire and Worcestershire Integrated Care System

Herefordshire General Practice

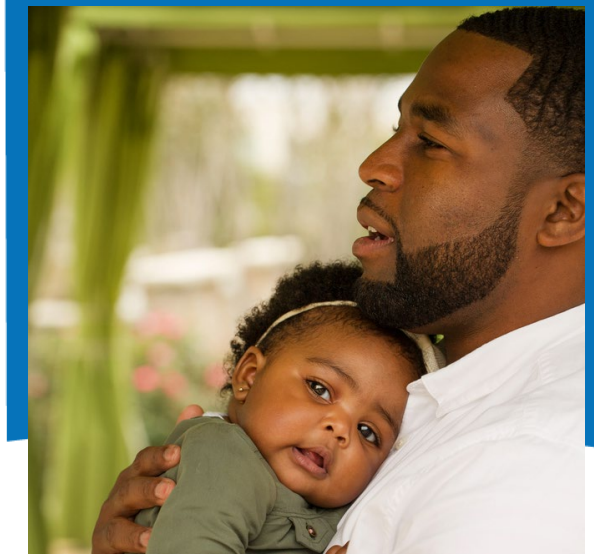
General Practice Worcestershire

NHS Wye Valley NHS Trust

NHS Herefordshire and Worcestershire Health and Care NHS Trust

NHS Worcestershire Acute Hospitals NHS Trust

NHS Herefordshire and Worcestershire



Driving the shift upstream to more prevention and best value care in the right setting

NHS Five Year Joint Forward Plan 2025/26 – 2029/30

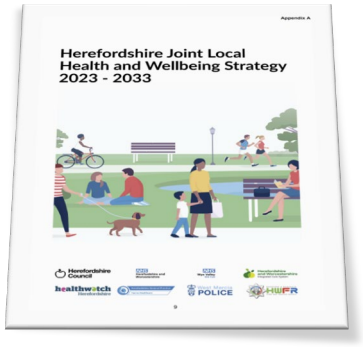
Version: 2025 Refresh, May 2025

The strategic intent of the Joint Forward Plan…

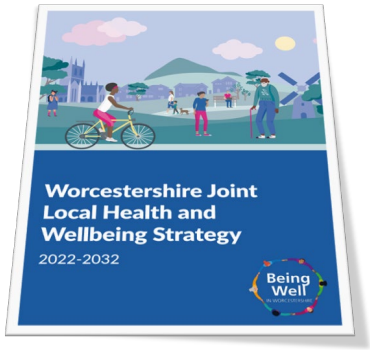
Driving the shift upstream to more prevention and best value care in the right setting

More focus on:

- **Self-care and independence**, enabling all people to look after their own health
- Promoting healthy behaviours which **reduce, delay and prevent** ill health
- **Co-production, personalised care and support**, meeting the needs of individuals
- **Population health management** and better use of data to target efforts
- **Sustainability of services,** and delivery of the right care models



Outlining the NHS contribution to the two Joint Local Health and Wellbeing Strategies.



Enabling reduction in:

- **Healthcare inequalities** – unequal access, outcomes and experience
- Days people spend in the **wrong care setting**
- The time spent **waiting** to access healthcare
- **Inefficient use of resources** and financial deficits
- **Avoidable pressures** on services
- People experiencing **digital exclusion**

Contents and navigating the Joint Forward Plan

Section	Content Summary		Page
The Joint Forward Plan **Main Document**	Introduction to the Joint Forward Plan by leaders from across the local NHS and the two Health and Wellbeing Boards in Herefordshire and Worcestershire		4
	This main document outlines the mandatory requirements for the JFP and the strategic planning framework within which it is developed. It goes on to describe the strategic context in terms of areas of strength to build upon and the biggest strategic and operational challenges. The section on workforce, outlines one of the biggest strategic challenges, but also one of the greatest opportunities. The section on finance sets out the financial context and outlining the approach to developing a medium term financial strategy. This section concludes with the main purpose of the plan – which is ***to drive a shift upstream toward more prevention and best value care in the right setting***.	Introduction to the Joint Forward Plan	5
		The strategic context for the Joint Forward Plan	10
		Workforce	14
		Finance	18
		Driving the shift upstream to more prevention and best value care in the right setting	20
		Population Health Management	25
		The engagement approach to developing the Joint Forward Plan	26
Appendix 1 Core service areas and pathways	This section of the plan provides information on the development, transformation and improvement plans for specific service areas identified below:		
	• Maternity and neonatal care • Early years, children and becoming an adult • Elective, Diagnostics and Cancer Care • Frailty • Palliative and End-of-life	• Learning disability and autism care • Mental health and wellbeing • Long-term Conditions • Stroke care and cardiovascular disease	• Urgent and emergency care • Primary Care • General Practice • Pharmacy, Ophthalmic and Dentistry
Appendix 2 Key enablers and strategic system development	This section of the plan provides information on the key strategic enabler programmes and strategic developments that will support the core service areas and pathways:		
	• Quality, Patient safety and experience • Clinical and professional Leadership • Medicines and pharmacy • Health inequalities • Prevention	• Personalised care • Working with communities • Commitment to carers • Support to veteran health	• Addressing need of victims of abuse • Digital data and technology • Research and Innovation • Greener NHS
	• NHS Trust Provider Collaboratives • Mental health collaborative	• One Herefordshire Partnership • Worcestershire Place Partnership	• Office for the West Midlands ICBs
Appendix 3 The statutory requirements	The section outlines how the ICB meets its statutory duties as set out in the national guidance.		
	• Cross reference to show how the JFP addresses the specific requirements of the two health and wellbeing strategies. • Nominated lead officer for each duty and a cross reference for demonstrating which section of the JFP addresses the requirement.		

Introduction to the Joint Forward Plan

This, the third Joint Forward Plan for Herefordshire and Worcestershire has been produced by NHS Partners across Herefordshire and Worcestershire. This version contains minor updates, and a fuller refresh will be considered later in 2025/26 after the publication of the NHS 10 year plan. It describes the shared priorities that partners will collectively work on over the next five years. in response to the Integrated Care Strategy and Joint Local Health and Wellbeing Strategies. The strategic intent is to collectively drive the shift upstream to more prevention and achieve best value care in the right setting.

We would like to thank the two Health and wellbeing boards for their ongoing support for the plan and recognising its contribution to delivering the two Joint Local Health and Wellbeing strategies. We will continue to work together to enable good health and wellbeing for the people of Herefordshire and Worcestershire.

As representatives of NHS partners in Herefordshire and Worcestershire we endorse the plan on behalf of our organisations, recognising our role in delivering the priorities within it.

Russell Hardy - Chair
Foundation group partner organisations

Crishni Waring - Chair
NHS H&W ICB

Mark Yates - Chair
H & W Health and Care NHS Trust

Dr Roy Williams - On behalf of Worcestershire General Practice

Dr Nigel Fraser - On behalf of Herefordshire General Practice

Opinion of Herefordshire Health and Wellbeing Board

The Herefordshire Health and Wellbeing Board are committed to improving the health of our local commu[illegible]es and tackling health inequalities. We recognise the val[illegible]rking with all our partners, and that our communiti[illegible]t the heart of how we work differently to em[illegible]s and reduce demand across health and so[illegible]

The NHS Five Year J[illegible] provides a key delivery mechanism for [illegible]mbitions as set out in the Integrated C[illegible]d the Joint Local Health and Wellbeing [illegible]gnising the importance of prevention and the wid[illegible]s that affect the health and wellbeing of our residents.

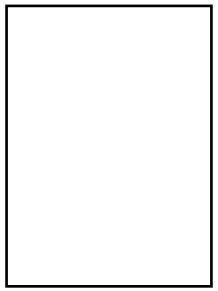
This opinion will be updated following the Herefordshire Health and Wellbeing Board – 9th June 2025

Councillor Carole Gandy
Chair of Herefordshire Health and Wellbeing Board

Opinion of Worcestershire Health and Wellbeing Board

Following the Worcestershire County council elections in May 2025 there will be a new Health and Wellbeing Board Chair, following which an opinion will be confirmed and included here.

This opinion will be updated following confirmation by the Worcestershire Health and Wellbeing Board Chair



To be confirmed,
Chair of Worcestershire Health and Wellbeing Board

Introduction to the Joint Forward Plan

The mandatory requirements for the JFP

- The Health & Care Act 2022 requires each Integrated Care Board (ICB) in England, and their partner NHS trusts and foundation trusts, to produce and publish a Joint Forward Plan (JFP).
- As well as setting out how the ICB intends to meet the health needs of the population within its area, the JFP is expected to be a delivery plan for the Integrated Care Strategy of the local Integrated Care Partnership (ICP) and relevant joint local health and wellbeing strategies (JLHWSs), whilst addressing universal NHS commitments.
- As such, the JFP provides a bridge between the ambitions described in the Integrated Care Strategy developed by the ICP and the detailed operational and financial requirements contained in NHS planning submissions.
- Systems have the flexibility to determine the scope of their JFP, as well as how it is developed and structured. Systems are encouraged to use the JFP to develop a delivery plan for the Integrated Care Strategy that is owned by the whole system, including Local Authorities and Voluntary Community and Social Enterprise partners.
- As a minimum though, it should describe how the ICB, its partner NHS trusts intend to meet the physical and mental health needs of their population through arranging and/or providing NHS services.
- This should include delivery of universal NHS commitments and address the four core purposes of ICS.
- The guidance that systems are required to follow sets out 3 principles for Joint Forward Plans:

Principle 1	Principle 2	Principle 3
Fully aligned with the wider system partnership's ambitions.	Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.	Delivery focused, including specific objectives, trajectories and milestones as appropriate.

The planning framework within which the JFP is set

The Health and Care Act 2022 put **Integrated Care Systems (ICS)** on a statutory footing and has provided the opportunity for local partners across the NHS, Local Government and the Voluntary Community and Social Enterprise to work in a more integrated way in the pursuit of better outcomes for local people.

The act established **Integrated Care Boards (ICB)** and required ICBs to come together with Local Authorities that provide public health and social care functions to form an **Integrated Care Partnership (ICP)**. The core purpose of the ICP is to provide a platform for local partners to come together to agree and **Integrated Care Strategy** for the whole ICS area, addressing the 4 core purposes of ICSs:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support broader social and economic development

The **Integrated Care Strategy** aligns to the two **Joint Local Health and Wellbeing Strategies (JLHWS)** in the ICS area, and identifies three shared priority areas, which address issues identified in the respective **Joint Strategic Needs Assessments**:

Integrated Care Strategy Shared Priorities across Herefordshire and Worcestershire		
Providing the best start in life	Living, ageing and dying well	Preventing ill health and premature death from avoidable causes

This **Joint Forward Plan (JPF)** sets out how NHS Partners will contribute to the delivery of:

- The shared priorities set out in the Integrated Care Strategy
- The priorities identified in the two Joint Local Health and Wellbeing Strategies
- National priorities for the NHS set out in the NHS Long Term Plan and mandatory national planning requirements.

The JFP will not set out new priorities; instead it will describe actions, timelines, targets and performance measures that will demonstrate the core areas of focus that NHS partners will focus on over the coming 5 years.

The JFP is the NHS contribution to ….. The Integrated Care Strategy ……

The Integrated Care Partnership approved the system Integrated Care Strategy in April 2023. The strategy sets out the shared ambition of system partners for achieving ***Good Health and Wellbeing for Everyone*****.**

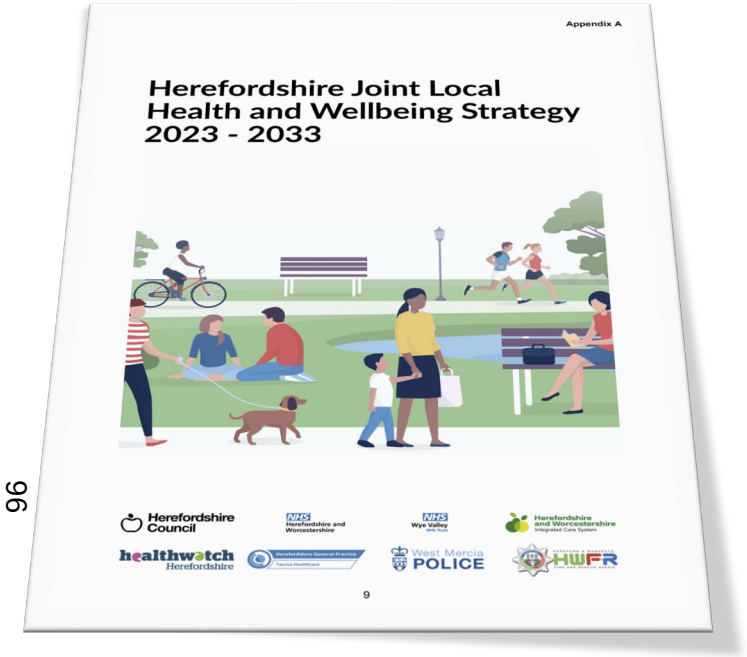
The ambition outlined in the strategy is for ***working together with people and communities to enable everybody to enjoy good physical and mental health and live independently for longer***.

Underpinning the strategy are 8 commitments that partners across the ICS have agreed as being fundamental to delivering integrated care.

The three shared priority themes and underpinning performance measures have been developed directly in response to the Joint Strategic Needs Assessments for each county and the priorities that are reflected in **Joint Local Health and Wellbeing Strategies**.

The strategic enablers bring partners together to work collectively in those areas that provide the essential platform for collaboration and working in a different way.

The JFP is the NHS contribution to ….. The two Health and Wellbeing Strategies



Herefordshire's Joint Local Health and Wellbeing Strategy (JLHWS) was approved in April 2023 and covers a 10-year period.

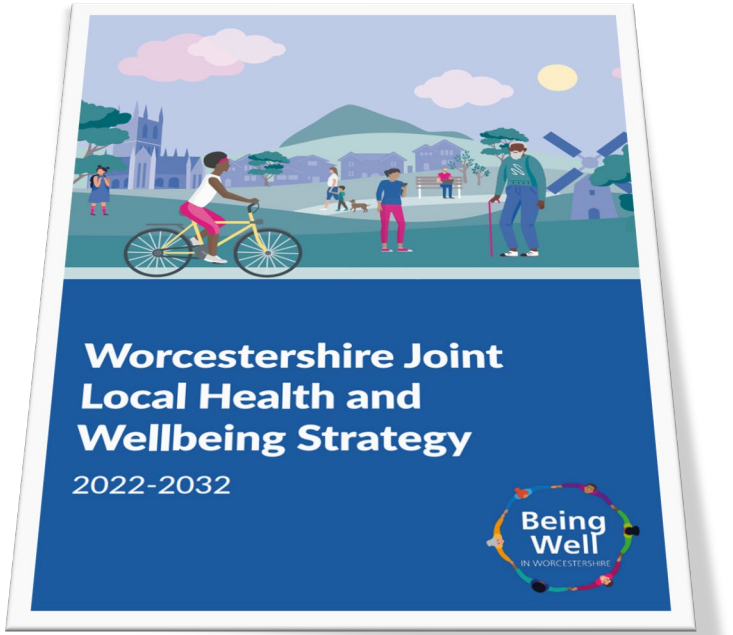
It was developed collectively by partners working together to agree a common ambition and set of priorities that were clearly identified through an extensive engagement exercise.

There is very strong alignment between the JLHWS and the Integrated Care Strategy, with both documents sharing a common vision and complementing priority areas of focus.

Worcestershire's Joint Local Health and Wellbeing Strategy (JLHWS) was approved in November 2022 and also covers a 10-year period.

Development of the strategy occurred in parallel with early work on developing the Integrated Care Strategy, which enabled strong alignment in some key areas.

Mental health runs through all three of the Integrated Care Strategy themes, mental health for children as part of the best start in life priority; good mental health through living ageing and dying well particularly focused on therapies and dementia care and reducing suicides as part of the third priority.



Herefordshire JLHWS Core Priorities	Integrated Care Strategy Priorities		
	Best start in life	Living, Ageing and Dying Well	Prevent ill health and premature death from avoidable causes
Best start in life for children	●	●	
Good mental wellbeing throughout life	●	●	●

Worcestershire JLHWS Core Priorities	Integrated Care Strategy Priorities		
	Best start in life	Living, Ageing and Dying Well	Prevent ill health and premature death from avoidable causes
Good mental health and wellbeing	●	●	●

● Directly aligned priorities where work led and undertaken at county level will directly deliver the Integrated Care Strategy priorities at System level

The key steps to deliver our JFP in 2025/26…

Building on what we have delivered together in the first two years of our JFP there are some specific pieces of work that will drive forward the delivery of our strategic intent during 2025/26:

Driving the shift upstream to more prevention and best value care in the right setting

The **'Building a Sustainable Future'** programme, a medium to long term transformation programme has been developed following a workshop with Senior Leaders in 2024/25 where a range of challenges from clinical sustainability, quality and safety, financial and strategic changes programmes were discussed. The Building a Sustainable Future programme forms the backbone of the system responses to the medium-term challenges of developing services able to meet the predicted increase in demand.

The overarching aim of the programme is to enable:

'Resilient services that have the capacity to meet the predicted demand, quality and performance standards, and which are delivered within our collective financial envelope'.

Key to the success in the development of the Building a Sustainable Future programme has been building a strong base of **strong Clinical Engagement** to provide input and support the programme and the longer-term vision.

A successful Clinical Engagement event in Feb 2025 generated positive feedback and enthusiasm to drive the Building a Sustainable Future programme forward.

To support the delivery of the **Medium-term Financial Framework** a **benefits realisation framework** has been developed to ensure that each intervention or initiatives impact can be quantified from an activity and performance, financial and workforce perspective. Understanding these impacts is a critical piece of work to ensure that we have the right services for patients and to support improving the financial position and delivery of our performance ambitions underpinned by the right workforce.

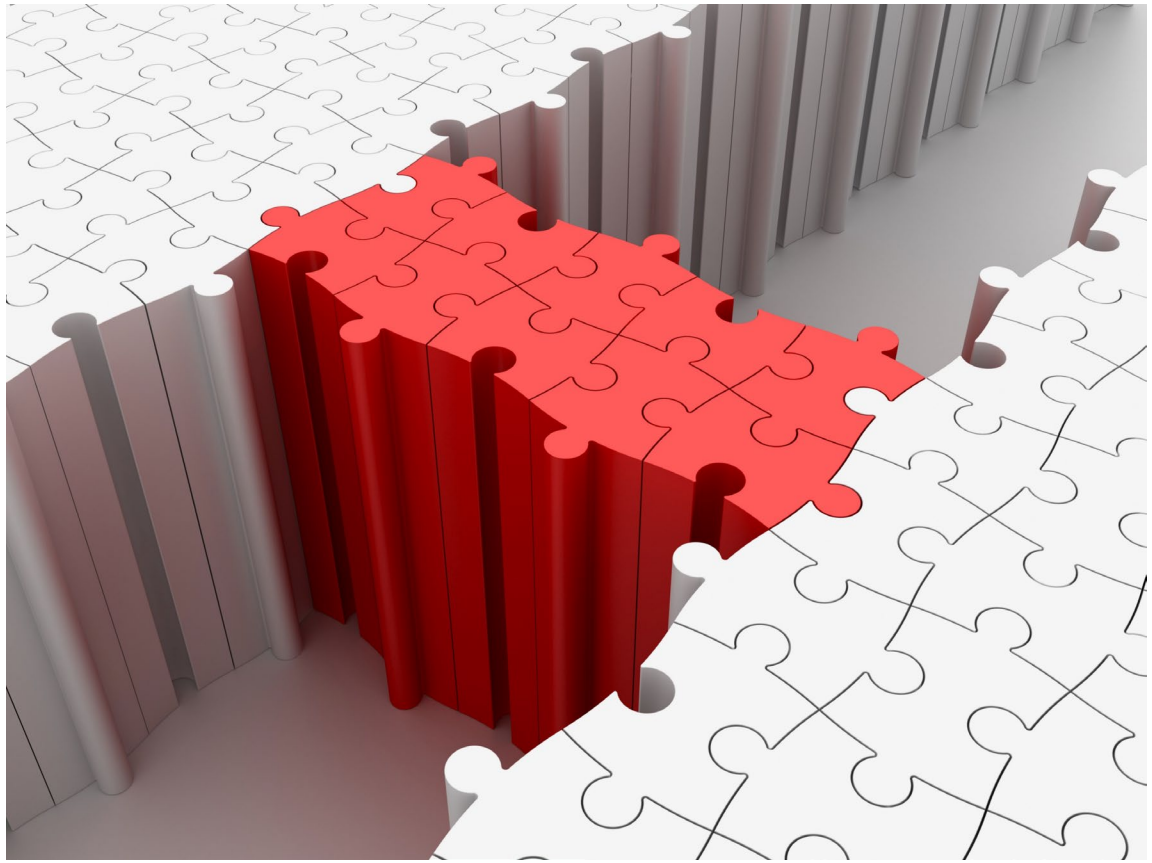
Delivering **Neighbourhood Health Activities** to Improve access to general practice and primary care. Prevent avoidable admissions to hospital, residential and nursing homes. Ensure unavoidable admissions are short and cost effective. Using population health management tools and techniques to standardise community services , develop multi disciplinary teams, intermediate care and home first, urgent neighbourhood services and modern general practice. This will support the **shift from acute to community**.

Develop and implement a **Work and Health Strategy** to articulate the NHS role in supporting **improved social and economic impact**. This will take the same type of strengths-based approach as we have done in targeting recruitment into health and social care from communities where access to employment opportunities are limited by existing barriers.

Herefordshire and Worcestershire are one of 15 systems across England to have been successful in bidding for a **grant of £2.4 million to deliver Workwell over 2 years.** The workwell programme is live and will continue to grow, using a coaching model to support people with health issues to stay in or return to work. This personifies our commitment to help address the wider determinants of health and to support vulnerable people in our communities by using existing partnerships across the NHS and Local Authorities. We will deliver a refreshed NHS Green Plan to contribute to wider sustainability.

Reducing health and healthcare inequalities remains a strong focus, with the local **Health Inequalities Ambassadors programme** now embedded through programmes. A key enabler will be the development of a **Population Health Management – Strategic Implementation Plan,** which will define a clear vision to engage our leadership and build a community of practice to enable us to provide access to the right data and insights and put it into the hands of those that can make a difference. A core facet of PHM is **engaging patients, service users and citizens** to understand their needs and look at how we can design services to effectively meet these needs within the resources available, improving access, outcomes, experience and reducing health inequalities. This will support the **shift from treatment to prevention.**

The Strategic Context for the Joint Forward Plan



Strategic Context - What is working well – The second year of our joint forward plan, 2024/25

Some of the best access to GP service in England

- The most recent ONS Health Insights Patient Survey at the beginning of 2025 ranked the ICB as the best in the country where 86% of patients reported a 'good' overall experience of access to general practice.
- GP Practices are providing patients with access to around 466,000 appointments a month. This is almost 80,000 appointments per month more than pre-pandemic.
- Excellent progress has been made in Self-referral pathways: adult audiology went live in 2024 and now Physiotherapy/Musculo-skeletal and weight management pathways have been developed. About 4,000 self-referrals are made each month.

Reduced waits for patients awaiting cancer diagnosis

- Achieved 78.6% for the 28-day Faster Diagnosis Standard performance in March 2025 which is above the 2025/26 Operational Planning target of 75%.
- Achieved 69.5% of patients received first definitive treatment within 62-days of referral, narrowly missing the 70% target.
- We are the 8th highest performing area for cervical screening coverage in England.
- Lower gastrointestinal (GI) Urgent Suspected Cancer referrals accompanied with a FIT (faecal immunochemical test) remains consistently above the 80% target and 2nd highest in the Midlands.

Better adult learning disability care in the community

- 77.9% of people with learning disabilities received an Annual Health Checks.
- LeDeR reviews performance metrics continue to exceed national and regional performance, demonstrating that people with learning disabilities and Autism are supported in the community rather than inpatient care.

Positive impact on reducing health inequalities

- 5,000+ reached with essential prevention services in the most underserved communities (vaccinations, health checks, screening and early cancer referrals).
- HWICB exceeded the 90% eligible referral target into the NHS Digital Weight Management Programme with 2,384 eligible referrals (95%).

Recovering diagnostic and elective services

- As of March 2025, there are 1464 people waiting longer than 52-week, this is less than the system Operational Planning target. We will continue to work on eradicating these long waits in 2025/26.
- HWICS continue to be one of the highest performing ICB for Value Weighted Activity in elective care at over 135%.
- Waiting times longer than 13-weeks in Audiology achieved a 58.9% reduction in the number of people waiting. Pathway mapping and improved triage processes have led to this improvement.
- The percentage of people seen for diagnostics within 6-weeks reached 81.1% in March 2025, better than the average national average of 81.9%.

Better access to urgent and emergency care

- Both WVT and WAHT have improved emergency access standard (EAS) as of March 2025, with a system level of 65.4%.
- Ambulance Category 2 mean response time achieved less than 30 minutes as at February 2025. The performance throughout 2024/25 was better than 2023/24.
- Launched less than 45-minute ambulance handover protocol in March 2025 to improve on the timeliness of the handovers from ambulances to Emergency Departments.

Strategic Context - The biggest strategic challenges that NHS partners need to address

Tackling increasing demand for health and care services

The national challenges for health and social care providers are well documented. Delayed and reduced services during the Covid-19 pandemic increased the backlog for people waiting for urgent and elective services. Overall, there has been an increase in demand and complexity of need and services are struggling to provide a positive experience with good outcomes for individuals.

At the same time the population is ageing, with over 44,000 more over 65 years olds living in Herefordshire and Worcestershire by 2031, over a quarter of the increase being over 85 years old. By 2033 there will have been a 50% increase in the number of people who are over the age of 80. Alongside this demographic growth, there will be an increase in frailty, with projections indicating that people living with the highest levels of frailty will increase by around 28% over the next 10 years.

Securing sustainable workforce and clinical models for all services

There are around 39,000 people working in health and care services across the system. Around 18,500 work in Primary and Secondary Care and 20,000 in Social Care. Turnover is slowly reducing in the sector from an all-time high post COVID. In recent years, turnover has been at 10% for staff in the NHS and 26% of staff in social care. Vacancy rates range between 7% -10%. Recruitment activity to bring more people into Healthcare and care worker roles has had a positive effect but there remain critical areas of workforce shortages in nursing, some medical specialities and social workers There are around 300 nurse vacancies across the system (200 in the NHS and 75 in Social Care) and a reliance upon international recruitment. There is also a lack of pharmacy professionals across the system, with increased numbers moving to community pharmacies.

Sickness rates fluctuate at around 5.5% across the NHS organisations with mental health being cited as the main cause. That said, Staff engagement has improved over the last year and is in the top third of NHS organisations across the Midlands.

Workforce shortages in some specialties have resulted in increased levels of service fragility, particularly in cancer and stroke pathways. In the most extreme examples, such as haematology, emergency service changes have been needed whilst sustainable options were identified. In other instances, to fill gaps in substantive rotas and minimise risks to patients, health and care services have relied heavily on bank and agency staff.

However, with spend on agency staff in 2024/25 being over £50m and accounting for 6.2% of the total workforce budget, this is not a financially sustainable solution. As well as the financial pressure it creates, it can also lead to inconsistency in care provision and poorer experiences. Partners across NHS services are working together to reduce the reliance on agency staff to reduce these risks going forward.

Demand and workforce challenges can impact the effectiveness of services to see and treat patients in a timely and clinically safe manner, negatively impacting on healthcare outcomes. Addressing the signs of vulnerability requires early identification and solution-planning with the engagement of clinicians. Subsequently proactive work to pre-emptively identify vulnerabilities has led to the system developing a fragile services framework.

Financial sustainability and optimising use of services

As a deficit financial system, there is a requirement imposed on all system partners to implement stringent productivity, efficiency and savings programmes. This requires partners to introduce rigorous cost control measures and explore options for reducing service levels to bring spending into line with financial allocations. This includes freezing any new income and halting any service developments or business cases that do not identify lower cost delivery models or have clearly identified funding streams. This downward pressure needs to be understood in the context of the system being overfunded using the national formula.

In September 2024, partners replicated the study undertaken a year earlier to audit whether people were being cared for in the most appropriate care setting for their needs at the time. The study showed that just over 70% of the 1,679 people reviewed were being cared for in the right care setting – if an optimal balance between capacity, demand and flow efficiency was achieved. Showing there is a significant opportunity to improve processes and re-balance capacity across care settings, to deliver optimal outcomes.

Alongside this, the strategic demand and capacity model work suggest that without change, the system will require between an additional 365 acute beds by 2033. The upper end of this range is comparable to building new wards that are equivalent in scale to about 2/3rds the size of Hereford County Hospital. Even if the finances were available to fund such expansion, the workforce would not exist to staff it. Therefore, finding mitigating actions and alternative solutions is critical to the delivery of improved health outcomes and reduced health inequalities.

A focus on ensuring care is accessed in the right setting which means moving activity, treatment and resources towards more preventative rather than reactive treatments, as part of the solution. As will ensuring that the wider social determinants of health are addressed through effective alignment of vision, plans and effort with local authority and VCSE partners. For example, the development of the “Community Paradigm” concept and relevant application to local circumstances will be one of the key platforms for making local services both sustainable and effective in supporting improved outcomes for the population.

The ‘Building a Sustainable Future’ programme, a medium to long term transformation programme has been developed following a workshop with Senior Leaders in 2024/25 where a range of challenges from clinical sustainability, quality and safety, financial and strategic changes programmes were discussed.

Strategic Context - Operational performance - Priorities for year 3, 2025/26

Reducing backlogs and long waits for elective care

- Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026

Reducing long waits for cancer care

- Improve performance against the headline 62-day cancer standard to 75% by March 2026
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026

Improving access to primary care services

- Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
- Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more

Reducing waste and improving productivity

- Deliver a balanced net system financial position for 2025/26
- Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
- Close the activity/ WTE gap against pre-Covid levels

Improving safety and reducing health inequalities

- Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three-year delivery plan'
- Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
- Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

Improving mental health and learning disability care

- Reduce average length of stay in adult acute mental health beds
- Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction

Reducing long waits for urgent care

- Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
- Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26

Strategic Context – Workforce - Creating a sustainable inclusive workforce

Building on the improvements of 2023/24, we have delivered a range of outcomes in attraction, retention, leadership and potential, the ICS Academy and culture and inclusion. We have also refocussed our efforts so that we can use these key 'workforce enablers' to help to alleviate some of the system challenges as well as to support the transformation work.

Another successful year of recruitment has reduced the number of vacancies across our NHS Providers. Each organisation has their own recruitment programme and there has been a system-wide attraction programme. Most of the NHS Trusts have recruited key posts in Nursing and Midwifery and are now managing turnover. We have commenced work on the NHS Universal Family Care Leaver Covenant Programme which will enable us to attract and recruit into our entry level vacancies. This is to tackle health inequalities, especially within under-represented groups, support workforce pipelines into both NHS and Social Care entry level roles/careers and to support the delivery of our Diversity and Inclusion objectives.

Turnover has been reduced through a range of mental health and wellbeing programmes delivered across the system. A combination of retention programmes, more flexibility, greater development and a focus on inclusivity has led to a greater number of people choosing to stay within the NHS. This is borne out in some strong engagement survey results for 2024.

In line with the NHS Long Term Workforce Plan, we have developed a shared workforce vision focused on providing opportunity for both existing and newly hired staff. To address our workforce challenges we have adopted a Grow Our Own approach to encourage local people into the system and are supporting them to stay through career and leadership development programmes. We have developed a shared approach to growing future nurses to mitigate against potential high levels of retirement over the next five years. This has been accomplished by working together to maximise the potential of our education providers and the new Three Counties Medical School. This work has allowed us to retain our staff through organisational support and crucially, prepared us to review and reform how services are delivered when workforce is not available.

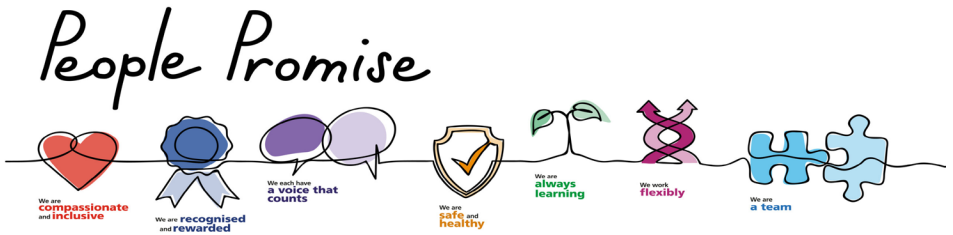
The collaborative and innovate work of the ICS Academy continues through the work of the faculty groups who meet as professional groups to share their workforce challenges and best practice. In 2024/25 the Healthcare Science faculty has improved connection between Herefordshire and Worcestershire teams and are now working together on career pathways and targeted recruitment activities in their field. The AHP faculty has worked to produce a fair share model for student placements. This will help to ensure that AHP students have a good placement experience. The Pharmacy faculty produced a workforce strategy and associated delivery plan. The VCSE faculty resumes in April 2025 with a new focus on workforce training and development. In 2025 a new Psychological Services Faculty will also be created and the Medical Faculty will expand to include Dental.

Training and development courses and resources offered through the ICS Academy Exchange continue to grow, supporting the ICS workforce to pursue their careers. Resources include career conversations supporting documents, career pathways in multiple fields, project and change management and the new ICS Leadership behaviours. A range of ICS wide course offers have also been advertised or booked through the ICS Academy Exchange including Mary Seacole Leadership Programme, QSIR, Reasonable Adjustment Digital Flag and Oliver McGowan which are easily accessible and popular.

During 24/25 we have co-designed and agreed our ICS Leadership Behaviours describing how we will all engage with each other when we are working across the system – these are Open, Inclusive, Courageous, Compassionate and Innovative. We launched the System Leader Connect programme, to engage and develop our senior leaders in effective system working with a key focus on building relationships. We have also expanded development support and capacity available to support the system and its leaders - including a cohort of new 360 feedback facilitators, a group of wider team and change facilitators and development opportunities to support our qualified coaches.

All NHS organisations have worked hard on to deliver an improved experience by delivering their people promise plans. The 2024 survey showed a positive shift in compared to 2023 demonstrating the impact of these efforts. All four NHS organisations have put a real focus on creating happy, safe and engaging places of work and the ICS has moved from the bottom half in the Midlands region to the top third on most of the indicators. A happy and engaged workforce will typically perform better and offer discretionary effort where it is needed so intrinsically linked to improvements in performance, and so, by extension an improved experience for the people who use their services.

In September 2024, we held our inaugural 'Big Inclusion Conversation' conference, where colleagues from across the system came together to celebrate our successes and plan our future work. At the event we launched 'Making Inclusion a Reality', our 5-year Culture and Inclusion strategy for the system and our new Active Bystander programme. We have now trained 18 facilitators who will deliver the Active Bystander programme across the ICS in 25/26.



Strategic Context – Workforce – Addressing our challenges

Workforce availability in some specialisms remains a key challenge for the system. Some of these are being covered by medical locums which can impact service delivery to patients. There is limited international recruitment and so we will work with the faculties and through direct engagement to understand the attraction and retention challenges for the different areas.

Our strategy is to grow-our–own skills wherever possible, particularly in entry level roles and Nursing and Allied Health Professional roles, encouraging local people to stay within the system and develop their career here.

Providing a good placement experience is vital to 'grow our own' particularly for Nursing, Midwifery and AHP students. An exercise to map the clinical student placement provision from NHS Trust and PCN providers and the allocation of students from different universities is currently being undertaken to find where more placements could be offered.

Targeted attraction of Health Care Assistants, Health Care Support Workers and Care Workers through marketing and promotional material provides a pool of entry level staff in short supply and where we compete with other local employers such as retail. We are also developing pipelines to ensure a sustainable route in for hard-to-reach groups and hard-to-fill vacancies.

Wellbeing, resilience and change management are an important focus for retention, enabling our people to navigate what appears to be a challenging period of change and transformation.

We will also work closely with our Transformation Programme – Building a sustainable future – as a key enabler we will work with leads to establish the workforce requirements of the different workstreams to enable change to support key priorities, including the three shifts (Hospital to community, treatment to prevention, analogue to digital).

System leader connect will have an eye to the future – ensuring that we have a succession plan for our senior leadership drawn from our aspiring, talented, local leaders.

Medical Staff	Clinical Support and Social Care	Pharmacy	Mental health nursing
• Medical 'faculty' working together with TCMS to increase the number of trainees across the system. • Working with Worcester University to ensure student placements do not limit student numbers. • Devising new approaches to attraction, including bespoke packages, new advertising campaigns and a focus on clinical leadership support • Target challenging vacancies through apprenticeships and grow our own initiatives • Promote and use career pathways to case studies and opportunities	• Growing numbers of Health Care Assistants and Health Care Support Workers through targeted outreach. • Improved promotional material to attract those New to Care including online presence. • Develop pipelines for employment through the universal family scheme and similar programmes. • Explore cadet/T-level and BTEC routes into this workforce • Leadership and management resources to aid retention • Establish a process to share apprenticeship levy to allow more social care providers to benefit from it.	• An innovative approach to attraction based on engagement with colleges in 2024 • Increased use of pharmacy apprenticeships • Development and promotion of career pathways, talent and succession plans. • Maintain and support the work of the pharmacy faculty.	• Engagement with the sector to understand attraction and retention challenges • Target areas of high vacancy for apprenticeships. • Outreach events targeted to Sixth Form and local colleges that offer relevant courses, and targeting regional universities with proximity to Worcestershire that have students qualifying in Mental Health Nursing in March 2026 • Agreed talent development offer for mental health nurses.

Strategic Context – Workforce – Attracting and Retaining People

Healthcare is a rewarding career but it can be stressful. In 24/25, NHS Trust providers have been asked to plan to deliver services with a significant reduction in bank and agency use and whilst reducing the number of non-clinical substantive roles. Retention, reduction in sickness absence and targeted attraction into vacancies that attract locum spend will be vital.

Continuing to maintain nurse capacity through 'grow our own' initiatives such as apprenticeships and other education programmes that ensure supply of critical clinical resources in the system will remain important to mitigate the risk posed by an aging workforce.

This includes our apprenticeship hub, which brings together system apprenticeship leads enables us to practically understand how we are prioritising our organisational levies and target these at the system risk areas. A case in point is the system approach to developing more nurses through the trainee nurse associate and registered nurse apprenticeship route.

Exit interview data and HR theory is clear that people want to feel that their wellbeing is supported, they have career opportunities to progress, they have good relationships with their line managers and that they feel a sense of belonging. Pay and reward are of course important factors but where the above is in place, they become slightly less pivotal.

Retention activities are therefore built around ensuring that these things are in place. Reducing sickness through providing quick access to Wellbeing support for staff, supported by capable managers, provides the basic cornerstone of retention. Offering development opportunities to move around in one's career and working with leaders and line managers to improve their capability means that people feel valued and empowered by their managers.

Delivering our Inclusion and EDI strategy means that everyone, regardless of their background will feel that they form an important part of the organisations in which they work. Through the work of the faculties and understanding key operational risks, these interventions will be targeted where they are likely to make the biggest difference.

The ICS Academy is now an established central point for collaborative working on innovative projects to ensure the retention of the ICS workforce. This yea this has included engagement outreach with local colleges where students participated in focus groups to understand how we can attract their age group into health and social care roles.

In addition, the new research and innovation strategy and the research consortium will be reporting into othe ICS Academy Steering group to showcase the work that is being undertaken and to highlight research as a career development opportunity that will keep high potential staff in our ICS workforce.

We will maintain our ambition to be a great place to work – our cross-system group will continue to meet to share best practice, learning and resources because we are better together – especially as we face into an uncertain period of change.

Activities to deliver this include:

- Development of pipelines for employment into entry level roles
- Development of bespoke attraction products to bring in medics to sure up fragile services
- Greater joint planning off the back of the staff surveys (end calendar year)
- Developing career pathways to enhance career ambitions for entry level jobs
- Wellbeing offer enhanced through leadership capability programme
- Improved placement capacity to support clinical education, including T-levels, apprenticeships and grow our own initiatives across the system including in the VCSE and Social Care Sectors.

Strategic Context – Workforce – Growing our Own and Reforming Services

Growing and developing our people, teams and organisations

While we will continue to attract people into our system to ensure we can deliver key services, we also want to retain key talent.

We therefore will focus on growing our own skills, offering job opportunities and long term careers for those that want to work within our system. The coming together of the organisations across the system offers a far wider range of options for people and an eco-system that they can move around in, while knowing that the experience that they gain will continue to benefit the sector locally.

Through offering a greater range of development opportunities for our various professions, developing educational links with further and higher education providers, creating more placements for the new Three Counties Medical School in Worcester University and making it easier for people to move around our organisations. We are also developing a suite of resources to support team development to not only enhance productivity and wellbeing but to improve attraction and retention.

We continue to deliver our 'Making Inclusion a Reality' strategy, through improving access to reasonable adjustments through a new Health and Wellbeing Passport for colleagues. We are also working to improve the experience of our neurodiverse colleagues with a 'Neurodiversity Toolkit'. Through the delivery of the Active Bystander programme, we will support colleagues to feel confident to take an early intervention approach to prevent negative behaviours from escalating. This will contribute to improving the health and wellbeing our staff and patients and people who draw on our support to grow a culture of civility and respect.

We link in with regional and national colleagues to develop system wide approaches to succession planning and talent management.

Activities to deliver this include:

- Development of innovative new roles, drawing upon clinical knowledge
- A joint talent and leadership development offer, available to all providers at ICS Academy, linked to career conversations and pathways
- Delivering our ICS Inclusion Strategy which brings together staff networks, ensuring everyone feels that they have representation
- Roll out and embedding of our leadership behaviours – developed with focus groups from across the system in 2024
- Delivery of our system leader connect programme

Reforming Services

While we can act quickly to bring in some of the skills we need, there are others that are so scarce nationally or take so long to grow that we must instead think differently about how we deliver our services. Making greater use of digital tools must also drive reform of services for the patient or user.

Providing organisational design and development expertise to clinicians and operational colleagues to think differently about the delivery of services is our approach to reimagining how services might be provided. This is supported with ongoing workforce planner business partnering to each service pathway so that when workforce is identified as a risk, they are able to help the service to consider how else it might continue to deliver.

Workforce is a key enabler for the 'Building a sustainable future programme. This work will focus our activities to those areas of transformation that have been prioritised to address critical need to reform the way services are delivered in Hereford and Worcester within its financial limits.

Activities to deliver this include:

- Developing workforce planning capability across the NHS through a transformation programme focussed on reviewing public health data for service pathways.
- The development of the faculties in workforce planning and consideration of public health data for their function.
- Deeper understanding of the operational workforce risks by service line using the STAR framework approach and how to mitigate those in the short and long term.
- The development of more integrated, cross-organsiational / systemwide roles where appropriate.
- Focussed work on converting high agency spend into longer term sustainable workforce through the use of apprenticeships, new roles and digital solutions.
- Aligning digital and data with people and workforce to increase the digital capability of staff, enabling them to be more open to future digitalisation of services.

Strategic Context – Finance - The financial history and financial plan for 2025/26

Actual Spending v Formula Allocated to Herefordshire and Worcestershire

Prior to the pandemic the system was under-funded against target using the national funding formula. The closing distance from target in 2019/20 for the 4 CCGs in the ICS area was -3.52%, equivalent to £35m. Any overspends against this allocation were funded using non-recurrent funding sources.

During the pandemic, costs were fully funded, and system baselines were reset at actual spend levels. In essence, this process resulted in historic overspends being incorporated into financial baselines generating a significant change to the base funding level for H&W ICS.

Going into 2025/26 this the system is now overfunded against fair share target, using the national funding formula by 3.9%. This is consistent with the previous financial year.

Change in spending pattern in recent years

Growth in spend over this period was seen in all areas, with the exception of running costs. The expenditure for the system includes Pharmacy, Ophthalmic and Dental (POD), as well as specialized commissioning (spec comm). Expenditure continues to grow in acute services, including the nationally allocated deficit support allocations and in continuing care. Growth has been seen in community services and primary care, these are lower than our forward-looking ambitions around a shift upstream to more prevention and out of hospital care, through neighborhood health care. The ambition over the life of the Joint Forward Plan is to change this position.

Spend Area	19/20	25/26 Plan	Change	
Acute	£559.2m	£1,032.6m	£473.4m	85%
Mental health	£110.5m	£176.0m	£65.5m	59%
Community Services	£130.0m	£215.6m	£85.6m	66%
Continuing Care	£68.0m	£119.4m	£51.3m	75%
Primary Care	£147.1m	£213.1m	£66.0m	45%
Primary Care Prescribing	£125.6m	£163.5m	£37.9m	30%
POD (Delegated)	£0.0m	£76.8m	£76.8m	100%
Spec Comm (Delegated)	£0.0m	£167.8m	£167.8m	100%
Other Programme	£22.3m	£24.3m	£2.1m	9%
Running costs	£16.3m	£11.1m	(£5.2m)	(32%)

The 2024/25 financial outturn

The original financial plan for 2024/25 was for a £79.9m deficit, before the inclusion of national deficit support to get the system to a balanced financial plan. Whilst the plan was not without financial risk in a number of areas, these were mitigated in-year across the system. Subject to external audit at the time of updating this document, the system has reported a balanced position for the year as shown in the table below. Efficiency delivery was slightly lowered than planned and whilst agency expenditure reduced from previous levels it was still above the plan agreed. Both areas were mitigated through non-recurrent financial opportunities.

The Plan for 2025/26

The system financial plan for 2025/26 has been agreed with NHS England at breakeven, in line with NHS England planning requirements. The position includes £73.2m of national deficit support monies. The plan includes a challenging efficiency requirement of £133.1m (6.1%), and a further reduction in agency expenditure to a maximum of £36.2m. Financial risks within the submitted plan have a level of identified mitigations but, the largest areas unmitigated relate to efficiency savings required. Management plans for both efficiency and financial risks are continually being developed. The table below sets out the plans for each organisation.

Surplus / (Deficit)	Integrated Care Board	Worcs Acute	Health and Care Trust	Wye Valley	ICS Total
24/25 plan (deficit)	+£8.8m	(£57.3m)	+£0.0m	(£31.4m)	(£79.9m)
24/25 out-turn (deficit)	+£11.3m	(£5.7m)	+£0.0m	(£5.6m)	£0.0m
25/26 plan (deficit)	+£0.0m	£0.0m	£0.0m	£0.0m	£0.0m
Delivery Plan Requirements for 25/26					
Efficiency savings	£42.1m	£53.0m	£13.5m	£25.0m	£133.6m
% efficiency saving	1.9%	6.6%	4.4%	6.0%	6.1%
Trust Agency expenditure	-	£22.0m	£6.1m	£8.1m	£36.2m
% of Staffing Cost	-	4.7%	2.6%	3.3%	3.8%

Strategic Context – Finance – Building a Sustainable Future and benefits realisation

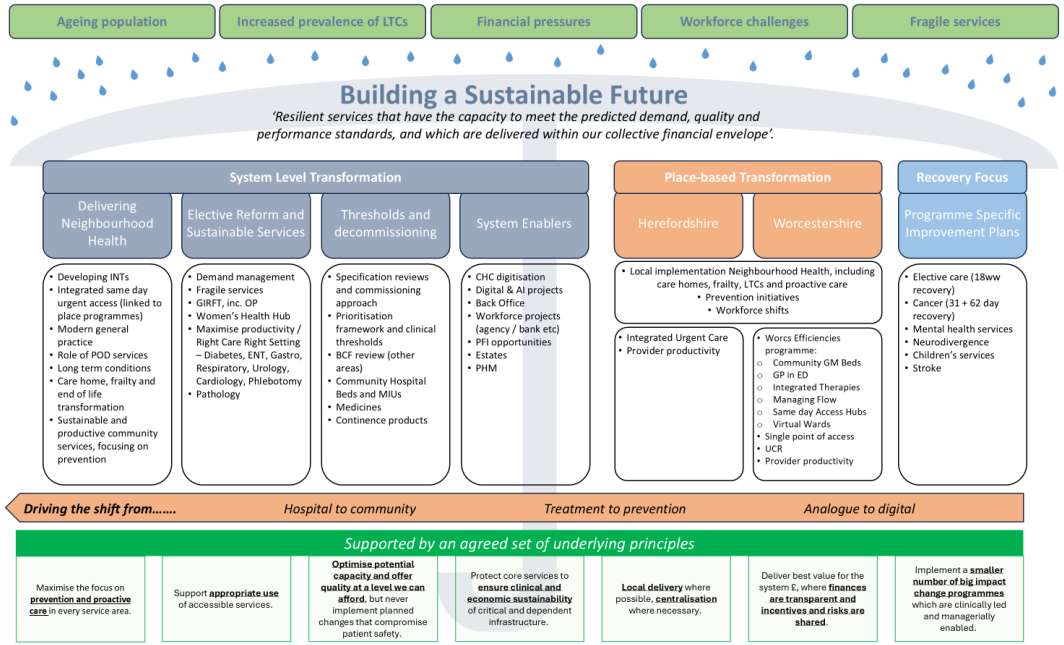
Building a Sustainable Future

Herefordshire and Worcestershire health and care partner organisations work together each year to develop a local operational plan that meets strategic and financial objectives as well as delivering the right services for our population. In recognition of the financial challenges facing the system in 2025/26 and beyond senior leaders, including Clinicians have worked together to develop a programme of work called "Building a Sustainable Future".

The overarching aim of the programme is to enable the delivery of:

'Resilient services that have the capacity to meet the predicted demand, quality and performance standards, and which are delivered within our collective financial envelope'.

The 'Building a Sustainable Future' programme, a medium to long term transformation programme has been developed following a workshop with Senior Leaders in 2024/25 where a range of challenges from clinical sustainability, quality and safety, financial and strategic changes programmes were discussed.



The Building a Sustainable Future programme forms the backbone of the system responses to meet the medium-term financial challenges, to deliver the predicted increase in demand, delivered within allocated budget. This supports all aspects of annual and medium-term planning, with a particular focus on the contribution to the Medium-Term Financial Framework.

Key areas of focus for 2025/26 have been agreed through the Building a Sustainable Future Board, chaired by the ICB Chief Executive Officer, and are summarised below:

1. Frailty
2. Elective Reform
3. Releasing time to care
4. Prioritisation of services
5. Population Health Management
6. Public awareness and education

The financial contribution to sustainability of the system is a key part of the detailed transformation plans which underpin the priority areas for 2025/26.

Benefits realisation

A benefits realisation framework has been developed to ensure that each intervention or initiatives impact can be quantified from an activity and performance, financial and workforce perspective. Understanding these impacts is a critical piece of work to ensure that we have the right services for patients and to support improving the financial position and delivery of our performance ambitions underpinned by the right workforce.

Investment Standards

Delivery of the Investment Standards that were developed for 2024/25, and continue into 2025/26, to support the Building a Sustainable Future programme have progressed, following the identification of potential savings. The focus has been on:

- Best Value Care in the Right Setting or "Left shift"
- Prevention and addressing Health Inequalities
- Virtual Wards
- Growing our own nursing workforce

Herefordshire and Worcestershire Integrated Care System

Herefordshire General Practice | General Practice Worcestershire | NHS Wye Valley NHS Trust | NHS Herefordshire and Worcestershire Health and Care NHS Trust | NHS Worcestershire Acute Hospitals NHS Trust | NHS Herefordshire and Worcestershire

The core focus

Driving the shift upstream to more prevention and best value care in the right setting

What do we mean by driving the shift upstream to more prevention and best value care in the right setting?

A greater focus on prevention

The major focus of the JFP is on driving a shift to a model of healthcare that places greater emphasis on the **importance of preventing ill-health** rather than a focus on treating the symptoms of it. The NHS cannot achieve this by working in isolation only through effective partnership working and good engagement with communities. This is the emphasis of the Health and Wellbeing Strategies and the Integrated Care Strategy. The core focus of NHS partners in this JFP is on the "20%" of factors that contribute to people's health and wellbeing outcomes (as per the diagram right).

Adapted from an illustration of the impact of healthcare and non-healthcare factors on a person's health. Source: Institute for Clinical Systems Improvement Going Beyond Clinical Walls. Solving Complex Problems (October 2014).

Whilst it is not the core business of the NHS to focus on the wider determinants of health, such as education, employment, housing and environment, as a major employer of around 2.5% of the local population (circa 20,000 employees), many of whom live in the ICS area, NHS bodies clearly have an important role to play and contribution to make.

The focus of this plan though is on the core business of the NHS, which is the provision of services. Through implementation of this plan, there will be a drive through planning and resource allocation approaches over time that increasingly rebalance the prevention v treatment equation:

During the early phases of implementation, the service areas outlined in appendix one, through their respective programme boards, will be charged with the task of identifying what specific actions can be implemented to contribute towards this overall ambition.

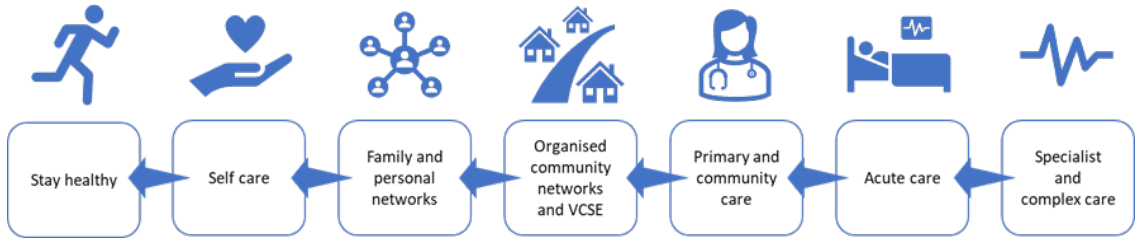
This ambition will also be incorporated in the medium-term financial strategy, 'Building a Sustainable Future'.

Providing best value care in the right setting

The role of the NHS is to provide care and treatment for people when they need it. The second element of shift in focus is on ensuring that the care is provided in the most optimal setting for the person's needs at any given point in time. Optimal represents the balance between quality, safety, appropriateness of setting and best cost care. Optimal is not just about cost reduction and financial savings, although savings are a clear beneficial by-product of getting optimal care.

Achieving optimal care settings will typically result in faster recovery from illness and a greater chance of return to independence. For example, a co-produced document called *"Supporting patients' choices to avoid long hospital stays"* highlighted that people's physical & mental ability and independence can decline if they are spending time in a hospital bed unnecessarily. As well as being at risk of acquiring hospital acquired infections, for people aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting. Thus, there is a significant quality and service improvement benefit to be achieved by getting this right.

Providing care in the optimal setting requires NHS partners to work together to deliver more care towards the left-hand side of the spectrum below.



The Point Prevalence Audit undertaken in 2022, 2023 and 2024 identified that around 25% of people could be cared for further along towards the left-hand side of the diagram above. The financial opportunity associated with this cohort, if scaled up annually, was in the region of £12 to £15m, even taking account of the need for the additional capacity required to accommodate them in the other setting. Alongside the quality improvements, the opportunity to achieve this shift in focus is therefore very compelling.

Understanding the issues and opportunities around “optimal care settings” – The Point Prevalence Audit

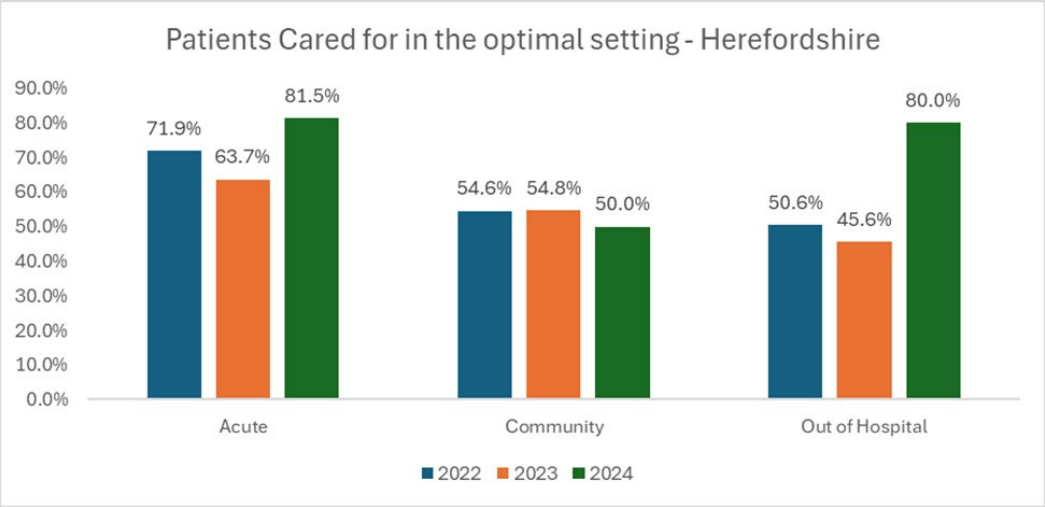
The Point Prevalence Audit

In September 2024 the system wide **Point Prevalence Audit** was conducted to assess the extent to which people in the health and care system are cared for in the most optimal care setting for their needs at the time. The audit, which replicated the method from 2022 and 2023 looked at 1,679 people across 103 care settings – including acute beds, community beds, discharge pathways and other home-based care such as community teams and virtual wards. The study showed that around 70% of patients audited were in the right care setting.

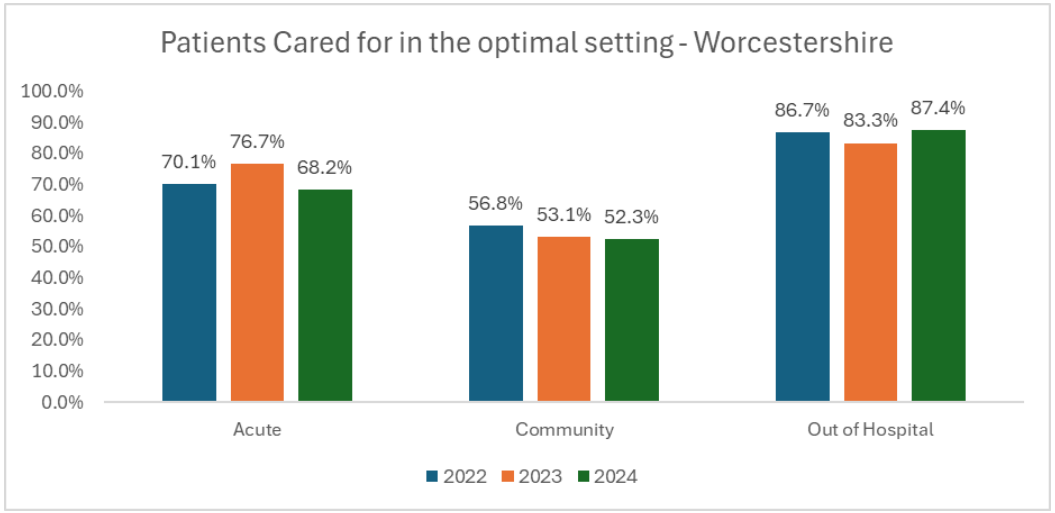
The charts below provide an overview of the shift in % of patients being cared for in the most optimal setting across the last three years.

Percentage of patients in the optimal care setting for their needs at the time

There were some notable changes to the results in PPA 3 compared to previous years, in particular in relation to Herefordshire’s results. There were a far higher proportion of patients assessed as being in the right care setting in both acute beds and out of hospital care. However, there was very little change in the position for community hospitals.



In Worcestershire the position was similar for community hospitals and there was some slight improvement from an already high baseline for out of hospital care. However, there was a fall in the proportion of patients deemed to be in the right care setting in acute beds.



Opportunities to optimise care settings – the balance between hospital and community

The opportunity to realise the government policy ambition to see a shift from Hospital to Community can be seen most clearly in the use of community hospital beds. Across both counties, in all three years, no audit has shown that more than 60% of patients are in the optimal care setting for their needs at the time.

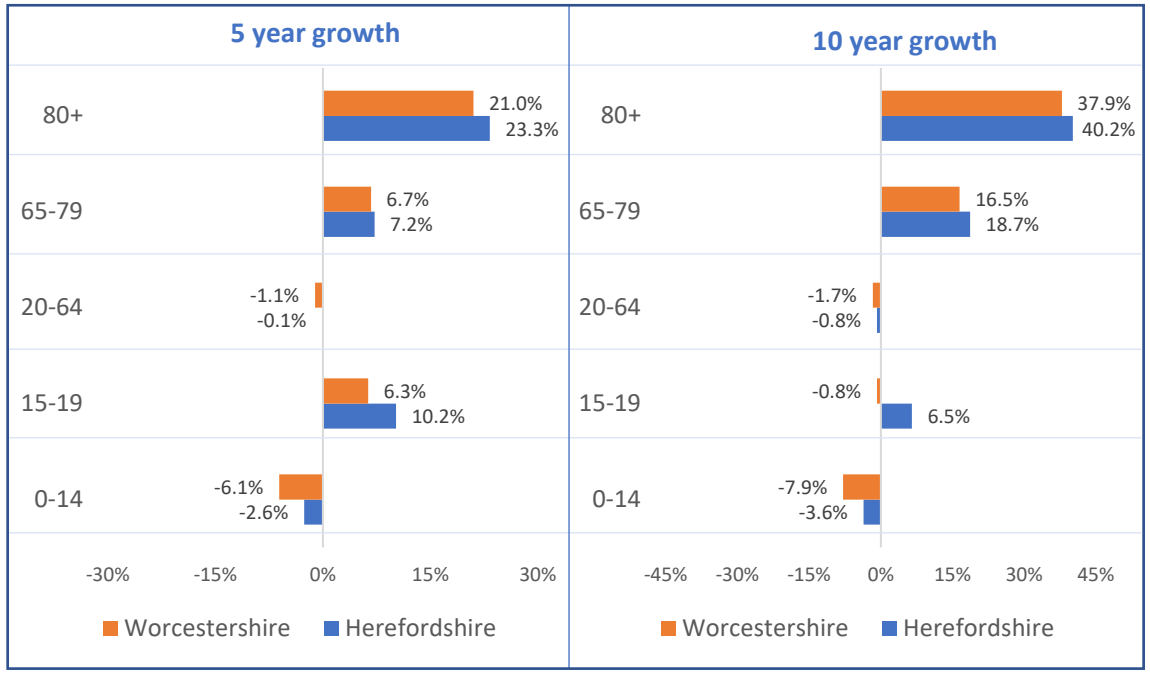
Creating additional capacity in home-based discharge pathways, accessing more capacity in domiciliary care and in residential / nursing homes would enable the system to operate more efficiently and effectively with fewer community hospital beds than are currently in use. The system will seek to address these opportunities through the Building a Sustainable Future Programme. This can be seen in the strategic demand and capacity modelling, described on the next two pages of this document.

If you would like to access further detail, you can do so here: Best Value Care in the Right Setting Update 2025

Developing a better understanding of future demand and capacity requirements

The final element in the strategic planning work to support the development of the JFP has been the development of a system wide **strategic demand and capacity model**. The point prevalence audit results indicated that there is a mismatch between demand and capacity; which ultimately leads to people being treated in care settings that are not optimal for their needs, frequently at higher cost to the system. The first phase of the demand and capacity model work has been to quantify the future impact over 5 years of not optimizing the provision of care. The second phase of the work, to be conducted during the first 3-6 months of JFP implementation will be to model the potential solutions to mitigate that growth in demand.

Population growth: Population numbers are forecast to grow most in the older age groups in the population – more than 20% over 5 years and nearly 40% over 10 years for people aged 80 years or more.



Likely Impact on Frailty Demand: Whilst age alone is not an indicator of future health demand, it does provide a basis for calculating likely levels of frailty that services are likely to be responding to. Initial model projections suggest the following impact:

Frailty Risk Category	10 Yr impact – Herefordshire	10 Yr impact – Worcestershire
No frailty score	+21%	+21%
Low score	+19%	+17%
Moderately low score	+28%	+27%
Moderately high score	+33%	+32%
Highest score	+36%	+38%

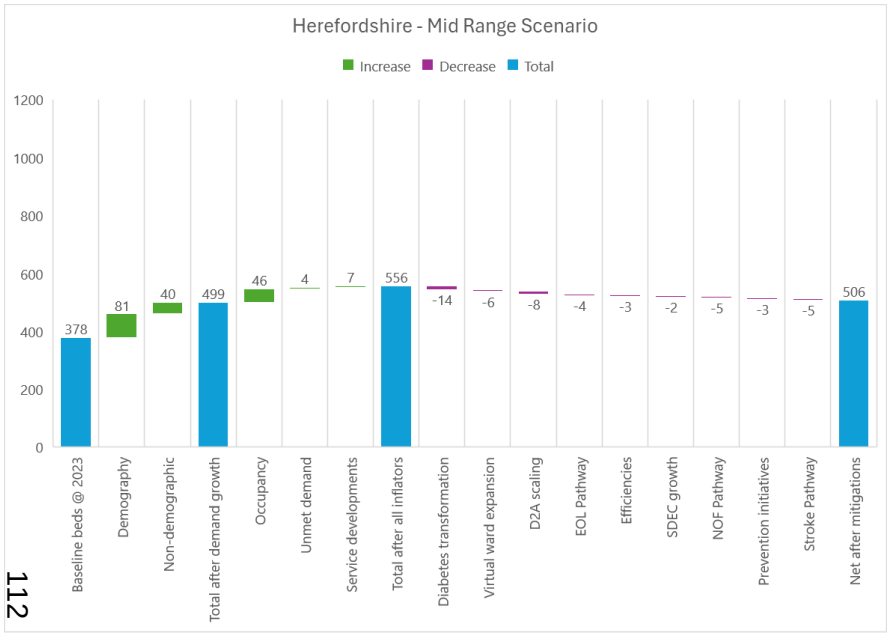
Unmet demand: The model calculates the impact of unmet demand (such as people waiting in ambulances or on trollies in A&E that would be admitted if beds were available). However, they are often cared for in unconventional settings for their whole hospital stay.

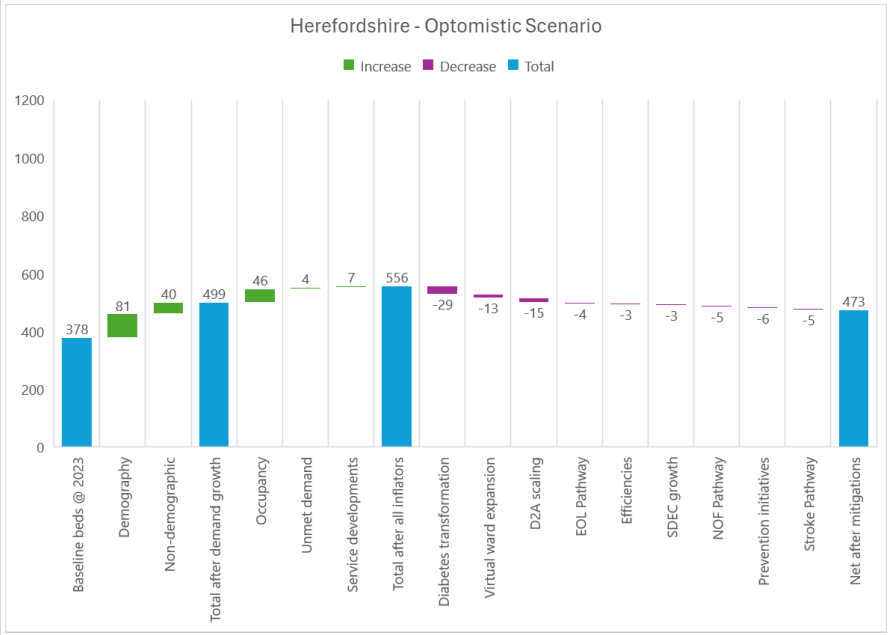
Sub-optimal flow: The model also calculates the impact sub-optimal flow on projected future bed numbers. There are two main mitigations to this, one of which is increasing the size of the bed pool to enable better flow, the other is to optimize practice to ensure that patients are only admitted when necessary and don't have any delays to their discharge.

Initial aggregate demand impact: Bringing together all aspects of growth, the draft model indicates future demand growth that will need to be mitigated by actions to be delivered under the JFP is an additional 274 beds.

Aggregate acute bed requirement in 10 years under the do nothing scenario	Acute Bed Impact	
Baseline beds	1,229	
Demographic growth	+236	
Non-demographic growth	+129	
Measure of un-met demand	+8	+311
Impact of sub optimal flow	+83	
New service developments	+28	
Mitigations, efficiencies and transformation programmes	-123	
Net ten year bed requirement for acute care	1,540	

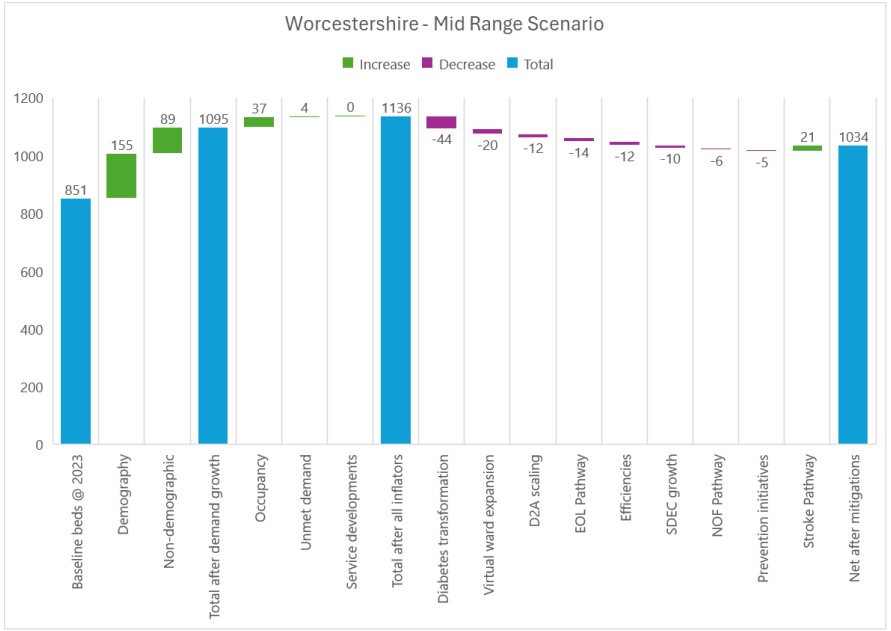
Developing a better understanding of future demand and capacity requirements – modelling the mitigations

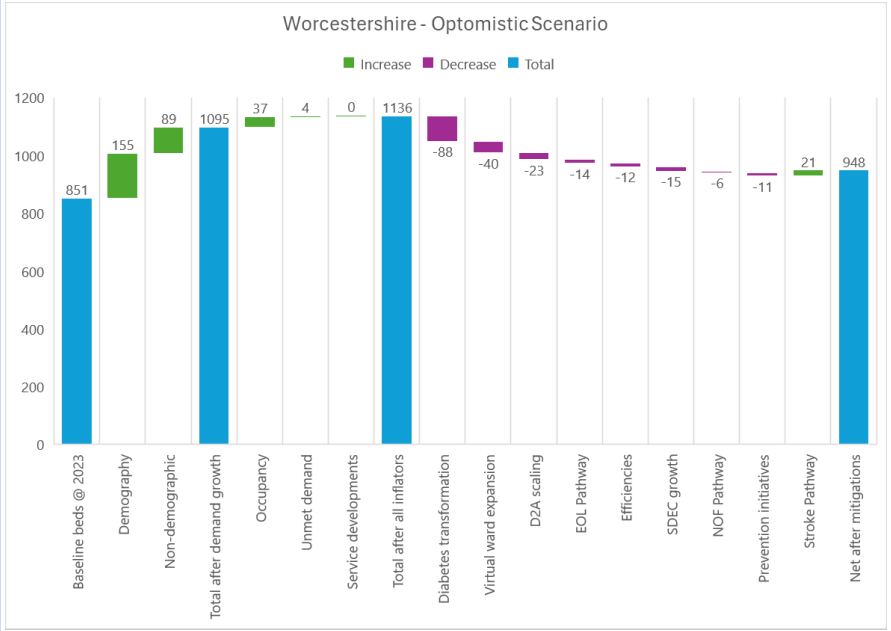




Herefordshire

- **Mid-range scenario** bed requirement by 2033 grows from 378 beds to 506 beds (+128).
- **Optimistic scenario** bed requirement by 2033 grows from 378 beds to 473 beds (+95).
- **Occupancy improvement** calculation is equivalent to 46 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations**: The biggest mitigation opportunities are diabetes transformation and D2A pathways.





Worcestershire

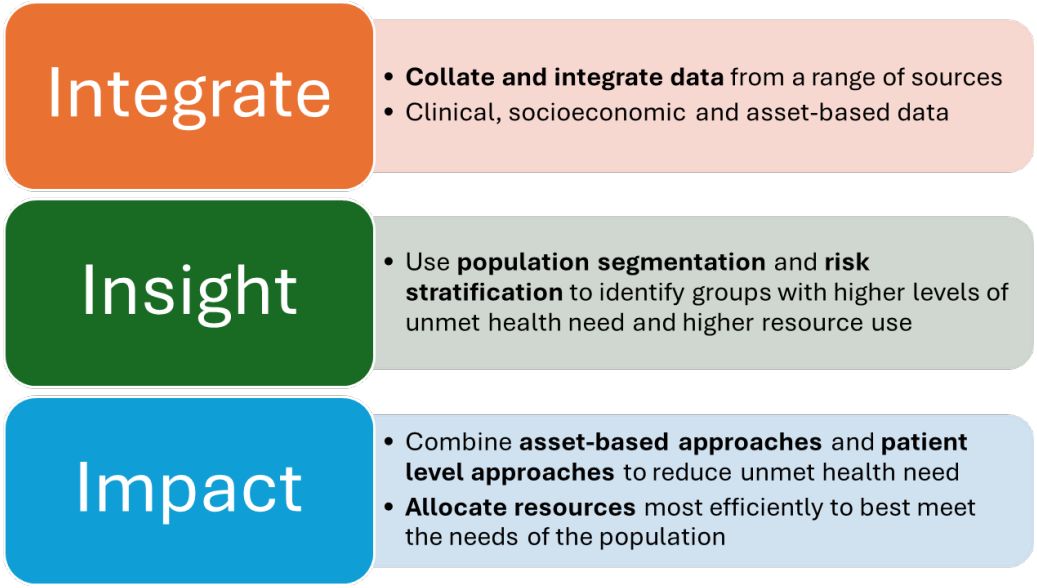
- **Mid-range scenario** bed requirement by 2033 grows from 851 beds to 1034 beds (+183).
- **Optimistic scenario** bed requirement by 2033 grows from 851 beds to 948 beds (+97).
- **Occupancy improvement** calculation is equivalent to 37 beds.
- **Unmet demand** metric is equivalent to 4 beds.
- **Mitigations:** The biggest mitigation opportunities are diabetes transformation and virtual ward scaling.

Population Health Management - Supporting the shift upstream to more prevention and best care in the right setting

Introduction

Population Health Management or PHM is for everyone working in integrated care. All ICS Partners working together to improve population health by data driven planning and delivery of proactive care to achieve maximum impact with the resources available, alongside the demand and capacity modelling described above.

PHM is a key strategic enabler delivery of the core areas of focus (Appendix 1) and the cross cutting themes (Appendix 2). PHM is not a new concept and is something that system partners already do. However. it is only at its most effective when both aspects come together and are tackled as part of a single coherent plan. In essence, PHM has three major components to it:



Population Health Management is a key enabler and sits within the **Building a Sustainable Future programme** as a key enabler. This includes both short and long-term activities. During 2024/25 the neighbourhood health accelerator sights tested the concept of integrated neighbourhood teams. Learning from this is being fed into the development of Neighbourhood Health activities. Increasing deployment of PHM is key to the successful delivery of this programme.

What next?

The ICB will facilitate the development and deployment of a of a system wide Population Health Management **Strategic Implementation Plan** during 2025/26, this will include:

- Taking astrength based approach, building on good practice where PHM tools and techniques are already being deployed.
- Identifying a clear leadership and programme delivery structure, brining together information, clinical and strategy capabilities.
- Endorsing a clear vision of PHM as an iterative evolution towards a new operating model to guide the change over a 5 years period.
- Calculating the return-on-investment time to support the shift upstream to prevention and enable Developing a community driving adoption, spread and sustainability via use cases choices, and building a movement.
- Developing a PHM infrastructure and analytics capability – including a clear road map linked to the wider analytics development plan.
- Developing an approach to linked data sets – including the required information governance agreements within a clear road map linked to the refreshed digital strategy.
- Building on the governance platform established through the Analytics Board and Health Inequalities, Prevention and Personalisation (HIPP) Programme Board.

How will we deliver?

Developing a robust Strategic Implementation Plan for Population Health Management is a central tenant of the shift upstream to prevention and will therefore become a key corporate project in 2025/26. Learning will be drawn from the national PHM Academy with opportunities to learn from other systems as well as from within Herefordshire and Worcestershire, focusing on the development of infrastructure to integrate data, draw insights and develop impactful changes to deliver improved outcomes for the comr

A system based PHM Steering group is being established to oversee the Development and delivery of the PHM Strategic Implementation Plan. This group will drive delivery, support shared learning and seek to mitigate Any risks to delivery of the plan.

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Engagement Approach

Developing the Joint Forward Plan – Engagement approach

As a health and care system we are committed to close working with individuals, communities, partners and wider stakeholders. In developing the **structure and content** of our second Joint Forward plan, we have built on existing insights from recent engagement, these include:

- **The HW Integrated care strategy : 3 phases of engagement** - A thematic review of relevant existing patient and public engagement undertaken over the last two years. Extensive stakeholder engagement and broader feedback following the publication of the draft integrated care strategy.
- **Joint forward plan insights** – Complimenting the Integrated Care Strategy engagement, narrowing the scope to focus in on health services in line with the NHS Long term plan.
- **Specific engagement** – With NHS partners, including the 3 NHS Trusts, General Practice representatives and the Integrated Care Board.

The engagement strategy for the JFP recognises the benefit of aggregating together information from various sources and using this as a basis for filling in gaps in knowledge. The table below describes some of the engagement that has been undertaken by the ICB in partnership with providers:

Engagement activity – 2024/25 included...	
• Quarterly voices report produced and published, including engagement Accessible information • Autism (Adults) • Cancer – Macmillan Cancer Inequalities Project, Cancer – Patient Experience Survey • Diabetes • Frailty • Complaints, Concerns and Compliments • Mental Health • Menopause	• NHS 10 Year Plan • Palliative and End of Life Care Strategy • Public Perceptions of Health and Social Care • Stroke • Urgent and Emergency Care • General Practice • Long Term Plan • Maternity • Engagement on communications for ICB communications & engagement framework

In addition, these specific engagement activities there are various ongoing programmes of engagement with patient representatives engaging in meetings and specific activities.

Engaging individuals and communities

You can find more detail in **Appendix 2: Key enablers**, about our commitment to early engagement and ongoing dialogue with people and communities. You can also find out more about our wider system approach to engagement in our **ICS Engagement Strategy**.

Involvement opportunities are made available here:

https://www.hwics.org.uk/get-involved/involvement-opportunities

The Joint Forward Plan is owned equally by the ICB, the three NHS Trusts and the two General Practice Organisations that operate across the system. This joint ownership means that we can work together to support effective engagement and evaluation of delivery throughout the life of the plan.

Engagement insights will be used to develop programmes and also to evaluate their effectiveness. With the publication of the Joint Forward plan being an opportunity to share the core areas of focus for the system over the next few years. This should make it easier for local people to understand where change and improvements are being made and to get involved.

Next steps

- Opportunity to feedback and get involved in more in-depth engagement for specific clinical services pathways
- Embedding engagement insights into the delivery of the core strategic intent: ***"Driving the shift upstream to more prevention and best care in the right setting"***

Implementing the Joint Forward Plan

The implementation approach for the Joint Forward plan is now embedded in the infrastructure outlined at the beginning of appendix 1. This also reflects the landscape in terms of strategies and plan:

- **NHS System operational plan for 2025/26** - This outlines the key operational delivery priorities for healthcare during the third year of the Joint Forward Plan.
- **The Integrated Care Strategy for 2023-2033 –** This brings together a broad range of partners across the Integrated Care System, around a shared vision for improving health and well-being for everyone and three key priority areas.
- **Worcestershire Joint Local Health and Wellbeing Strategy** – This identifies a key priority focus on Good Mental Health and Well Being, supported by healthy living at all ages; safe thriving and healthy homes, communities and places; quality local jobs and opportunities.
- **Herefordshire Joint Local Health and Wellbeing Strategy** – This identifies two key priorities of Providing the Best Start in Life for Children's" and "Mental Health and Wellbeing", supported by six enablers: access, living and ageing well, good work for everyone, supporting those with complex vulnerabilities, housing/homelessness, reducing carbon footprint.

The Joint Local Health and Wellbeing Strategies and the Integrated Care Strategy provide the long-term frame, with the Joint Forward Plan translating this into NHS focused medium-term delivery priorities; and the Operational Plan focusing in turn establishing the annual priorities.

Year 3 implementation focus

During the second year of implementation there are two main streams for the Joint Forward Plan:

- **Stream 1:** Developing and implementing the opportunities for **driving the shift upstream to more prevention and best value care in the right setting** maximising on the three shifts, expected within the NHS 10 year plan. Delivered through Population health management, evidence based decision making increasing the provision of pro-active care.
- **Stream 2:** Continued delivery of the year 3 priorities for the **core areas of focus and cross cutting themes** building on what we have delivered in year 1.

There is a significant role for existing programme boards with the system governance structure to develop, align content and instil ownership of delivery of the plan from the outset.

Stream 1: Developing and implementing the opportunities for **driving the shift upstream to more prevention and best value care in the right setting** maximising on the approach to Population health management, evidence-based decision making increasing the provision of pro-active care.

Stream 1: Driving the shift upstream to more prevention and best care in the right setting.	Phasing
Development of Building a sustainable future programme on Neighbourhood Health	2025/26
Drive the shift from Treatment to Prevention through delivery of key prevention programmes, including implementation of the Population Health Management Framework	2025/26
Drive the shift in Acute to Community through implementation of actions outlined in response to the Best Value Care in the Right Setting and Poist prevalence reports	2025/26
Deliver the Building a sustainable Future priority programmes – System enablers. Including Digital Strategy and Transformation	2025/26

Stream 2: Continued delivery of the year 3 priorities for the **core areas of focus and cross cutting themes** building on what we have delivered in year 1 and 2.

Stream 2: Delivery of year 3 priorities for core areas of focus and cross cutting themes	Phasing
Delivery of the year 3 priorities for the core areas of focus: See appendix 1.	2025/26
Delivery of the year 3 priorities for the cross-cutting themes: See appendix 2.	2025/26
Ongoing focus on system development, ensuring that mechanisms for collaboration are strong and effective in enabling delivery of the priorities within the JFP.	2025/26

Joint forward plan – 25/26

Appendix 1:
Core areas of focus

This section sets out how the Joint Forward Plan addresses national requirements set out in **the NHS Long Term Plan** and **local priorities** to ensure the NHS makes a positive contribution to improved health outcomes for the population through delivery of high-quality patient centered pathways that are overseen by programme boards across the ICS. This includes a summary of what we have delivered in 2024/25 and what our focus is for 2025/26 and beyond.

Version: 2025 Refresh, May 2025

Delivering High quality, patient centred integrated pathways: INTRODUCTION

There are a broad range of work programmes across Herefordshire and Worcestershire, within place and neighbourhoods. These are established to develop and deliver programmes of work focused on local and national priorities including those set out in the https://www.longtermplan.nhs.uk/.

In this section you will find a high-level summary of year 2 delivery, and the priorities that are developed and overseen at a system level through Herefordshire and Worcestershire ICS Programme Boards.

Core areas of focus can be found in this document, which include:

1. Maternity and neonatal care
2. Early years, children and becoming an adult
3. Elective, Diagnostics and Cancer Care
4. Frailty
5. Palliative and End-of-life
6. Learning disability and autism care
7. Mental health and wellbeing
8. Long-term Conditions
9. Stroke care
10. Urgent and emergency care
11. Primary Care
12. General Practice
13. Pharmacy, Ophthalmic and Dentistry
14. Specialised Services

Cross cutting themes can be found in Appendix 2 and include:

1. Quality, Patient safety and experience
2. Clinical and care professional Leadership
3. Medicines and pharmacy
4. Health inequalities
5. Prevention
6. Personalised care
7. Working with communities
8. Commitment to carers
9. Support veteran health
10. Addressing the needs of victims of abuse
11. Digital data and technology
12. Research and innovation
13. Greener NHS

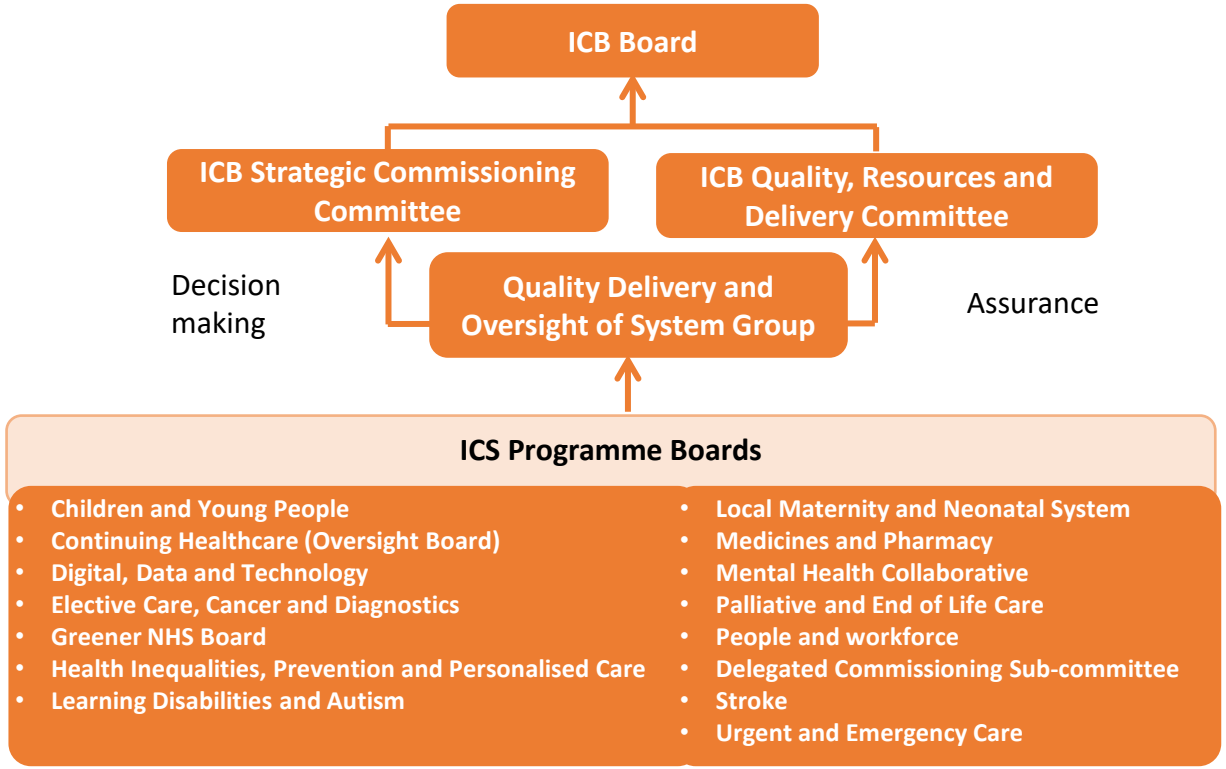
The role of an ICS Programme Board

The ICS Programme Boards are responsible for overseeing delivery of programmes across Herefordshire and Worcestershire, including the Joint Forward Plan, which will include regular reporting on progress against plan delivery and mitigating / escalating risks to delivery through to the ICB Quality, Resources and Delivery Committee.

The ICS Programme Boards bring together organisations to coordinate and oversee delivery of improvement and transformation activities across Herefordshire and Worcestershire. They are responsible for setting the strategic direction and ensuring that comprehensive delivery plans and monitoring frameworks are in place. Whilst the Programme Boards are not decision-making forums, the governance framework allows timely decision making through the ICB Strategic Commissioning Committee.

Joint ownership

The membership of each ICS Programme Board represents the key stakeholders engaged in a particular programme area, including NHS and Local authority partners, Healthwatch, networks and alliances and representatives of the patient voice, in addition to operational and clinical staff. The chart below summarises the governance structure.



Core areas of focus

In this section we answer the following questions for each core area of focus. The programmes of work included will be reviewed and refreshed in the Joint Forward Plan annually.

1. Why this is important?
2. What we are doing
3. What will we deliver and when?
4. Where you can find more detail

High quality, patients centred services: MATERNITY AND NEONATAL CARE

Theme 1

1. Why is this important?

The Local Maternity and Neonatal System (LMNS) vision is to work together to deliver consistent, high quality, safe personalised care that is delivered equitably according to local need.

High quality maternity and neonatal care is essential in ensuring every child across Herefordshire and Worcestershire has the best start in life.

During 2024 we saw an increase in deliveries to 6,315.

- Our smoking in pregnancy rates remain higher than the national ambition of 6%.
- Whilst our initiation of breastfeeding rates were higher than the national average, we know that there are groups within our population where breastfeeding is much lower, and further work is needed to support this.
- Over a quarter of women who booked for maternity care had BMI>30, similar to 2023.

All of these factors contribute to health inequalities and poor outcomes for babies and families. Our LMNS continues to work in partnership to reduce health inequalities and providing safe, personalised, equitable care.

The LMNS consists of Herefordshire & Worcestershire Maternity and Neonatal Voices Partnerships, Wye Valley NHS Trust, Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Integrated Care Board, Herefordshire and Worcestershire Health and Care NHS Trust, Herefordshire Council and Worcestershire County Council.

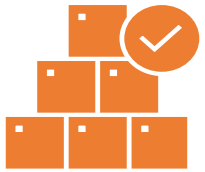
2. What have we delivered in our first two years, 2023 - 2025?

- The LMNS completed a 3-year pilot of Perinatal Pelvic Health Services and the service is now commissioned across Herefordshire and Worcestershire. The team have been recognised nationally as an area of good practice.
- The Maternity and Neonatal Voices Partnership (MNVP) has continued to develop, with Neonatal Champion role to ensure the voices of local Families who experience neonatal care are heard. An MNVP strategic role has commenced to enable further capacity for engagement across the system.
- A system led approach has been taken to ensuring our Trusts are compliant with the expectations of the Saving Babies' Lives Care Bundle Version 3. This will have an impact on reducing neonatal and maternal mortality, still births and intrapartum brain injury. The compliance rate for Saving Babies Lives has improved in Worcestershire from 49% in 23/24 to 94% 24/25 and in Herefordshire from 59% in 23/24 to 87% in 24/25.
- The LMNS continues to implement the Perinatal Quality Surveillance model, ensuring that there is trust board and ICB oversight of key factors that impact on perinatal quality and safety, such as staffing, culture and learning from incidents.
- The LMNS has worked with stakeholders to co-produce a strategy that outlines our deliverables and local plans for implementation to align with the NHS England Three Year Delivery Plan. The Digital and Reducing Health Inequalities strategies are being refreshed to ensure a continuous focus on digital innovation and reducing health inequalities, specifically reducing prematurity, access and prevention. The Infant Feeding Strategy was produced in 2024 and monitored through the Perinatal Health and Wellbeing Group.
- The LMNS continues to conduct Perinatal Mortality reviews to ensure shared learning to improve care. This has increased the opportunities for shared learning and external peer review.
- The LMNS programme team has conducted a series of insight visits, supported by NHS England Regional Perinatal team to review quality, safety and culture within our system.
- The LMNS has supported the Trusts to implement the BRAIN pneumonic to aid shared decision making and has funded birth rights and inclusive language training based on feedback from the MNVP.
- The locally delivered Movements Matter campaign highlighted the importance of acting on reduced fetal movements and not using home dopplers. It had a wide reach and social media activity showed a high click rate particularly from men.
- Partnership working within the system has improved through the LMNS Board Development programme facilitated by the Kings Fund, and through collaborative working with our buddy LMNS Coventry and Warwickshire.
- A preconception campaign (in collaboration with Tommy's & C&W LMNS) aimed at reaching more vulnerable groups is launching in March 25, linked to the Womens Health Hubs.

3. What are the priorities going forward?

In addition to national priorities, our local shared priorities of the LMNS are:

- Intelligence to identify and act on issues as early as possible
- Prevention and reducing health inequalities.
- High quality, safe maternity and neonatal care
- Listening to local women and birthing people and our staff



High quality, patients centred services: MATERNITY AND NEONATAL CARE

Theme 1

4. What will we deliver and by when?

Priorities	Deliverables	Year of delivery
Listening to women and families with compassion	• Enable women to have personalised care through personalised care and support planning. • Provide Perinatal Pelvic Health services that meet the needs of patients. • Enable and empower our Maternity and Neonatal Voices Partnerships to gather intelligence and represent our local families, coproducing maternity and neonatal services.	2025/26
Growing and developing our workforce	• Develop and implement local evidence-based retention action plans • Deliver supervision, training and support as needed by staff. • Listen to, and act on, staff and student feedback • Continue to facilitate a workforce and culture that supports learning and delivers safe, equitable care.	2025/26
Developing and sustaining a culture of safety	• Share learning from incidents across the Local Maternity and Neonatal System and learning from incidents at a national and regional level. • Promote positive culture through supportive leadership. • Identify any concerns, raising them early and addressing them. • Improve quality through delivery of the SCORE action plan.	2025/26
Meeting and improving standards and structures	• Implement national evidence-based guidance such as the Saving Babies Lives' Care Bundle V3 and monitoring local progress against outcomes. • Use evidence-based tools such as MEWS and NEWTT-2 to better detect concerns and act sooner on safety issues. • Make better use of digital technology in maternity and neonatal services through implementing the Local Maternity and Neonatal System digital strategies. • Regular oversight and open scrutiny of intelligence to identify issues, inform learning and improve quality.	2025/26
Prevention and tackling health inequalities	• Deliver equitable care through the implementation of the LMNS reducing health inequalities strategy. • Improve outcomes through a focus on healthy lifestyles and mental health, from pre-conception through the perinatal period, and understanding and removing barriers to access • Support women and families with multiple complexities during pregnancy/perinatal period • Develop a dashboard to assist understanding of health inequalities, enabling focussed work to reduce Health inequalities.	2025/26

5. Where you can find more detail?

There are two active Maternity and Neonatal Voices Partnerships (MNVP) in Herefordshire and Worcestershire, this is an opportunity for members of the public to have a say in how maternity services are run in both counties.

If you would like to get involved please contact:-

hwicb.herefordshiremvp@nhs.net – Herefordshire MNVP
hwicb.worcsmvp@nhs.net- Worcestershire MNVP

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

1. Why is this important?

- Across Herefordshire & Worcestershire Children and Young People (CYP) represent approx. 19% of our population, with approximately 140,000 0-19 years old (Public Health Profiles 2021).
- Overall, this is a good place to live. There are relatively low levels of poverty and deprivation, and many children and young people are happy.
- For children and young people living in areas of high deprivation or experiencing poverty, there are barriers to accessing services.
- Some children and young people are at the biggest risk of poor outcomes. Including those with additional needs; exposed to family and behavioural risks; or with experience of the care system.
- 14.1% of children in Worcestershire and 12.2% in Herefordshire are living in low-income Families.
- 65% of children achieve a good level of development at the end of reception in Worcestershire and 71.8% in Herefordshire.
- Emotional wellbeing is a cause for concern in 39% of looked after children in Worcestershire and 42% in Herefordshire.
- The prevalence of overweight (including obesity) of children in Reception is 20% in Worcestershire and 25% in Herefordshire.
- Hospital admissions for children aged 0-14 is a rate of 71.9 per 10,000 for Worcestershire and 100.1 per 10,000 for Herefordshire.
- In Worcestershire 3.9 % of pupils have an Education Health and Care Plan and 2.6% in Herefordshire.

2. What have we delivered in our first 2 years 2023-2025?

- Development of CYP Health Inequalities pack to support interventions to improve health outcomes.
- Commissioned Lumi Nova, a digital based app suitable for 7-12 year olds to support low level anxiety related mental health issues.
- Undertaken a procurement exercise for emotional wellbeing and mental health services for 0-25 year olds. The service will commence in April 2025.
- Rolled out the national Asthma Care Bundle, delivered a pilot programme of community-based nurse led intervention and support to children at risk of poor asthma control and worked with housing colleagues on environmental factors and schools to support awareness raising and improve pupil attendance.
- Established a 2-year pilot programme of youth workers employed to support young people with long term conditions to transition from children to adults' health services.
- Piloted a psychological therapy programme to assist those children & young people with epilepsy.
- Jointly held transition clinics with adult services for children and young people with diabetes.
- Employed a Designated Clinical Officer for Special Education Needs & Disabilities (SEND) in Herefordshire.
- Agreed additional recurrent funding to support Paediatric therapist recruitment in Herefordshire and in Worcestershire.
- Initiated an evidence-based review of children's therapy delivery across the ICS – transformation in progress.
- Funding provided to Parent Carer Forum, and recruitment of Co-Production officers in Worcestershire to support SEND improvements through engagement and coproduction.
- Engaged with parents, carers and other stakeholders to design a future neurodivergence provision, including assessment and support.
- Engaged in two Local Area SEND Partnership inspections and started to address the improvements identified.

3. What are the priorities going forward?

- Development of locality based care pathways, redesigning community services.
- Review the CAMHS service ensuring clinical pathways are evidence based with a defined service specification.
- Continue to deliver the NHSE National Children and Young People's Transformation Programme to meet the commitments in the NHS Long Term Plan, as identified in the delivery plan.
- Enhance preparation for adulthood, recognising the needs of young people with long-term conditions and/ or complex needs.
- Continued engagement in Public Health-led Best Start in Life, particularly in early language and communication skills, as well as early identification and appropriate support of child development (at universal level).
- Continue to improve Special Educational Needs and Disabilities provision, including future model of community health services to address the needs of children and young people and reduction in waiting times particularly for neurodivergence assessments.
- Procure Neurodivergence support service.
- Review of Phlebotomy pathways across the system.

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Asthma - to support CYP with asthma, including diagnosis, care planning, and reducing emergency admissions.	• Co-production and launch of school asthma guidance to support best practice • Develop accreditation of asthma friendly schools in Herefordshire as part of the Healthy Schools programme • Pilot within Worcestershire with the Housing Association to review housing stock where Children and Young People with asthma are identified. • Roll out of resources to support families living with damp and mold, reducing the risk of an asthma attack.	By 2025/26
	• Embed the Asthma Care Bundle, risk stratification in Primary Care, understand & support clinical and CYP training needs • Toolkit for schools including development of training packages including videos for education settings to complement the schools asthma policies. • Develop local pathways of care for early diagnosis of asthma, ensuring appropriate referrals through to secondary care	By 2027/28
Epilepsy - Standardised approach to management of childhood Epilepsy.	• Continued improvement to the capacity of epilepsy nurse specialist support across ICS. • Evaluation of PAVES and Youth Worker projects to support development of options appraisal for provision of psychology and mental health support for Children and Young People with epilepsy.	By 2025/26
	• Identify and embed transition to adult services for children and young people with epilepsy. • Embed pilot projects as business-as-usual	By 2027/28
Obesity – to support a reduction in overweight and obese children across ICS.	• Obesity / Health Weight Summit as part of the Integrated Care Partnership Assembly to develop system wide strategy • Incorporate and embed CYP into the system wide Obesity strategy. • Pilot Social Prescribing/Coaching roles to take a Whole Family Approach	By 2025/26
	• Hard-to-reach CYP & Family's at risk of obesity & in areas of deprivation, are supported to access & shape support to address barriers to lifestyle changes.	By 2027/28
Diabetes - Reducing inequality and variation in outcomes.	• Evaluation of youth worker pilot • Further investigation and implementation of technology with individuals affected by health inequalities. .	By 2025/26
	• Prevention and education aligning with Obesity workstream and improving care and outcomes for CYP living with type 2 diabetes.	By 2027/28

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

Priorities	Deliverables	Year of delivery
Infant Mortality – to reduce the infant mortality rate across Herefordshire and Worcestershire	• Continue to audit Saving Babies Lives V3 compliance • Work as a system within the Perinatal Health and Wellbeing Group to coordinate prevention and transformation work streams feeding into place based Best Start in Life programmes.	By 2025/26
	• Improve systems to identify and support families whose children are at risk of infant mortality due to modifiable risk factors	By 2026/27
Urgent & emergency care	• Develop and embed a robust seasonal illness plan • Further development of the Handi App, adding additional conditions to support self management • Continue to develop common conditions pathway document across both Herefordshire and Worcestershire	By 2025/26
	• CYP are engaged in transition services and effective management of long-term conditions to avoid crisis presentations. • Consistent pathways across the ICS to provide CYP appropriate care in the most appropriate setting.	By 2027/28
Neurodivergence	• Embed CYP components of All-Age Autism Strategy. • Improve timely and appropriate access to services providing support, advice, information, training and interventions across the system.	By 2025/26
	• Improve waiting times for children's Autism and ADHD diagnostic assessments • Raise awareness and understanding of Neurodivergence in CYP workforce. • Implementation of redesigned Neurodiverse pathways • Increase take-up of annual health checks for 14-25 yrs	By 2027/28
Special Educational Needs and Disability (SEND)	• Continued increase in the number of children who are school-ready with appropriate plans in place. • Continued transformation of Paediatric Therapies model of delivery to enhance timely support	By 2025/6
	• Further develop joint commissioning of support & intervention services in both counties. • Improve transition into adulthood • Deliver the SEND improvement plans in both counties (and priority action plan in Worcestershire)	By 2027/28
Address healthcare inequalities to improve outcomes for Children and young people	• Continue to follow the national framework for the Core 20 plus 5 model, developing interventions to address inequalities.	By 2025/6

High quality, patients centred services: EARLY YEARS, CHILDREN AND BECOMING AN ADULT

Theme 2

Priorities	Deliverables	Year of delivery
Mental Health and Emotional Wellbeing Transformation Plan.	• Improve timely information, advice, and support • Improve mental health support for 0-25yrs and their families • Enhance pathways to avoid crisis & enhanced community-based solutions • Improved CYP mental health access rates by offering a range of services	By 2025/6
	• Improve mental health services within schools – aligned with the national guidance of MHST's in all schools by 2030	By 2027/28
Health and Wellbeing of Children Looked After (CLA)	• Review of Looked After Children's Services model in Worcestershire to ensure statutory health assessments for CLA are completed within timeframes and health needs are identified and addressed. • Pilot and evaluation of Initial Health Assessments contracting arrangements • Improve the process & timeliness of Adoption Medicals in Worcestershire. • Increase uptake of vaccinations within LAC across Worcestershire – review of children on the caseload with reduced vaccination status, complete RHA and raise awareness of vaccination • Herefordshire to raise awareness of vaccinations within schools and young people - co-produce promotional materials, raise awareness with engagement. Review of communications sent to parents. Increase HPV vaccine uptake amongst boys	By 2025/6
CYP Community Health Services	• Review and update service specifications for CYP community health services • Review Community Paediatric provision - Capacity and Demand modelling to commence April 2025 • Complete review of Children Community Nursing services with particular focus on EoL care in Herefordshire • Implementation of redesign of provision in Therapy Services incorporating 'The Balanced Approach' - universal, targeted and specialist provision. • Provider led review of Worcestershire Child Development Service • Continued development of a universal strand of provision in Occupational Therapy and Physiotherapy with a prevention / early intervention focus.	By 2025/26
	• Embed system adoption of universal, targeted and specialist approach within children community health services linked with development of the Best Start in Life programme with a focus on prevention and Family Hubs • Explore shared workforce opportunities across the system.	By 2027/28
Children's Cancer and planned Care	• Work with NHS across Region to ensure specialist care continues to meet children's needs. • Support & enhance Paediatric oncology shared care unit (POSU) at Worcester Acute Hospital to deliver injection-based outpatient chemotherapy • Develop level 2 Paediatric Critical Care capability at Worcestershire Acute Hospital.	By 2026/27

4. Where you can find more detail?

Engagement opportunities are circulated through parent carer forums and the ICS communications system.

We listen to the voice and experience of children, young people and Family's facilitated by Action for Children and specific feedback via existing youth forums, compliments and complaints.

The identified priorities reflect the Place based Children & Young Peoples Plan where regular updates are provided

Requests for information can be made to the CYP team at hwicb.cypteam@nhs.net

High quality, patients centred services: ELECTIVE, CANCER AND DIAGNOSTIC CARE

Theme 3

1. Why is this important?

To improve patient safety, outcomes and experience we must eradicate all long elective, cancer and diagnostic waits for assessment and treatment.

Waiting times remain in a challenged position post-COVID with waiting times being higher than we would like.

Despite having the 2nd lowest referral rate per 1,000 population, demand has increased circa 14% year on year.

The pandemic had a significant impact on planned care services, with access to many elective services paused, limited access to diagnostic tests and a significant reduction in patients being referred with suspected cancer. Demand has now returned to above pre-Covid levels, resulting in many services struggling to manage the levels of demand alongside addressing the backlog of patients that accumulated during the pandemic. This has resulted in patients are waiting longer for the diagnostic investigations, clinical assessment and treatment of cancer and non-cancer conditions.

In addition to recovering services, incidence of many health conditions such as cancer is expected to increase, with Cancer Alliances nationally predicting a 10% year on year increase in urgent suspected cancer referrals.

2. What have we delivered in our second year, 2024/25?

- Elimination of elective waits over 104 weeks, and over 78 weeks in most specialties with significant progress towards elimination of 65-week waits .
- Continued good performance against diagnostics targets, although a small number of challenged modalities remain.
- Patient Initiated Follow Up (PIFU) and Personalised Care Follow Ups (PCFU) continuing to be rolled out across a number of specialties enabling more people to self-manage their follow-up pathways.
- Fragile services framework in place with agreed ways of working to increase service resilience and sustainability.
- Utilisation of the Independent Sector Provider accreditation framework to support patient choice and ensure quality of the services delivered.
- Routinely providing access to FIT testing in primary care in +80% of urgent suspected colorectal cancer referrals to enable higher risk referrals to be effectively identified and managed accordingly.
- Robust Getting It Right First Time (GIRFT) programme of work in place across a range of specialties to ensure effective use of resources.
- Consistently performing above stretch target for Specialist Advice.
- Development of common conditions documents to support management in primary care.
- Elective Surgical Hubs live in both Worcestershire and Herefordshire.
- Ongoing development of CDC2 in Hereford City with expected go live summer 2025.

3. What are the priorities going forward?

- Continuing recovery of elective, cancer and diagnostic services in line with 2025/26 Operational Planning priorities. This includes achievement of cancer standards, restoring waiting times in diagnostics and reduction in elective waiting times with 65% (or minimum improvement of 5% on 2024/25 performance) waiting less than 18-weeks by March 2026.
- Delivering the priorities identified within the Elective Care Reform guidance including transforming and transitioning services to maximise productivity and improve quality across the elective, cancer and diagnostics pathways, ensuring services are safe, sustainable and accessible to patients, embracing the digital agenda to enable services to modernise through better use of technological developments such as AI.
- Development of guiding principles in Planned Care services on what represents good quality services, working with Healthwatch in Herefordshire and Worcestershire to obtain patient and public feedback.
- Ensuring patient choice is available and offered to patients, whilst also ensuring equity of access to NHS services.
- Ensuring effective integration across services and providers of planned care by adopting a pathway approach to service change and improvements to support earlier intervention and therefore diagnosis.

High quality, patients centred services: ELECTIVE, CANCER AND DIAGNOSTIC CARE

Theme 3

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Restore waiting times for elective, diagnostics and cancer	• Work collaboratively with all providers locally, regionally and nationally to increase capacity to support elimination of long waiting times across planned care services. • Optimisation of system elective surgical hubs - Alexandra Redditch (WAHT) and Hereford (WVT) • Launch of Community diagnostic centre in Hereford – increase volume of diagnostic capacity Summer 2025 • Delivery of 65% (or minimum 5% improvement on current performance) patients waiting no longer than 18 weeks for elective treatment • Delivery of 95% diagnostic tests within 6-weeks.	By 2025/26
Outpatient transformation • Referral Optimisation • Maximise Productivity • Reduction of follow ups • Reduce elective waits	• Delivery of Out-Patient Transformation programme across the ICS to include embedding patient initiated follow up (PIFU), helping put patients in control of their follow up appointments and achieving national requirement (5% discharged/moved to PIFU pathway) • Deliver an appropriate reduction in outpatient follow up activity including use of remote consultations. • Explore opportunity to embed one stop clinics, aligned to diagnostic development of Community Diagnostic Centres (Phase 2/CDC 3). • Ensure optimum use of Specialist Advice to support effective referral management. • Delivery of robust GIRFT and Further Faster programme to maximise productivity and support ongoing reductions in waiting times. • Embed digital support/solutions to support delivery of patient pathways and improved patient experience.	By 2025/26
Improving screening uptake	• Reducing variation in screening uptake in the registered and non-registered populations, and addressing poor uptake in harder to reach cohorts or cohorts with poorer outcomes; • Optimisation of the PCN DES Supporting Earlier Diagnosis – targeting non-responders and hard to reach groups;	By 2025/26
Supporting earlier diagnosis	• Implementation of Lung Cancer Screening Programme (Q4 2025/26) and continuing focus on utilisation of FIT testing in primary care; • Targeting populations at higher risk of developing cancer such as people with learning disabilities and autism; • Implementation of Non-Specific Symptoms pathway; • Offering improved access to liver surveillance in patients with fatty liver disease/ cirrhosis to support earlier identification of liver cancer.	By 2025/26
Implementing Best Practice Timed Cancer Pathways (BPTP)	• Ensuring 5 BPTP are in place across the ICS with a focus on achieving above the 80% 28-FDS standard and delivery of over 75% patients starting their cancer treatment within 62-days; • Undertaking audits in line with national requirements to confirm compliance with BPTP and areas for improvement; • Reducing treatment variation across cancer pathways in line with best practice recommendations outlined in clinical and GIRFT audits; • Transformation and innovation in pathology services	By 2025/26
Empowering patients through personalisation of care	• Optimisation and expansion of Personalised Care Follow-up pathways; • Use of digital technology to support a better patient experience, including use of a Patient Portal to support self-management, electronic End of Treatment Summaries to improve transition of care between secondary and primary care, and improved communication. • Improving support services for patients living with cancer such as delivery of HOPE courses, better access to psychosocial care;	By 2025/26

High quality, patients centred services: ELECTIVE, CANCER AND DIAGNOSTIC CARE

Theme 3

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Understand and address health inequalities in planned care	• Ongoing understanding of inequalities in access, experience and outcomes of care for Core 20, BME populations and Inclusion Health Groups across Planned Care. • Working closely with stakeholders such as Healthwatch to reduce the impact of health inequalities on outcomes in planned care.	By 2025/26
Longer term vision for planned care	• Development of a system wide strategy for planned care based on the 10 Year Plan (and Cancer Plan) due to be published early in 2025.	By 2025/26

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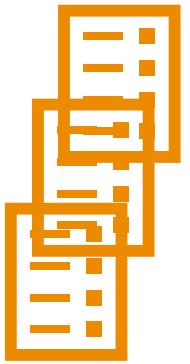
4. Where you can find more detail?

Regional and national strategies for Planned Care can be found at:

- Getting It Right First Time
- Home - West Midlands Cancer Alliance (wmcanceralliance.nhs.uk)
- NHS England » Publication of the plan to reform elective care for patients
- NHS England » 2025/26 priorities and operational planning guidance

Link to the National Cancer Patient Experience Survey:

- Tell us about your experience of cancer care - National Cancer Patient Experience Survey



High quality, patients centred services: FRAILTY

Theme 4

1. Why is this important?

Herefordshire and Worcestershire has an older population than the rest of England, with the number of people over 65 years increasing and younger populations decreasing.

By 2030 (compared to 2021), it is predicted that the number of people aged 80-84 years will increase by 48% in Herefordshire and by 51% in Worcestershire. The increase in the over 85 age group is forecast to be 36% in Herefordshire and 35% in Worcestershire.

The projected increase in ageing population means that a greater number of people living in Herefordshire and Worcestershire will be at risk of developing or living with Frailty.

Frailty is a long-term condition in which multiple body systems gradually lose their reserves and functions, resulting in an increased vulnerability and risk of unpredictable deterioration from minor events. The development of Frailty is strongly linked with increasing age but can affect anyone at any age. This growing number of people at risk of living with poor health will lead to more people needing greater support and care from social and health services.

The prevalence of Frailty within Herefordshire and Worcestershire is significant. In 2024, it was known that over 7,000 people registered with a GP are living with severe frailty, and 8% of Herefordshire's and Worcestershire's population that are aged 65 years or above are living with moderate Frailty.

2. What we have delivered in our second year, 2024/25?

- Delivery of an Integrated Care System (ICS) Frailty Strategy,
- Worcestershire Acute Hospital Trust (WAHT) have initiated their own internal Frailty Transformation Programme that aligns to ICS' Frailty strategy, and endorse the ethos of 'Making Frailty everyone's business',
- Frailty Same Day Emergency Care areas have been established in two of WAHT hospital sites, that are supported 7by Geriatric Emergency Medicine services (GEMs),
- Single Point of Access (SPoA) service has expanded to integrate both community and acute workforce which support Ambulance service to appropriately direct frail patients to the best place to meet their care needs and wishes,
- Enhancements proactive assessment and care planning for people with Frailty through more Comprehensive Geriatric Assessments being undertaken within General Practices, and progress being made with standardising across all Herefordshire and Worcestershire NHS healthcare providers.
- Progress with piloting Frailty focussed Integrated Neighbourhood Teams, which aims to improve the care coordination and delivery of care for patients living with Frailty,
- Wholistic review of the Falls care pathways and assessments, with improving access and outcomes of preventative and reablement services, alongside public resource to raise self-awareness about risk of falls and self-management.

3. What are the priorities going forward?

It remains that our integrated care vision that **"People living in Herefordshire and Worcestershire who are at risk of, or living with frailty will, live well in a supportive community with accessible, personalised and coordinated high-quality care delivered in the most appropriate setting whenever they need it."**

This vision will be realised through a wholistic and place-based approach whereby to health and social care organisations across Herefordshire and Worcestershire will work together to collaborate, develop and enhance integrated care services for people at risk of or living with Frailty, to improve their health outcomes and quality of life.

The ICS Frailty strategy states the nine key desired outcomes of which all transformation plans undertaken must strive to deliver:

1. Increased community interventions measures to prevent the onset and progression of frailty
2. Increased early identification of people living with or at risk of frailty
3. High quality proactive comprehensive assessment of people living with or at risk of frailty.
4. High quality accessible and coordinated personalised care for people living with frailty, their Family's and carers in every care setting
5. Frailty attuned acute care which facilitates timely discharge and smooth transitions between care settings
6. High quality reablement and rehabilitation after a period of illness and at times of transition from hospital
7. High quality end-of-life care for people with frailty, their Family's and carers.
8. Compassionate, timely and effective advanced care planning in all health and care settings.
9. A workforce with the appropriate skills to provide specialist care to patients in all health and care settings.

High quality, patients centred services: FRAILTY

Theme 4

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Frailty onset prevention	• Map and raise awareness of the community resource available to residents to support them with reducing their risk and/or delay on the onset of Frailty.	By 2025/26
Early identification and proactive care for those living with Frailty	• Develop a standardised approach to proactively identify those living with Frailty in Primary, Community and Secondary Care services, supported by the development of risk stratify tools and consistent implementation of nationally recommended clinical frailty scoring *i.e.,* Rockwood Frailty Score. • Continue to develop and implement the proactive care and management in primary care of those living with Frailty through the Clinical Excellence and Investment Framework (CEIF) and requiring utilisation of a standarised multidimensional holistic assessments (*i.e.,* Comprehensive Geriatric Assessment) to inform care and treatment plans. • Self-assessment against national Proactive Care Framework, to seek and identify further opportunities for improving of proactive Frailty care across the ICS, and establish improvement plans for those opportunities deemed high priority and attainable.	By 2025/26 & beyond.
Reactive Care	• Establish the current urgent and emergency care processes and provision variation and fragmentation for those living with Frailty at place, and neighborhood levels by undertaking reactive pathway mapping. • Following mapping the 'as is' reactive pathway, co-produce the 'future' reactive pathway that addresses the inequities and inequalities with accompanying transformation plans. • Continue the development and expansion of Frailty Same Day Emergency Care Services as per the national FRAIL Strategy, • Reinforcement and develop Frailty specific Advice and Guidance services whereby primary care clinicians can access to specialist clinical advice, enabling a patient's care to be managed in the most appropriate setting, strengthening shared decision making.	By 2025/26.
Reablement, rehabilitation and recovery	• Undertake a system wide self-assessment against the National Intermediate Care Framework to establish current alignment to nationally recommended good practice and guidance for step-down intermediate care for adults who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover. • Utilise the learning from the self-assessment to scope, prioritise and devise improvement plans for the gaps and opportunities identified.	By 2025/26

4. Where you can find more detail?

NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty

NHS England » FRAIL strategy

NHS England » Advice and Guidance

Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge

High quality, patients centred services: FRAILTY

Theme 4

3. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Data & digital enablement	• Scope the development and maintenance of frailty integrated registers across primary, community and secondary services, and were possible social care and public sector services. • Move toward a Population Health Management approach and function to help drive a data led focus on person-centered care for those at risk of or living with Frailty. • Establish the system need and digital capabilities for community remote monitoring for those who are housebound and living with Frailty.	By 2025/26 & beyond.
Workforce	• Understand system partners Frailty workforce infrastructure and capabilities, alongside roles and responsibilities of providing care for those living with Frailty to establish required competencies and identify any upskilling needs. • Collaborate and co-produce standardised training and education support and resources for clinician and care providers across Herefordshire and Worcestershire. • Establish model for an 'Integrated Core Frailty' team that across all health and social care sectors and aligns to national Neighbourhood health Guidelines.	By 2025/26 & beyond.
Care Homes Transformationa nd Quality Improvement Programme	• Establish a system Programme which aims to improve health outcome and care practices for those who reside in Care Homes through a strategic and integrated Quality Improvement and Transformation programme approach and is sensitive place-based needs within Herefordshire and Worcestershire. • Review and recommission Enhanced Health Care Homes framework delivery, addressing the known variation in service provision, accessibility and outcomes. • Evaluate and continue to develop remote monitoring within Care Homes across Herefordshire and Worcestershire. • Establish the need and capabilities for Care Homes to have direct access to SPoA to appropriately direct frail patients who reside in a Care Home to the best place to meet their urgent care needs and wishes.	By 2025/26 & beyond.
Communication and Engagement	• Devise communications and engagement plans with system partners to advocate and champion Frailty across public and professional communities. • Set as standard the requirement across all Frailty and Care Home improvement work for planned and purposeful engagement with our communities, experts by experience and staff groups to encourage collaborative working on the redesign of services and pathways were appropriate.	By 2025/26 & beyond.

4. Where you can find more detail?

NHS England » Population Health Management

NHS England » Neighbourhood health guidelines 2025/26

NHS England » Providing proactive care for people living in care homes – Enhanced health in care homes framework

NHSE (online) Ageing well and supporting people living with frailty. Available from: NHS England » Ageing well and supporting people living with frailty

British Geriatric Society. (2023) *Joining the dots: A blueprint for preventing and managing frailty in older people.* Available from: Joining the dots: A blueprint for preventing and managing frailty in older people | British Geriatrics Society (bgs.org.uk)

High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

1. Why is this important?

Ageing population

Herefordshire and Worcestershire's population is due to increase by approximately 5.4%. H&W have older population structures than the rest of England, with over 65+ increasing and younger populations decreasing.

Increased multimorbidity

The ageing population increase will reflect a significant increase of people living with dementia, frailty and other long-term conditions.

Increased number of deaths

Nationally, deaths are predicted to increase by 22% 2030-2040

Increased number of people dying at home

- The majority of bereaved Family's included in the national VOICES survey believed the deceased had wanted to die at home (81%), with a selected sample showing 22% had home as place of death documented on death certificates.
- Community services will need to be available to support people to die well at home, if it is their wish and where it is possible.

2. What have we delivered in our second year, 2024/25?

- We continue to work towards improving the sharing of information with the use of the Shared Care Record. This has an End-of-Life tab which shares data coded in EMIS in line with the End- of-Life Professional Record Standards Body data set for appropriate health provides across the system to view.
- Our digital ReSPECT plan is in development with phase 1 planning to go live during early 2025
- A standard advance statement document called My Wishes has been created for use across the system. A paper version has been launched and this will go live on the patient portal app across the ICS early 2025
- Successful Fast Track Home pilot in Worcestershire which has been rolled out and is now business as usual
- Standardised EMIS protocol agreed for the safe prescribing of anticipatory medications across the ICS
- Development of a PEoLC dashboard collating data across the system
- Development of Bereavement Toolkit on ICS Academy Exchange
- Development of Transitions Toolkit for CYP

3. What are the priorities going forward?

The Palliative and End-of-Life Programme Board is implementing the Herefordshire and Worcestershire Personalised End-of-Life Care Strategy 2020-2025, working in partnership with representatives across the ICS.

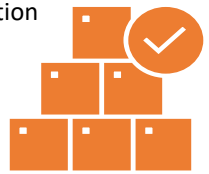
The vision is that "adults and children living in Herefordshire and Worcestershire, regardless of their diagnosis, will be supported to live well until the end of their life". It is imperative that care at the end-of-life is compassionate, tailored to the dying person and people important to them, and includes effective communication and assessments.

The six strategic outcomes are:

1. Increased and early identification of people who would benefit from end-of-life support and personalised care planning
2. High quality care for people at the end of life, their Family's and carers in every setting
3. Accessible, coordinated and digitally enabled palliative and end-of-life services for all patient groups
4. A workforce with the appropriate skills to provide people at the end of their life with high quality care and support
5. High quality bereavement care, support and information available to all
6. An embedded ReSPECT process which supports compassionate, effective and timely Advance Care Planning in all care settings

The key areas of delivery are:

- 24/7 Single point of access for palliative and end-of-life care advice and support for patients
- Making the best use of digital opportunities to improve communication and sharing of information, e.g. digitalisation of ReSPECT and Advance Statement; digitalisation of the palliative care register; and developing the Shared Care Record (ShCR)
- Review of Bereavement services
- Review of Anticipatory medications
- Development of Palliative and end-of-life care Virtual Ward



High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

4. What will we deliver and when?

Priorities	Deliverables	Year of Delivery
24/7 Single point of access to timely support and advice	Scope service need and options	By 2025/26
Coordinated education and training across the ICS focusing on communication and clinical skills to improve timely recognition of dying, promoting personalised care and advance care planning discussions	Early identification, ambitions mapping, ICS academy, End of Life Care Hub (ECHO) opportunities for sharing learning	By 2025/26
	Continued ambitions self-assessment, developments required based on those assessments. Continued development and work with ECHO hubs and the ICS academy	By 2027/28
Shared access to electronic patient information	Complete capability to share information: - Shared Care Record interoperability with EMIS. - Worcestershire out of hours access to the Shared Care Record	By 2025/26
	Develop access for Care Homes to Shared Care Record	By 2027/28
Embed digital ReSPECT process	Launch and promote digital ReSPECT Launch and promote digital Advance Statement	By 2025/26
	Review data collection, patient and carer feedback to inform promotion and take-up of ReSPECT	By 2027/28
Increased early identification of people who will benefit from end of life support and personalised care planning	Develop education for Primary Care and other practitioners.	By 2025/26
	Review of the new primary care template Develop ICS wide palliative care register-possibly with using clinithink	By 2027/28

High quality, patients centred services: PALLIATIVE AND END OF LIFE

Theme 5

4. What will we deliver and when continued ?

Priorities	Deliverables	Year of Delivery
High quality care for people at the end of life, their Family's and carers in every setting	Data dashboard to include core 20+5 data. Identify inequalities, geographical inequalities, engaging with hard-to-reach communities. Continue anticipatory medication work. CHC FT review and re procurement.	By 2025/26
	Review services and address inequalities ICS PEoLC virtual ward Review impact of changes from the anticipatory medications work CHC FT impact of new service	By 2027/28
Data dashboard and strategic needs analysis (SNA)	Work with data analytics team to create new data dashboard and collect new data to inform population needs. Meet with stakeholders to explore results of the SNA as part of new strategy	By 2025/26
	Continue to monitor and update data dashboard Develop any proposals to reflect findings of the SNA	By 2027/28
High quality bereavement care, support and information available to all	Bereavement group, mapping of services and update leaflets	Completed 2024/25
	Continue to monitor and review bereavement services	By 2027/28

5. Where you can find more detail?

Palliative and End of Life Care Programme:

- Herefordshire and Worcestershire Personalised End of Life Care Strategy 2020-2025 file (herefordshireandworcestershireccg.nhs.uk)
- Ambitions for Palliative and End of Life Care: A national framework for local actions 2021-2026 ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)
- NHSE NHS England » Resources and support
- Please email jadebrooks@nhs.net for more information, or to become a patient representative or person with lived experience on any of the palliative and end of life care groups.

High quality, patients centred services: LEARNING DISABILITY AND AUTISM CARE

Theme 6

1. Why is this important?

National LeDeR report findings from 2021:

- 49% of deaths avoidable/ amenable to good health and social care (and at least 2 times higher than general population)
- Life expectancy 20 years less than general population

In addition, for autism, life expectancy is at least 10 years less than average for population, and over 80% of autistic adults experience mental health difficulties in their life.

One of the main factors is that people with a Learning Disability and autistic people (LDA) are underserved groups and do not have consistent access to health services in a timely way due to lack of reasonable adjustments and diagnostic overshadowing. This means health care is sometimes accessed or provided at a late stage of presentation, when the health condition is at an advanced stage or the person is in a crisis (leading to Mental Health Act assessment and hospital/ restricted environment admissions, Emergency Department attendance) and core universal services such as routine vaccinations and or cancer screening are delayed or missed.

2. What have we delivered in 2024/25?

- Continued to maintain Annua Health checks take up above national target.
- On track to complete sensory friendly assessments of 66% of all GP Practices.
- Continued local rollout of RADF, asking local organisations to audit their compliance as per national checklist.
- Fully recruited to key worker service and halved number of CYP in T4 beds
- LeDeR performance consistently above regional and national averages.
- Review of neurodivergence pathway for CYP ongoing.
- Invested £225k to reduce waiting times for young people aged 16-18 in Worcestershire.
- Primary Care CPD Day Held on September 2024 to improve awareness of LD Annual Health Checks.
- New templates in place for Annual Health Checks and Health Action Plans.
- New proposed pathway for LD Bowel Screening presented to the ICB Elective, Cancer and Diagnostic board for approval.
- 'Keeping well and looking after your lungs' video on respiratory health co-produced with Speak Easy Now and disseminated

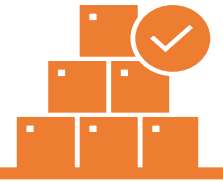
3. What are the priorities going forward?

The Learning Disability and Autism Programme Board have oversight of the plans to improve outcomes for people with disabilities and people with Autism.

Our vision is that all people with a learning disability and/or autism can live healthy and positive lives, and we will do this by promoting reasonable adjustments and tackling health inequalities across the system.

In line with the NHS Long term plan commitments, we will:

- Taking action to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.
- The whole NHS family will improve its understanding of the needs of people with a learning disability and autism, working together to improve their health and wellbeing. Including training for the workforce, reasonable adjustments and a digital flag in patient records
- Reducing the waiting times for children and young people with suspected autism
- Increased investment in personalised care and community support.
- Continue to focus on improving the quality of inpatient care and timely discharge where appropriate.



High quality, patients centred services: LEARNING DISABILITY AND AUTISM CARE

Theme 6

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Rollout sensory-friendly and accessible environments for autistic people into other NHS settings	At least 5 NHS settings will be assessed and have an improvement plan	By 2025/26
Good quality Learning Disability Annual Health checks routinely given to all people with a Learning Disability	Sustain up take of AHCs at 85%, Health Action Plans over 90%, including 14-24 year olds, supported by quality improvement programme focusing on Health Action Plans	By 2025/26
Vaccination and screening rate for people with a learning disability and autism comparable to general population	Awareness raising and targeted work, built around AHCs	By 2025/26
Reduction in avoidable deaths - Learning from the Deaths of People with a Learning Disability Review programme (LeDeR)	Programmes of work following on from LeDeR Learning into Action workstream. Current focus is healthy lifestyles; suicide reduction for autistic people	By 2025/26
Reduction in waiting times for autism diagnosis	Comprehensive review of neurodivergence pathway for CYP to ensure consistency across ICS and more timely diagnosis	By 2025/26
Support to autistic people post-diagnosis	Continued investment in adult support service and explore option for a service for CYP and families	By 2025/26
Raise awareness and inclusion of autistic people in mainstream services	Continued roll-out of Oliver McGowan Mandatory Training programme	By 2025/26
Keep number of young people in Tier 4 beds and adult inpatient numbers within national targets	Sustain low number of young people in T4 beds and reduce numbers of adults in locked rehab beds.	By 2025/26
Increase community Occupational Therapist, Physical Therapist, Speech and Language Therapist and epilepsy support capacity	Deliver service enhancements following agreed investment in community health service	By 2025/26
Tackle heath inequalities Ensure that people with complex needs are supported to live in the community and admission to in-patient units is avoided	• Over 85% of eligible people with a learning disability have an annual health check and over 90% of those have a health action plan • Vaccination and screening uptake is at least on a par with the rest of the population • In-patient rates are in line with or better than the national targets • Waiting lists for community support is less than 18 weeks • Oliver McGowan Mandatory Training has been rolled out across the system	By 2027/28

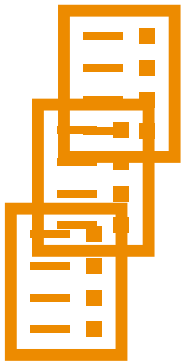
5. Where you can find more detail?

https://www.hwics.org.uk/our-services/learning-disabilities-and-autism

Co-production underpins our approach and we work closely with the Learning Disability Partnership Boards and the Autism Partnership Boards in Herefordshire and in Worcestershire. Experts with lived experience are actively involved, with support, in all strategic developments, and co-chair the Partnership Boards. Family carer voices are also strongly represented.

People with a learning disability can contact SpeakEasy NOW if they wish to become involved https://speakeasynow.org.uk/contact-us/

Our partnership arrangements also include the Acute and Community Provider Trusts, both Councils and the voluntary and independent sector.



High quality, patients centred services: MENTAL HEALTH AND WELLBEING

Theme 7

1. Why is this important?

We know that people are waiting longer than they should to access diagnosis and treatment.

After a decade of improving population wellbeing the COVID-19 pandemic is widely considered to have negatively impacted population mental health and wellbeing. Measures of population wellbeing worsened, particularly during the two main waves of the pandemic and have not fully recovered to pre-pandemic levels.

The proportion of adults aged 18 and over reporting a clinically significant level of psychological distress increased from 20.8% in 2019 to 29.5% in April 2020, then falling back to 21.3% by September 2020. There was a subsequent increase to 27.1% in January 2021, followed by a further decrease to 24.5% in late March 2021.

While there has been considerable economic recovery from the initial shocks of the COVID-19 pandemic, new challenges have emerged, with high levels of inflation and a rise in the cost of living.
Concerns have been raised about the impact this may have on population mental health, and nationally providers continue to report greater acuity of need across mental health services.

Furthermore, these challenges have highlighted and widened some of the existing inequalities in mental health and wellbeing in the population.

2. What have we delivered in 2024/25?

- Access to mental health services for children and young people has expanded significantly and will continue to expand into 2025/26, including broader treatment options through new commissioned services (e.g. Lumi Nova).
- A 3-year Mental Health Acute Inpatient Strategy has been developed to support improved quality of services, closer to home.
- Rapid expansion of NHS Talking Therapies staffing through trainee recruitment, to bring H&W Talking Therapies services in line with national workforce expectations and expand access to services.
- Re-procurement of Children and Young People's Emotional Wellbeing and Mental Health Services, including additional investment and expansion, across both counties.

3. What are the priorities going forward?

A key strategic development as part of the creation of the Integrated Care System has been the establishment of a **Mental Health Collaborative,** which brings together commissioning and provider functions, primary and secondary provision and broader connections to local stakeholders.

The overarching reason for creating the mental health collaborative has been to put the responsibility for organising services and pathways as close as possible to the front-line services that provide patient care. This marks a significant change from the traditional commissioning model of developing detailed services specifications that providers respond to; much more towards a model of agreeing outcomes that providers design service delivery models to address.

In 2024-25 a review was undertaken of the existing Mental Health Collaborative arrangements, with a series of recommendations to ensure clarity of governance processes and improve outcomes for patients. One of the key recommendations is to develop a mental health strategy.

Priority areas for 2025-26 include:

1. Reduction of inpatient average Length of Stay to prevent unnecessary delays, and Out of Area Placements
2. Redesigning Inpatient and Rehabilitation Pathways across the ICS
3. Increasing access to Individual Placement Support (IPS) services
4. Maintain and continue to increase access to CYP mental health services
5. Continue to expand NHS Talking Therapies workforce capacity while maintaining quality standards
6. Improve waits in UEC pathways for patients with mental health illness in line with national standards

The role of the Herefordshire and Worcestershire Mental Health Collaborative is described in more detail in Appendix 2, theme 15.

High quality, patients centred services: MENTAL HEALTH AND WELLBEING

Theme 7

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Children and young people	Continue to increase access to CYP mental health services (please see slide 8 on CYP mental health transformation)	By 2025/26
NHS Talking therapies	Delivery of all completed treatments and expansion targets while maintaining quality and waiting standards	By 2026/27
Early intervention in Psychosis	Continue to deliver required standards	By 2025/26
Dementia	Improve post-diagnostic support and timeliness of diagnosis	By 2025/26
Perinatal Mental Health	Maintain access standard for perinatal mental health services	By 2025/26
Out of areas placements (OAP) and inpatient LoS	Reduction of average Length of Stay and eliminaton of inappropriate OAPs in line with national standards	By 2025/26
Physical Health for people with a serious mental illness (SMI)	Maintain delivery of SMI health checks	By 2025/26
Adult community mental health	Take forward local review recommendations following Independent Mental Health Homicide Review	By 2025/26
Urgent mental health care	Delivery of 10 High Impact Actions for urgent mental health services	By 2025/26
Mental Health Strategy	• Mental Health JSNA to be completed • New Mental Health Strategy to be developed by the Mental Health Collaborative • Delivery of new national priorities • Reduction in health inequalities for people experiencing mental health illness	By 2025/26

5. Where you can find more detail?

The Worcestershire Health and Wellbeing Strategy 2022-2032 contains a strong mental health focus and is available here:
Health and Wellbeing Strategy 2022 to 2032 | Worcestershire County Council

The Herefordshire Health and Wellbeing Strategy 2023-2033 also contains a strong mental health focus and is available here:
Herefordshire Joint Local Health and Wellbeing Strategy 2023 - 2033

The Herefordshire and Worcestershire Mental Health Strategy is due to be reviewed during 2025, in line with new national NHS strategy.

Public engagement opportunities are advertised through the ICB and local authority websites, as well as on the Herefordshire and Worcestershire Health and Care NHS Trust website.

High quality, patients centred services: LONG TERM CONDITIONS

Theme 8

1. Why is this important?

The prevalence of LTCs in H&W is projected to increase substantially over the next 10 years. Approximately 20, 000 more people will be living with Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Stroke or Diabetes in 2033 compared to 2023. This increased prevalence is estimated to cost the system £11 million more per year in urgent care utilisation alone.

These projections are in part driven by the increase in are over 65-years old population, which we anticipate to increase by 36, 000 by 2030. However, we are also seeing an increasing prevalence of type 2 diabetes in the 15-19 and 40-49 age ranges in our two counties, demonstrating a need for increased education and prevention to improve quality of life for younger people with LTCs and to prevent LTCs developing so early in life.

We are increasingly aware of growing excess mortality resulting from cardiovascular disease and this trend is greatest in our most deprived communities. People in our most deprived communities are developing multiple LTCs at a younger age than those in our least deprived communities. It is essential that we tackle this inequality difference to ensure all people can live as well as possible.

2. What have we delivered in our second year, 2024/25?

- Long Term Conditions Strategy 2024 – 2029 approved and published.
- Cardiovascular disease forum embedded (ICB & PCN Leads), focussing on sharing best practice and achievement of
- CVD Clinical Excellence and Improvement Framework (CEIF) developed to reduce unwarranted variation across areas which are resulting in high cost and poor health outcomes.
- Continued roll out of a video library for patients, enabling education and supported self-management across long-term conditions.
- Continuous Glucose Monitoring is being delivered as business as usual, with above average uptake regionally.
- Hybrid Closed Loop is being rolled out, with progress exceeding regional average.
- All Primary Care Networks delivering Spirometry testing, with continued increase in activity.
- Fractional exhaled Nitric Oxide (FeNO) testing is increasing by 23% average month on month.
- Continuation of the National Diabetes Prevention Programme demonstrating high retention rate.
- Following roll out of NHS Type 2 Diabetes Path to Remission Programme, there are positive results relating to course completion and weight loss.
- Reduction in both major and minor amputation rates resulting from Diabetes Foot Care service improvements.

3. What are the priorities going forward?

The work on long-term conditions is overseen and delivered through multiple programme boards, aligning to the strategy, which has the following priorities:

Prevention

- People will be actively signposted to appropriate education and organisations that can increase their knowledge, skills and confidence to live as well as possible, reducing their risk of developing long-term conditions.
- People will have improved access to evidence-based high impact interventions that prevent deterioration of long-term conditions.

Early and Accurate Diagnosis

- People who are at increased risk of developing a long-term condition will be proactively identified and supported.
- More people will have their LTC(s) identified sooner and closer to home.

Personalised Management

- People will be provided with education, support and resources to enable them to take a more active role in decisions about their care.
- People with multiple LTCs will receive proactive, holistic assessments, including medication and mental health reviews

Right care in the right setting

- Increase collaboration by services to enable care to be delivered as close to home as the complexity allows.
- Increase adoption of digital technologies that enable more effective self-management outside of a hospital setting.

High quality, patients centred services: LONG TERM CONDITIONS

Theme 8

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Strategy	Long Term Conditions Strategy - Continued delivery in three priority areas of Diabetes, Respiratory and Cardiovascular Disease (including Heart Failure), with monitoring of delivery plans through maturity matrices.	Ongoing to 2029
Cardiovascular Disease (CVD)	Continued and enhanced delivery of high impact interventions for secondary prevention: • Community pharmacy hypertension case finding • Cholesterol search and risk stratification • NHS health checks • Case finding and direct-acting oral anticoagulation to prevent atrial fibrillation related strokes • Cardiac rehabilitation for patients post-ACS and diagnosis of heart failure • Optimisation of hypertension treatment • Optimisation of heart failure treatment through annual reviews • Optimising management post ACS, including lipid management.	By 2025/26, but ongoing throughout delivery of JFP
Diabetes National: Local:	• Develop an all ages Diabetes Service Specification that spans multiple providers and services. This will clarify the pathway, drive collaboration and support system wide accountability for outcomes. • Further improve the delivery of 9 diabetes care processes, including enhancements, e.g. the roll out of the Type 2 Diabetes in the Young programme. • Improve identification of individuals at high risk of Type II Diabetes and signpost to NHS Diabetes Prevention Programme or structured education as appropriate. • Improve NDPP uptake and engagement with people who have a Learning Disability or Autism, reducing inequalities. • Delivery of NICE Technology Appraisal for Hybrid Closed Loop by 2029 and improve access to Continuous Glucose Monitoring. • To begin / continue delivery of the following high impact interventions for secondary prevention. • Improve equity of access, and the quality of Diabetes structured education across the two counties.	Ongoing throughout delivery of JFP
	• Improve the Digital offer for enabling supported self-management in Type 1, including in Children and Young People. • Improve pre-diabetes screening and symptom awareness, with particular focus on addressing inequalities • Improve peri operative care of people with diabetes to reduce length of stay and outcomes. • Further development of a Diabetes Support Team in Primary Care Networks to deliver care closer to home (DiAST model of care) • Improve clinical leadership for MDFT	By 2027/28
Respiratory	• Reduce inequalities in access, experience and outcomes in pulmonary rehabilitation. • Establish Getting it Right First Time programme of work. • Ensure that Spirometry and FeNO provision is reflective of NICE guidance, is accessible, and of good quality. • Achieve accreditation for the Pulmonary Rehabilitation service. • Deliver Pulmonary Rehabilitation 5-year plan • Establish and embed a coordinated asthma transition pathway.	By 2025/26 By 2027/28
Neurology	• Develop an ICS plan to support service improvement across Neurology services.	By 2025/26

5. Where you can find more detail?

- Multiple_LTCs_Survey_-_Engagement_Report_-_Final.pdf (hwics.org.uk)
- https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/
- National Asthma and COPD Audit Programme (nacap.org.uk)
- pulmonary-rehabilitation-service-guidance.pdf (england.nhs.uk)
- spirometry-commissioning-guidance.pdf (england.nhs.uk)
- CVDPREVENT

High quality, patients centred services: STROKE CARE

Theme 9

1. Why is this important?

1. Lack of 7-day service provision in Hyper Acute/Acute stroke services, and unlikely to deliver in current format;
2. Current medical workforce challenges mean moving the service from 5 – 7 days (in and out of hours) is unlikely to be achievable;
3. Services at both Wye Valley NHS Trust (WVT) and Worcestershire Acute Hospitals NHS Trust (WAT) are classed as fragile due to longstanding medical establishment staffing gaps;
4. Increasing demand for stroke services over the next ten years increase this challenge further with expected demand to increase by 20% over the next 15 years across the ICS.
5. Achievement of **key clinical and performance standards** will continue to be a challenge and unlikely to be achievable unless changes are made to the existing service models;
6. National Clinical Guideline 2023 recommendations presents challenges in compliance;
7. Acute Stroke services have a current risk score of 16 on H&W ICB Risk Register.
8. System and regional level support for Service change to deliver a sustainable stroke service within the ICS for the future.

2. What have we delivered in our second year, 2024/25?

- Sustainable delivery of 7-day acute stroke care model
  - Proposed single site acute stroke model at Worcestershire Royal Hospital endorsed by NHS Clinical Senate;
  - Clinical Senate recommendations agreed by Stroke Programme Board and local action plan developed;
  - Pre-Consultation Business Case and Outline Business Case have been drafted to include demand modelling, workforce requirements and impact assessments.
- Service Improvement programme
  - Roll out of 'CT Perfusion' (advanced imaging) at both acute hospital sites to enable physicians to make faster, more accurate triage or transfer decisions;
  - Wye Valley NHS Trust are part of a national programme to improve Thrombolysis rates, with shared learning into Worcestershire;
  - SQuIRE quality improvement programme concluded with 4 improvement projects implemented across the ICS.

3. What are the priorities going forward?

ICS Stroke Programme Board (SPB) involves stakeholders across the stroke pathway (Herefordshire, Worcestershire and Powys Teaching Health Board) Healthwatch, West Midlands Ambulance Service, Stroke Association and Patient engagement. The Programme Board focusses on the entire Stroke Pathway, from Hyper-acute to Rehabilitation and Life After Stroke.

Priority 1: The Stroke Programme Board is committed to delivering a new, **sustainable 7-day acute stroke services model**. This will modernise how services assess and treat patients; ensuring optimal clinical model of care and the best use of resources across the entire pathway, including staffing and use of technology. To achieve this vision, the SPB has commenced a pre-consultation process, and a preferred clinical model has been agreed. SPB are now looking at the post-acute pathway, including life after stroke and are working towards an options appraisal process to agree a pathway that will align with the proposed endorsed acute pathway. It is recognised that this pathway model will require capital investment and is the longer-term strategy required to deliver sustainable stroke services for the future.

Priority 2: The **Stroke Services Improvement programme** focusses on:

- Workforce development;
- Digital enablers (for example, pre-hospital video triage);
- Performance Standards;
- Development of patient pathways, in line with national standards;
- Focus on health inequalities with a targeted CVD prevention programme to reduce the incidence of Stroke.

The Stroke Programme is aligned to and supported by the Integrated Service Delivery Network (ISDN) and The National Stroke Quality Improvement in Rehabilitation (SQuIRe) programme.

High quality, patients centred services: STROKE CARE

Theme 9

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Service Improvement Programme	• Workforce developments resulting in robust medical and nursing workforce with joint working/posts across Hereford County Hospital and Worcester Royal Hospital to ensure resilience. • Advances in digital technology embedded, with virtual consultations part of everyday practice where appropriate. • Development of a service specification for an integrated community stroke service. • Development of Clinical Guidelines for Stroke. • Improvement in performance standards.	By 2025/26
Sustainable delivery of 7-day acute stroke care model	• Agreement of post-acute pathway including Life After Stroke.	By 2025/26
	• Completion and presentation of Pre-Consultation Business Case and Outline Business Case. • Commencement of the Pre-Consultation process.	By 2025/26
	• Stroke services transformed with agreed pathways embedded and services delivered in line with national guidelines and performance standards.	By 2027/28

5. Where you can find more detail?

In January 2022 we considered all the previous patient and public feedback we had received about stroke services. This was summarised in a paper, which is available here.

A further Stroke Services issues paper was written in September 2022 and further engagement undertaken :-

Stroke Services :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)

Integrated Community Service Specification - Feb 2022

National Clinical Guideline for Stroke 2023

Stroke - Getting It Right First Time - GIRFT

Integrated Life After Stroke Support

High quality, patients centred services: URGENT AND EMERGENCY CARE SERVICES

Theme 10

1. Why is this important?

The Urgent and Emergency Care (UEC) system in Herefordshire & Worcestershire is in a challenged position. However, ICB and system partners remain committed to making sustainable improvements across the entire health system to support timely care and efficient patient flow.

The National delivery plan for recovering UEC services sets out core indicators to Increase urgent and emergency care capacity by March 2024 including:

1. No less than 78% of patients (in Emergency Departments) are seen within 4 hours
2. Ambulance category 2 mean response time is less than 29 minutes
3. Achieve an average adult G&A bed occupancy of 96% or below

The system forecast outturn for 2025-26 against these targets which demonstrate the challenged situation are:

1. 78%
2. 29
3. 96%

2. What have we delivered in our second years, 2024/25?

- Launched of Single point of access covering Community and Acute Trusts, improving the coordination of people to the most appropriate service (in both counties)
- Continue to grow virtual ward beds in line with the UEC strategy of a model hospital
- Improvement in ambulance category 2 response times
- Implementation of national call-before-convey requirement, building upon the success of the urgent community response service.
- System Coordination Centre fully compliant with national standards and oversight of the day-to-day urgent and emergency care pressures.
- Improved and enhanced same day urgent care pathways
- Further development of same day emergency care with Frailty SDEC established at one of the sites

3. What are the priorities going forward?

- The Urgent and Emergency Care Programme Board is driving forward improvements for a responsive and affordable urgent and emergency system that meets the population's needs. This includes preventative or activities to manage ill-health before it becomes an emergency, and timely and efficient patient flow, resulting in less ambulance handover delays and minimising waits within Emergency Departments.
- Delivery of 78% EAS by March 2026.
- Delivery of less than 30-minute category 2 response times throughout 25/26
- Significant reductions to numbers of patients waiting over 12 hours in our Emergency Departments

The six priorities are:

1. Population management - To apply population health management approach to identifying those most at risk
2. Care at Home - To maximise the coordination of services to proactively intervene early and prevent the deterioration of frailty and ill-health
3. Future model of urgent care - To establish a model of integrated urgent care that supports people to access advice and interventions. This will include a procurement of out-of-hour GP provision, outbreaks management and enhancements to single point of access.
4. Emergency care - To consistently demonstrate an effective and efficient emergency care provision.
5. Discharge and recovery - To have a 'zero delay' approach to discharge planning with coordinated support for people to optimise their recovery.
6. Operational resilience - To demonstrate effective resource allocation to de-escalate or prevent pressure.

High quality, patients centred services: URGENT AND EMERGENCY CARE SERVICES

Theme 10

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Population Health Management	• Implement data gathering on health inequalities • Undertake population health assessments • Tailor approaches to people most-at-risk of requiring urgent & emergency care	By 2025/26 By 2025/26 By 2025/26
Care at Home	• Care at Home delivered by Integrated Neighbourhood Teams • Development of virtual hospital • Frailty competent workforce	By 2025/26 By 2025/26 By 2026/27
Future model of urgent care	• Procurement of Integrated Urgent Care including out-of-hours GP service, outbreak management and enhanced single point of access. • Delivery of a single point of access and enhance care navigation	By 2025/26 By 2025/26
Emergency care	• Consistently achieve under 29 minutes category two ambulance response times. • Achieve high performing Emergency Departments (emergency access standard) • Implement 'front door' streaming to right care setting • Maximise same day emergency care, including access to diagnostics 7-days	By 2025/26 By 2026/27 By 2025/26 By 2026/27
Discharge and Recovery	• Commit to returning home sooner #Homeforlunch • Enhance Frailty Rehabilitation & Discharge pathways • Improve Discharge-to-Assess pathways across the system	By 2025/26 By 2025/26 By 2025/26
Operational resilience	• Conduct annual winter and surge planning • Run public awareness campaigns to support people to use the right service • Develop shared training, common approaches and local knowledge across the workforce • Operate 7-day working across urgent & emergency care	Ongoing By 2025/26 By 2026/27 By 2026/27

5. Where you can find more detail?

The ICB and ICS system partners are refreshing the UEC Strategy, a link will be shared when this is available.

More information and context for the ICBs priorities can be found within the national recovery plan:

- B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf (england.nhs.uk)

Findings from Healthwatch talking to our patients will inform the focus of other workstreams to ensure care in the right place, at the right time, as close to home as possible, further engagement will be planned with Herefordshire:

What patients told us about why they "walk in" to A&E Departments in Worcestershire | Healthwatch Worcestershire

High quality, patients centred services: PRIMARY CARE SERVICES (GENERAL PRACTICE)

Theme 11

1. Why is this important?

Every day, more than a million people benefit from the advice and support of primary care professionals – acting as a first point of contact for most people accessing the NHS & providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves.

The most recent ONS Health Insights Patient Survey at the beginning of 2025 ranked the ICB as the best in the country where 86% of patients reported a 'good' overall experience of access to general practice.

Workforce challenges for General Practice include the attraction and retention of GPs and Practice Nurses. 28% of the GP workforce and 30% of the nursing workforce are over 50 years. In 2024-25 Partner numbers continue to decrease (-4%), but the numbers of salaried GPs is increasing (+16%). Overall the GP workforce has increased by 3.6 FTE.

2. What have we delivered in our second year, 2024/25

Implementation of the local Herefordshire and Worcestershire Primary Care Access Recovery Plan – Year 2

- Delivered **5.5 million appointments** in General Practice (2024). This is 20% more appointments than before the COVID-19 pandemic, and an increase on 2023. GP Practices are providing patients with access to around 466,000 appointments a month. This is almost 80,000 appointments per month more than pre-pandemic.
- By the end of March 2025, all practices will have implemented the Modern General Practice Access (MGPA) model to tackle the 8am rush, provide rapid assessment and response and avoid asking patients to ring back to book an appointment.
- For cloud-based telephony, online access to patient records, digital communication tools and Online Consultation solutions, we have 100% of our Practices offering these services.
- Online consultations are currently averaging around **70,000 admin or clinical contacts per month**.
- Excellent progress has been made in Self-referral pathways: adult audiology went live in 2024 and now Physiotherapy/Musculo-skeletal and weight management pathways have been developed. **About 4,000 self-referrals are made each month**.
- Primary-Secondary Care Interface is working in line with their 'working better together principles'. Consultant to Consultant referrals policy allows direct inter-hospital referrals when clinically needed, rather than going back through the GP.
- Bureaucracy has been reduced as part of the 'red tape challenge' event in December 2024. A Primary Care Liaison Officer is in post to work across the system on any barriers to facilitate change and improve capacity and patient care. NHS Trusts have established clear call and recall systems for patients for follow up tests or appointments.
- The Herefordshire & Worcestershire ICB's published Primary Care Access Plan was approved by the H&W ICB Board on 20 November 2024, which can be accessed via the website at agenda item 8: https://herefordshireandworcestershire.icb.nhs.uk/meetings/past-board-papers and was commended by NHS England.
- The ONS Health Insights Survey ranks Herefordshire & Worcestershire ICB top across the whole of England for patients reporting a 'good' overall experience of access to general practice.

Workforce

- Recruitment to the Additional Roles Reimbursement Scheme (ARRS) continued during 2024. On 1st August 2024, the government announced additional funding to support GP recruitment from Oct-March 24-25. By Jan 25, 6 PCNs had appointed 5.7 WTE ARRs funded GP.
- 25-26 funding has been expanded to included practice nurses as well as continued funding for GPs & GP joiners and leavers data has improved since March 2024.
- 371 direct patient care staff recruited up to Jan 25.
- General Practice Staff Survey – year 2 participation. Results demonstrate H&W equal to national survey average.
- General Practice workforce retention and attraction schemes implemented for 24-25.
- Support Level Framework (SLF) visits with Practices identified priorities and support offered through ICB General Practice Improvement Programme (GPIP) /Service Development Funding (SDF).

Estates

- Revision of General Practice estates plans as part of the draft ICS Infrastructure Plan 24/25, submitted 31st July 2024.
- Funding bid submitted in March 2025 to support General Practice to increase premises and appointment capacity as part of NHS England's Estates Modernisation and Utilisation Fund.

Governance

- Established the Delegated Commissioning Sub-Committee in July 2024, to provide a governance mechanism for the assurance and oversight of the delivery of nationally mandated Primary Care services that are delegated to the ICB (Primary Medical Services, Pharmacy, Ophthalmic, Dental Services)

High quality, patients centred services: PRIMARY CARE SERVICES (GENERAL PRACTICE)

Theme 11

3. What are the priorities going forward?

Enabling General Practice Strategy priorities

Planning and oversight is currently governed via the GP Sustainability and Transformation Forum, with overall accountability with the Strategic Commissioning Committee. Delivery via Herefordshire General Practice and General Practice Worcestershire Boards.

Integrated Neighbourhoods Teams – developing and supporting services delivered at a neighbourhood level – are central to transformation priorities of the Herefordshire & Worcestershire Integrated Care System

Enhancing services in primary care by prioritising workforce, estates and technology investment at a neighbourhood level will enable our citizens to have better local access to a wider range of services they need when they need it

Creating the conditions to better manage patient demand for primary care will enable GP practices to provide continuity of care to those who want and need it and give increased focus to prevention – support the ICS aspiration to reduce inequality and enhance outcomes.

All designed to ensure that the people who need and want to access primary care can get it, and that GPs have more time to provide continuity of care and deliver more preventative care going forward

5. Where you can find more detail?

- **Long Term Plan**
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

- **Hewitt Review**
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/1148568/the-hewitt-review.pdf

- **Fuller Stocktake**
https://www.england.nhs.uk/wp- content/uploads/2022/05/next-steps-for- integrating-primary-care-fuller-stocktake- report.pdf

4. What will we deliver and when?

Priorities	Deliverables	Year of delivery
Implementation of Fuller Report	• Lead & co-ordinate ICS response to Fuller & the moving towards a new model of care at Neighbourhood level. Starting in 2024\25 we want the System to orientate itself around 15 Neighbourhoods to reflect the needs of our Communities.	By 2024/25
General Practice	• Lead the co-production of a "Enabling General Practice" 3 year strategy with short, medium and long-term priorities. Set in the context current pressures, whilst raising ambition. • Drive a standardised and consistent offer to all residents of the highest standard • Focus and target unwarranted variation across all practices and see an improvement across accessing and ease of contact with practices as well as a broad range of long term conditions • Co-produce with General Practice a transformation programme which supports all practices in reaching their potential and builds capacity within practices to manage change and drive improvement	By 2024/25
Primary Care Estates	• Support General Practice to access funding and implement schemes to increase estates and access capacity via the Estates Utilisation and Modernisation Fund	By end of 2025/26
Primary Care Access Recovery Plan	• Engage on at scale solutions which sit within our PCARP and use this as a springboard to resilience, sustainability and transformation, utilising digital technology as additional forms of access. • Utilising additional workforce from the ARRS funding, and community pharmaices offering extra capacity for primary care. • Lead and coordinate the response to Year 2 of the National Access Recovery Plan – supporting practices and PCNs deliver their Access Improvement Plans, navigating the national Improvement Programmes to maximise implementation of transformation support tools locally to enact the necessary change. • Work across the system to enhance left shift activities delivering clear closer to patients while preventing unnecessary workload for GPs that should be undertaken in acute settings.	By end of 2025/26
GP Retention Review and refresh around	• Implement a GP Retention Plan and expect a drop in numbers leaving in early stage of their careers and a rise in well being • Review years 1 and 2 of – Enabling general practice and Dental Access strategy • Redefine priorities based on progress made and updated PCN/General Practice Contract from April 2024	By 2027/28 By 2024/25

General Practice Worcestershire's vision is to offer patient-centred healthcare which is high quality, cost-effective and fully integrated with our local partners to ensure a sustainable health service for our communities across Worcestershire. Our vision will be delivered by ensuring we have a happy, valued, supported multi-disciplinary workforce across General Practice.

What we delivered in 2024/25…

Access-

✓ Continued work to meet the three domains of Modern General Practice Access;

- Better digital telephony: telephony systems include call back functionality and reporting mechanisms to support capacity planning and access improvements
- Simpler online requests: online clinical and administrative requests can be submitted during core hours with appropriate responses and signposting enabled
- Faster care navigation, assessment and response.

✓ Introduction of PCN Hubs. The Same Say Urgent Access Hubs were introduced in Worcestershire in Autumn 2024 to support increasing demand for patients needing on the day care in General Practice and to reduce the impact of this on the wider system including Accident and Emergency. The hubs have been successful with high levels of uptake. Each of the 10 PCN's are providing a hub to support patients from their constituent practices, providing flexibility of access when demands across the network differ, whilst still providing care closer to home and maintaining some degree of continuity. When individual PCNs are under pressure, the hubs can be repurposed for cross county support.

Workforce-

✓ We have maintained recruitment within the ARRS workforce to meet national targets and flexed according to the ARRS changing criteria

✓ Introduction of Work & Health Coaches in collaboration with system partners as part of the Workwell initiative.

Sustainability

✓ **T**hrough General Practice Worcestershire Board, working to become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient.

✓ Metered dose inhaler changes as part of CEIF

Delivery of Integrated Neighbourhood Teams

✓ Continued work on the programme and timeline for implementation of the Fuller stocktake with phased delivery, via the Place-plan. Building on the learning from the 3 Accelerator sites to rapidly scale up efficiency and integration across community teams, general practice and social care.

✓ Continued District Collaborative working, with a focus on Prevention and Tackling Health Inequalities. Particular focus on CVD with targeted initiatives for this patient cohort. Increase in community involvement in local services such as menopause, smoking cessation, ageing well, diabetes prevention events.

✓ Working with our Community and Acute partners on Frailty, Virtual Ward, Primary/Secondary interface.

Work with the ICB on the "Enabling General Practice" 3 year strategy

✓ General Practice Worcestershire Board established and includes elected practice manager, ICB, LMC. The Board has continued to operate throughout 24/25 as central point of contact and has supported system wide meetings with GP representation.

What will we deliver over the next five years?

- **Access-**delivery of the national access priorities including integrated urgent care, direct access, improving prevention and tackling health inequalities, and supporting improved patient outcomes in the community through proactive primary care. Focus on patients who would benefit most from continuity of care and the creation of a patient charter detailing what patients can expect from their GPs and practices. A recent national survey highlights significant improvement in patient experience of GP access, with the latest results for Hereford and Worcestershire showing the highest patient satisfaction of GP access of any across the country.

- **Workforce-** continue to flex recruitment to the ARRS workforce, stabilise General Practice workforce including the partnership model and retaining the workforce including clinical roles in training. Development of a local general practice workforce strategy for Worcestershire to support Recruitment, Retention & Reform, working closely with Partners.

- **Sustainability**-Become a proven platform for future investment in general practice, supporting sustainable general practice and investment in care closer to the patient. Continue to deliver high quality, value for money services, harnessing the use of digital innovation in primary care where this supports patient need.

- **Delivery of Integrated Neighbourhood Teams -** Extend the Population Health Management approach beyond GP data and use the intelligence to maximise the impact of integration and reduce duplication as part of the implementation of the Fuller stocktake programme. Hosted visit from Claire Fuller to Stourport Medical Centre to highlight innovation in both counties

- **Deliver the general practice actions outlined in the "Enabling General Practice" 3 year strategy – progressing** beyond the ending of the PCN DES in 24/25, focusing on sustainable and resilience general practice.

High quality, patients centred services: GENERAL PRACTICE HEREFORDSHIRE

Herefordshire General Practice

Theme 12

In 2023/24, we established Herefordshire General Practice Collaborative. This model has successfully united representatives from all 19 Herefordshire practices, the Local Medical Committee (LMC), Primary Care Networks (PCNs) and Federation (Taurus Healthcare) to strengthen our working partnerships. The aim of the changes is to improve the delivery of 24/7 General Practice, create greater resilience for practices, provide variety and development for our workforce and to amplify the voice of General Practice in our local health and wellbeing system and is focussed on delivering this over the next five years.

Neighbourhood health

- HGP is committed to supporting and helping lead this next stage of development into neighbourhood health, and to build on use of the population health data.
- Ensuring we are an effective system partner, working with communities, health, care and voluntary partners to improve the experience of our services through integrated neighbourhood working and securing resources to deliver effective and appropriate out of hospital care
- Building on current success in expansion of MDT teams to further develop into future neighbourhood health integrated models

24/7 Integrated Urgent Care

- Developing the IUC agenda bringing together the pressures in the community alongside those of the acute, with integrated data sets that reflect capacity and demand in all sectors.
- Explore and develop a localised element of 111 that dovetails with existing IUC in a more seamless way, ensuring patients are supported to find the right care at the right time
- Retaining the OOH contract for local control that supports continuity of care and increasing integration of services.
- Build on the effective remote hub HRH, to support the IUC across the system, testing out the impact of face to face overflow.

Accessible, Sustainable general practice

- Continuing to deliver the modern general practice program to improve access
- Underpin the fair share of resources to ensure practices and primary care at scale remain financially viable, through both the national contracts, and the development of local contracts eg LES, CEIF
- Support the movement of work from the acute to the community, but with an appropriate shift of resources.
- Shape development & support delivery of ICS estates & digital plans, facilitating access and the delivery of integrated health & social care anchored around our neighbourhoods.

Develop New Services

- Deliver a new ADHD service that can provide a quality service that dovetails with general practice and mental health services, creating a more financially resilient service for the future.
- Explore the movement of services into the community that can support the system backlog and allows care closer to home, through subcontracting opportunities.

Primary secondary care interface

- Build on the supportive relationships to ensure that primary and secondary care reduce unnecessary shift of workload, reducing unnecessary appointments, whilst supporting workload shift into the community that is appropriately resourced.

Prevention

- Continue to develop the prevention agenda in the community, with talk wellbeing working alongside PCNs and practices to promote activities that support wellbeing and tackle inequalities
- Continue the workwell project to support people getting back to work

Thriving General Practice workforce

- Develop & implement a local General Practice workforce strategy to support recruitment, retention and role redesign, and that identifies the needs of our teams and attracts, values and supports our workforce
- Continue to implement ambitious plans to not only recruit but support and develop additional roles in General Practice, maximising our collective skills and expertise and our productivity
- Work together to embed new models of care, such as Herefordshire Remote Health, that not only supports patient access but offers increased flexibility for clinicians.

High quality, patients centred services: PRIMARY CARE SERVICES - PHARMACY, OPTOMETRY AND DENTAL (POD)

Theme 13

1. Why is this important?

NHS England delegated the commissioning of

the Pharmacy, Optometry and Dental (POD) services to H&W ICB in April 2023. The Office of the West Midlands (OWM) was established to support the six ICBs to deliver their commissioning responsibilities.

The Office of the West Midlands (OWM) is hosted by BSoL ICB who provide, oversight, leadership, and support for the workforce who were transferred from NHSE. This arrangement is supported by a formal hosting agreement between the West Midlands ICBs. All decisions are made through the 3 tier Joint Commissioning arrangement and their sub-groups which each ICB is a member of.

Herefordshire & Worcestershire has the Strategic Lead Role for POD services. What this means is – Simon Trickett, via the West Mids CEO Group is the Chief Exec lead for specific programmes such as developing a needs-based allocation formula to support Dental Services for example and escalating any issues to NHSE that may require dispute/resolution.

Specialised Services was also devolved in April 2024, and additional services such as Vaccinations & Immunisations and Screening programmes will be delegated in 2026.

Over the last 10 years there has been a decline in the number of Dental Practitioners providing NHS dental services to patients, this is particularly prevalent in Herefordshire and improving access to Dental services is a key priority in 2024/5.

2. What have we delivered in our second year, 2024/25

- Established the Delegated Commissioning Sub-Committee in July 2024, to provide a governance mechanism for the assurance and oversight of the delivery of nationally mandated Primary Care services that are delegated to the ICB (Primary Medical Services, Pharmacy, Ophthalmic, Dental Services)
- Development of a local Dental Recovery Plan, which aims to improve access and support the dental workforce.
- Development of a Dental Services Equity Audit by the Consultant in Dental Public Health, which has helped to inform commissioning intentions.
- Dental access is slowly improving. Between March 2022 to December 2024, dental access increased from 46% to 56% for children and 33% to 36% for adults, with the benchmark being 55%, which was the level of access pre-pandemic.
- Mobilisation of a new dental practice in Hereford City in June 2024, with a 2nd site due to open in May 2025. Combined, these two new services will provide much needed additional dental access for around 7,000 residents.
- Implementation of a proof-of-concept Dental Training Centre, which aims to recruit more dentists from overseas, and support them through the mentoring process.
- Continued to build on relationships with Local representative Committees such as the Local Dental Committee (LDC), Local Optometric Committee (LOC) and Local Pharmaceutical Committee (LPC) to understand the challenges and opportunities for providers to inform future strategic commissioning intentions.
- Worked closely with Community Pharmacies to implement the community pharmacy element of the national Primary Care Access Recovery Plan. In the two-year programme:
  - *Pharmacy first commenced for seven common health conditions at the end of January - Sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women without the need to visit a GP practice in addition to 40+ conditions pharmacies routinely manage. To date **13,906 consultations** have been referred by GP practices FY 24 25 (4,557 through clinical pathways and 9,348 as minor illness referrals).*
  - *Oral contraception service has been expanded. Between April 2024 and December 2024, **3,124 consultations** completed for initiations and ongoing supply of oral contraception.*
  - *Blood pressure check service has been expanded, encouraging utilising technology, to improve efficiency of referrals to community pharmacies. 89 pharmacies signed up and the service is delivering over target at **139.3%** (Nov 2024)*
  - *Discharge medicine service - Working closely with secondary care pharmacy teams to increase referrals into this service. All 3 NHS Trusts have commenced the service helping to reduce 30-day readmissions*
  - *Approved for 3 H&W sites to host independent prescribing pharmacist clinics – acute conditions; contraception; hypertension and CORE20PLUS5 initiatives. Herefordshire and Worcestershire ICB are the only ICB to fulfil all sites.*
  - *Pharmacy Engagement PCN Lead role, working with PCNs to increase patient, public awareness and referrals.*
  - *Ensure safe use of medicines and the position of community pharmacy is routinely built into our commissioning arrangements including a major provider of Flu and COVID-19 vaccine delivery across HWICS*

3. What are the priorities going forward?

- Accelerate Pharmacy First National Services so that there is an equitable offer for patients to self-refer or be referred increasingly into pharmacy-based services. GP connect update and access record is required to be switched on in GP practices by October 2025 to enable more streamlined messages on clinical services provided by pharmacies.
- Continue to implement the local Dental Recovery Plan priorities.
- Continue to build relationships with Community Optometrists, and the development of integrated pathways
- Increase clinical pathway referrals from practices.

4. What will we deliver and by when?

Priorities	Deliverables	Year of delivery
Primary Dental services	Implement the local Dental Recovery Plan actions, in addition to the government manifesto for additional urgent dental appointments.	During 2025/26
Delegated responsibilities	Continue the governance and oversight of Pharmacy, Ophthalmic and Dental delegated responsibilities (in addition to General Medical Services) via the Delegated Commissioning Sub-Committee, established July 2024. .	During 2025/26
Increase Dental Access	Mobilisation of the 2nd dental service in Hereford City to increase access for patients Commence commissioning plans for additional dental activity, in accordance with the local Dental Recovery Plan	May 2025 By June 2025
Optometry	Continue to build relationships with Community Opticians and develop integrated pathways where clinically appropriate	During 2025/26
Community Pharmacy	Accelerate referrals into Pharmacy First services for minor conditions and clinical pathways plus BP checks and contraception services through integrated pathways. Full digital integration into discharge medicine pathways confirms patient understanding of changes made to medicines whilst in hospital after they are discharged. Continue to input into national learnings of independent prescribing by community pharmacists as part of the national pathfinder programme – essential to workforce plans	During 2025/26

5. Where you can find more detail?

Dental patients to benefit from 700,000 extra urgent appointments - GOV.UK

Pharmacy First: what you need to know - Department of Health and Social Care Media Centre (blog.gov.uk)

High quality, patients centred services: SPECIALISED SERVICES

Theme 14

1. Why is this important?

Specialised Services are a diverse portfolio of NHS pathways accessed by a small group of people living with rare or complex conditions, including cancer, neurological, genetic and complex mental health needs.

ICBs were established to work with all partners to create a system where decisions are taken as locally as possible.

In 2024/25 the ICB became responsible for 59 acute specialised services delegated from NHSE, following the delegation of pharmacy, optometry and dental services in 2023/24. In 2025/26 a further delegation of other acute and mental health specialised services, as well as vaccination, screening and child health information services, is to be delegated.

What does this mean for the population of Herefordshire & Worcestershire? It means that the ICB will be able to influence the development of an integrated care pathway (for example, a cancer pathway) thereby ensuring that it reflects the local needs of our population within the larger over-arching commissioning policy across the West Midlands.

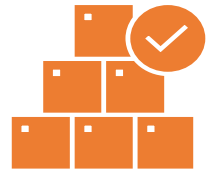
2. What have we delivered in 2024/25?

2024/25 saw the continuation of the joint work between NHSE and ICBs to facilitate the safe transition of the delegated services across the 11 Midlands ICBs. It is proposed that in 2025/26 - subject to consultation – NHSE staff in the West Midlands supporting all these services will transfer to NHS Birmingham and Solihull Integrated Care Board.

3. What are the priorities going forward?

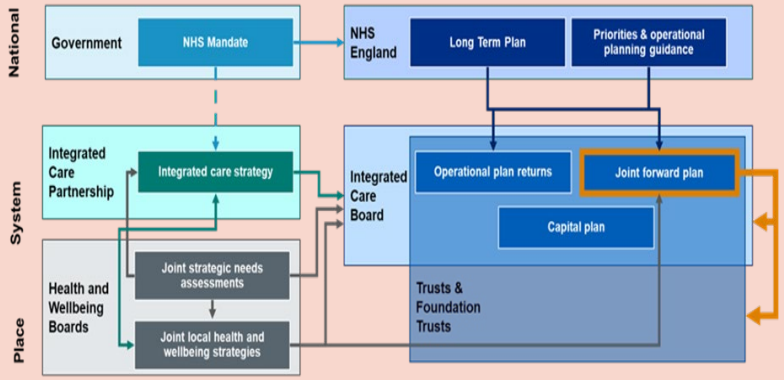
The over-arching national priorities for Specialised Services in 2025/26 are:

- Continue to reduce elective care waiting times – with 65% of patients waiting less than 18 weeks.
- Improve ambulance response and A&E waiting times – with a minimum of 78% of patients seen within 4 hours
- Improve patients access to general practice and urgent care dental care access, including 700,000 additional urgent dental appointments
- Accelerate patient flow in mental health crisis and outpatient care pathways



High quality, patients centred services: SPECIALISED SERVICES

Theme 14

Priorities	Deliverables	Year of delivery
To demonstrate NHSE priorities align with wider system partnership (ICB) ambitions, support subsidiarity and be delivery focused.	Production of an Integrated Commissioning Plan for 24/25 building on existing local strategies and plans, emphasising collaboration with local entities, and reflecting universal commitments. Whilst maintaining a delivery focused approach, incorporating specific objectives, trajectories, and milestones to ensure actionable plans and measurable outcomes 	**2024/25**
	Delivery of the integrated commissioning plan	**2025/26 and beyond**

5. Where can you find more detail?

[NHSE Midlands]

Joint forward plan – 25/26

Appendix 2: Strategic Enablers – Cross cutting themes

The section also identifies **how key enabling strategies** will be delivered to support the improved outcomes described in the core areas of focus section.

The section also describes the **strategic system developments** that will ensure that the system has the right structures, capacity and capabilities to deliver the plan.

Version: 2025 Refresh, May 2025

Strategic Enablers - cross cutting themes and strategic development areas

Cross Cutting Themes

Underpinning and supporting delivery of the core areas of focus outlined in Appendix 1 are a set of strategic enabling functions. These "cross-cut" all service areas and are fundamental components of delivering high quality, patient centred integrate services:

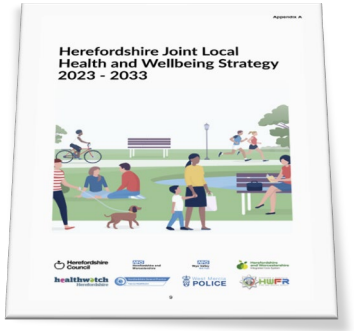
1. **Quality safety and patient experience**
2. **Clinical and care professional leadership**
3. **Medicines and pharmacy**
4. **Health inequalities**
5. **Prevention**
6. **Personalised care**
7. **Working with communities**
8. **Commitment to carers**
9. **Support veteran health**
10. **Addressing needs of victims of abuse**
11. **Digital, data and technology**
12. **Research and innovation**
13. **Greener NHS**

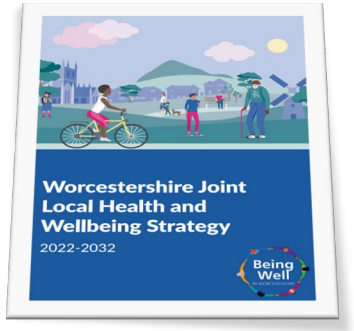
Strategic System Developments

In addition, there are a suite of strategic system developments that will support improved ways of working to maximise the opportunity for integration, enable greater focus on upstream prevention and delivery of best value health care in the right settings:

14. **Mental health collaborative**
15. **NHS Trust collaboratives**
16. **One Herefordshire Partnership**
17. **Worcestershire Place Partnership**
18. **Office for the West Midlands ICBs**

Together these supporting enablers provide the platform from which local NHS and Primary Care Partners can work together to deliver the priorities set out in the Integrated Care Strategy, the two Joint Local Health and Wellbeing Strategies and the NHS Long Term Plan





1. Quality, Safety and Patient Experience

Theme 1

Why is this important?

- What matters to people matters to us, listening to patients, their families and carers experience is essential to continuous improvement of services
- We have collective and individual responsibility to act in a manner that seeks ensure safe, effective and high quality care delivery and safeguard those in need of health and social care
- ICB has a Duty to ensure continuous quality improvement and as an ICS we are committed to this
- Learning and improvement cultures enable collaboration that leads to assurance of sustainable improvements in safety, clinical effectiveness and personalised experience

What have we delivered in 2024/25?

- Implementation and embedding of Patient Safety Incident Response Framework with continued growth of a system Patient safety specialist network and ICS Patient Safety Community of Practice to provide system opportunities for improvement and shared learning.
- This pilot project to safely develop, test and deliver an innovative approach of implementing AI into a patient management system to lead to better process flow and outcomes in CHC that is now being scaled up
- Improvement work related to Learning Disability and Autism including exemplary work around sensory friendly GP practices and children and adult admission avoidance. Surveillance status downgraded to 'by exception' which is the lowest level of surveillance the system can achieve.
- Establishment of ICS Collaborative for C-Diff Quality Improvement
- Oversight and governance processes established across the ICB to ensure patient safety quality and patient experience are central to ICB oversight

What are the priorities going forward?

- Improving indicators and experience of emergency care
- Improving system position for C-diff trajectories through quality improvement.
- Focus on implementation of Primary Care Patient Safety Strategy
- Further strengthen patient safety oversight with the development of patient safety dashboard
- Establish an ICS Deterioration Network and develop ICS strategy for PIER framework and Martha's Rule
- Delivering the national ambition to reduce still births, maternal and neonatal deaths and intrapartum brain injury Check planning guidance

ICS System Quality Group

The ICS System Quality Group met bi-monthly during 2024/25. The key aim of the group is to generate a shared commitment to improving quality and enable progress to be made on key system wide priorities.

The Group consists of key senior leaders from across the ICS and partner organisations who have a commitment to continuous quality improvement. Through discussion on key agenda items members have started to establish agreement about key cross cutting system priorities for improvement that are not otherwise managed through ICS Programme Boards.

During 2024/25 members have shared learning themes generated from organisation, 'place', system or Regional level processes, for the purpose of enabling system wide improvement.

What are we measuring?

During 2025/26 population health level dashboards will provide refreshed opportunities to understand what matters to people and track progress against priorities

- Rates of infection and antimicrobial prescribing
- Trends in mortality from specific causes and excess mortality
- Key metrics aligned to Saving Babies Lives Care Bundle
- Metrics agreed within each Trust and the ICS Patient Safety Incidents Response Plan
- Agreed quality, safety and experience Patient Safety Dashboard

Who is accountable?
ICS Forum for Healthcare acquired infection, Local Maternity and Neonatal System Board, ICS Mental Health Collaborative, ICS System Quality Group, Quality, Resources and Delivery Committee

Where can we see more detail?
System wide strategies on ICS webpage

Next steps
Continue working with partners across the system and regulators to agree, through the ICS System Quality Group, key system quality priorities that add value over and above the quality focus of each of the ICS Programme Boards.

2. Clinical and Care Professional Leadership

Theme 2

Why is this important?

As a system we are committed to embedding clinical and professional leadership throughout Primary Care Networks, neighborhood's, place and system structures and in our multidisciplinary forums across Herefordshire and Worcestershire. We have very string Clinical and professional Leadership forums in our two places, which are key but also are developing a culture of grass roots clinical engagement in service redesign and the "Building a Sustainable future" Programme, the system is held acocuntable to this through the Clinical Advisory Subcommittee which oversees Clinical transformation and policy.

Clinical and professional leaders

- Are trusted voices – connected with patients, communities and people working in health and care services
- Have the knowledge and expertise to make difficult decisions about how to use our limited resources most effectively, taking account of these int eh decisions they make
- Can use their diverse professional voices to create innovative solutions to problems
- Work effectively together across system and place, avoiding duplication, adding value, making a difference
- Are committed to collaboration and will seek to understand each others' professions and the unique contribution they make to improving health and care outcomes for local people – Including those who haven't been as involved in the past.
- Will make time for networking and building relationships across sectors
- Build on good practice and what works well, understanding that the transition to statutory ICS is an opportunity
- Embody leadership values and behaviours reflecting and connecting place and system

What will we deliver and when?

Clinical and Care leadership through delivering priorities: There is a strong clinical presence in the existing governance structures in H&W that support clinically led decision making

- Clinical leadership in the delivery of the **Getting it Right First Time (GiRFT) priority clinical areas**, focused on clinical productivity as a key enabler for reset and recovery and supporting the best use of resources programme.
- Clinical engagement and leadership of the **Building a sustainable future programme.**
- ICB Medical director, chair the **Quality, Delivery and Oversight** group and **Clinical advisory sub-committee,** providing support and challenge around solution focused decisions.

Who is accountable?

Clinical leader are in post to increase the capacity and capability in the ICB, driving improvement and transformation, Reporting to the CMO:

- Deputy Chief Medical Officers
- Interim Chief Clinical information officer
- Primary care, Veteran, military health and Vaccinations
- Clinical lead for social change
- End of life
- Ageing well and frailty

Where can you see more detail and get involved?

- The Clinical and Care Professional Leadership Framework describes the approach.

3. Medicines and Pharmacy

Theme 3

Why is this important?

- Medicines are the most common medical intervention in the NHS[1] and are an important part of preventing disease or slowing disease progression.
- In England in September 2024, 1,054,989 people received 10 or more medicines with 429,259 of them being aged 75 or over (8% of the population) and 143,982 aged 85 or over (8.9% of the population).[2]
- In December 2024[3], 7.2% of over 75s in H&W were prescribed 10 or more regular medicines in primary care which is a slight increase on December 2023 but lower than the national average.
- A person taking 10 or more medicines is 3 times more likely to suffer harm and 16.5% of unplanned hospital admissions are due to adverse drug reactions and polypharmacy. Over a 7-year period there was a 53% increase in the number of admissions caused by adverse drug reactions.[2]
- However, medicines are not always taken correctly, and it has been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended.[1]
- The NHS in 22-23 spent £18.5 billion on prescribed medicines in primary care in England.[4] H&W annual spend on medicines is in excess of £230 million, with approximately £152 million in primary care.
- Antimicrobial resistance (AMR) which is the loss of antimicrobial effectiveness is increasing. The UK Government recognizes this and supports effective and careful use of antimicrobials (antimicrobial stewardship AMS) in the NHS. [5]
- Community pharmacy is an essential part of primary care, offering easy access to health services with 80% of people in England living within a 20-minute walk of a pharmacy.[6] Community pharmacy is delivering an increasing number of clinical services, supporting the primary care access recovery plan.
- The expertise of pharmacists and the role of pharmacy technicians has evolved and expanded significantly to deliver clinically focussed person-centred care integrated into multidisciplinary care teams and local systems across primary care, in general practice, in community care and in hospital pharmacy. This has led to pressures within the existing workforce which combined with the reforms to Foundation Year (FY) training for pharmacists makes workforce a key priority.[7]

Who is accountable?

- Medicines and Pharmacy Board, involving representatives from all sectors of the pharmacy profession across the ICS, with oversight of the Medicines and Pharmacy Strategy.

What will we deliver and when?

- Our vision is to ensure the population of Herefordshire and Worcestershire receive safe and effective access to medicines and technologies at the right time and in the right place. Working collaboratively, we will strive to improve and transform services, reduce health inequalities and deliver new ways of working, always keeping the population and patients at the heart of activity.

References

1. NICE Medicines Optimisation Quality standard Introduction | Medicines optimisation | Quality standards | NICE
2. Health Innovation Network: The mechanics of tackling overprescribing and problematic polypharmacy, February 2025
3. Data from Epact polypharmacy dashboard
4. NHSBSA: Prescribing Costs in Hospitals and the Community
5. NICE. Antimicrobial Stewardship
6. Delivery plan for recovering access to primary care. May 2023
7. NHSE. Initial education and training of pharmacists (IETP) reform. February 2024

3. Medicines and Pharmacy

Theme 3

	Our key priorities are:	What we have delivered in 2024/25	What we plan to deliver in 2025/26
Improve Health Outcomes	• Defined clinical use of medicines and technologies across the ICS through up to date and approved clinical policy, guidance and position statements.	• Horizon scanning and planning for new interventions anticipated during 2025/26. • Introduction of anticipated new medicines for endometriosis, kidney disease, migraine, and weight management. • Year 1 of a 5 year plan for hybrid closed loop systems for managing blood glucose in type 1 diabetes for those with greatest clinical need. • Extension of the eligibility for COVID-19 treatments • Ongoing work in relation to the National Patient Safety Alert on valproate	• Prioritising the introduction of new medicines for respiratory and kidney disease, skin problems, migraine, endometriosis, diabetes weight management and the menopause. • Year 2 implementation of hybrid closed loop • Further extension of eligibility for COVID-19 treatments.
Reduce Avoidable Harm	• Working across all sectors to co-ordinate work designed to improve medication safety focusing on high-risk medicines. • Focus on safety as patients move between organisations eg. discharge from hospital with changes to medicines supported by the Discharge Medicines Service (DMS) across the ICS. • Increase system awareness and undertaking in medicines audits. • Support and implement local antimicrobial stewardship (AMS) plans.	• Increasing the use of the Discharge Medicines Service • Introduction of an ICS Medicines Safety Group • Production of a primary care AMS dashboard to focus on total antimicrobial prescribing, course length and choice of antimicrobial agent.	• Re-launch of Community Pharmacy Intervention Scheme • Reduction in total antimicrobial prescribing • Production of structured medication review data to support the national drive to tackle over prescribing • Participate in national project work to address inappropriate antidepressant prescribing • Use the ICS Medicines Safety Group as forum to oversee implementation of National Patient Safety alerts and share learning.
Productivity & Achieving Best Value	• Working with clinicians to ensure cost effective medicines choice and reducing use of medicines or technologies considered ineffective or low priority.	• Improved use of technology e.g Electronic Prescribing and Medicines Administration system (ePMA) • Introduction of biosimilar medicines in ophthalmology, dermatology, diabetes and gastroenterology. • Updated pathways for use of medical retinal treatments. • Improved use of blood glucose testing strips with the lowest acquisition costs.	• Introduction of more biosimilar medicines in ophthalmology, dermatology, diabetes and gastroenterology. • Review use of first line biologic medicines used for chronic diseases • Improved use of Hybrid Closed Loop devices with the lowest acquisition cost • Normalising use of generic consenting principles to ensure early adoption of cost-effective agents
Service Delivery & Sustainability	• Develop a pharmacy workforce plan to help build a sustainable workforce across all sectors of pharmacy • Using community pharmacy professional expertise for common conditions management; safe medicines use following hospital discharge; blood pressure checks; contraception services; vaccination services and new clinical services as they are introduced. Ensure referral pathways are robust for complete episodes of care.	• Production of Pharmacy Faculty workforce newsletters, attendance at careers/recruitment events and supporting providers with the Foundation Year training reforms. • Introduction of Pharmacy First service; Blood Pressure Checks and Contraception services through community pharmacy. • Community Pharmacy Independent Prescriber Pathfinder Programme.is live in all HW approved sites • Working together locally and across the Region to understand and plan for future service needs to support the aseptic (sterile) preparation of medicines. • Community Pharmacy PCN Engagement Role employed to increase collaborative working between GP practices and pharmacies – focusing on and integrating work into the neighbourhood accelerator work • Delivered a Pharmacy Connect IP Teach and Treat programme to build independent prescribing in the community pharmacy setting	• Evaluation of Community Pharmacy Independent Prescriber Pathfinder Programme. • Development of strategies for workforce and community pharmacy to complement the overall Medicines and Pharmacy Strategy. • Explore options for improving the number of pharmacist FY placements in Herefordshire and Worcestershire e.g. by creating a database of Designated Prescribing Practitioners (DPP) and supporting existing pharmacist Independent prescribers to become DPPs • EPMA roll out should increase DMS referrals – work closely with Acute Trusts • Further increase vaccination programme delivery via community pharmacies
Greener NHS	• Promote the use of environmentally friendly medicines and packaging	• Ensuring sustainability considerations for all new medicine applications. • Promoting switches away from unit dose eye drops to alternative preservative free eye drop bottles. • Eliminating the use of desflurane by using lower carbon anaesthetic gases	• Improve use of inhalers with a lower carbon footprint • Consideration of available medicine/device recycling schemes. • Identifying solutions to reduce use and waste of nitrous oxide

4. Health Inequalities

Theme 4

Why is this important?

- ICB's and Local Authorities have legal duties to have regard to reduce health inequalities.
- The NHS Long Term Plan requires every local area to develop plans and take action to reduce health inequalities.
- The range in life expectancy across the social gradient of the region is 7.9 years for men and 5.6 years for women in Worcestershire; (Fingertips Public Health Outcomes Framework) and 5.4 years for men and 4 years for women in Herefordshire (Herefordshire JSNA Summary 2024).
- Marmot Review estimated that health inequalities cost society £31bn in lost production per annum, in 2010 prices. Whilst this is a national figure, its in local jobs and economies where this impacts.
- The additional treatment costs of health inequalities are estimated to be in the region of £5.5bn per year to the NHS. These will be replicated locally – equivalent to around £77m on a flat population share basis.

What have we delivered in 2024/25?

- Established the Health Inequalities Ambassador (HIA) Network comprising of 25 named individuals representing every ICS programme Board and enabler group, to apply a health inequalities to everything the system delivers. An innovative approach that has been recognised as best practice nationally.
- The ICS HIPP Board has received 12 health inequality focused discussions by HIAs across a range board and work areas.
- ICB allocated £4.4m to work programmes that have tackling health inequalities as their core purpose. With most funding allocated out to Primary Care Networks (PCNs) - over £3.9m to support the development and delivery of local health inequality plans and CVD targeted improvements as part of the Clinical Excellence and Investment Framework (CEIF).
- Development of a Core20PLUS5 dashboard by PH Herefordshire, using EMIS data for to support PCNs with the identification and development of projects to address health inequalities, as funded through CEIF.
- PH Worcs LSOA analysis of statistically high ED admissions to help inform targeting of preventative programmes of work to address unmet need.
- This includes the ICB and partner commissioned outreach prevention services in Herefordshire and Worcestershire, targeting our most underserved communities offering a range of services to meet individual needs. The Herefordshire service was shortlisted for a national award and the Worcestershire service has won an award.
- A mid-point evaluation has been completed independently by Worcester University which has provided a Plan, Study, Act, Do cycle ensuring the services continually improve and flex the local needs and insight.
- A pilot of the high intensity user programme with the British Red Cross in Worcester has been evaluated and will be rolled out across Herefordshire and Worcestershire in 2025/26. This will complement the upstream work of the LSOA ED analysis, to intervene earlier.
- The ICB was successful in a bid for Community Connectors across H&W. Employed and managed by the VCSE, the Connectors are engaging with GRT communities and Pakistani and Bangladeshi women to uncover the insights on barriers to healthcare. The valuable insights are being shared across the system services and programmes to make changes that improve access, experience and outcomes.
- This includes read across to the partnership cancer health inequality programme with Macmillan – which focuses on the same cohorts.

What are the priorities going forward?

- The aim of the ICS Herefordshire & Worcestershire strategic intent remains to make addressing health inequalities everyone's business,, through the continuation of a range tangible actions:
- A review of the HI Ambassador Network will provide a series of recommendations to enhance and strengthen the network.
- Maximising on our outreach prevention services by removing barriers to access to secondary prevention services, by targeting areas using data, engagement and evidenced based interventions.
- Delivery of the DWP Workwell programme through PCNs, supporting people who at risk of leaving employment due to ill health, to remain or return to work.
- Continuing to build awareness and skills within the workforce of the practical and relevant actions that can be taken to reduce health inequalities, to make it everyone's business.
- Evaluation of the outreach prevention services and a view on long-term sustainability.

What are we measuring?

- Development of a Health Inequalities, Prevention and Personalised Care dashboard, by bringing together HIPP related metrics from across all ICS Boards into a single view to track progress.

Who is accountable?

- Health Inequalities SROs have been identified within ICB and across all provider Trusts.
- Responsibility and delivery of reducing health inequalities sits at system, Place, PCN and neighbourhood level – as such it should cut across all work.
- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health.

Where can you see more detail and get involved?

CORE20PLUS5 (england.nhs.uk)
CORE20PLU5 Children and Young People(england.nhs.uk)

5. Prevention

Theme 5

Why is this important?

Integrated Care Boards have a duty under Section 14Z34 of the Health and Care Act 2022:

"Each integrated care board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness".

What have we delivered in 24/25?

- Tobacco Dependency services fully implemented across all acute inpatient, mental health inpatient and maternity services in H&W as of June 2024. This achieves the Long Term Plan (LTP) deliverable of all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- There have been 2,012 eligible referrals into the Digital Weight Management Programme (DWMP) between April 24 and January 25, achieving 80% of the target so far. H&W have consistently been in the top 10 referring ICBs nationally for the DWMP for this financial year so far as of January 2025 data, as well as having the highest number of practices referring into the programme (91%).
- There have been 4,198 referrals into the NHS Diabetes Prevention Programme (NDPP) between April 24 and February 25.
- There have been 225 accepted referrals into the Type 2 Diabetes Path to Remission Programme between April 24 and January 25. There is an 80% acceptance rate for referrals into the programme. 127 service users have reached 6 months and have an average weight loss of 12.5kg. 38 service users have reached 12 months and have an average weight loss of 9.6kg.
- Continuation of the prevention outreach response services in both Herefordshire and Worcestershire, providing opportunistic testing of AF, blood pressure and lipid optimisation to our most underserved communities.
- CVD strategy has been drafted. An ICB Workshop was held in November 2024 to discuss opportunities to raise profile of national CVD high impact interventions.
- The development of a local dashboard and intelligence to map the patient journey. This work will complement the CVD Prevent Dashboard and information on this has been shared to promote engagement.

What are the priorities going forward?

- A broader review of the weight management pathway e.g. needs assessment, ICS system engagement.
- Exploration of targeted work with the National Diabetes Prevention Programme local provider, and GP practices to encourage referrals from PLUS groups (GP unregistered and rural communities) and exploring opportunities for LD/A groups.
- Delivery of prevention outreach service – targeting of GP unregistered citizens and the most underserved populations.
- Continuing to support Public Health colleagues and partners with the Loneliness and Isolation work within Worcestershire e.g. community grants.
- Monitoring of the delivery and implementation of the Joy Social Prescribing App across Worcestershire PCNs.

What are we measuring?

- A key element to the NHS LTP is tackling tobacco dependence, as tobacco smoking is the largest modifiable risk factor for health. The NHS will contribute to reducing the number of people smoking tobacco by delivering on the commitments outlined in Chapter 2 of the document: Prevention and Health Inequalities.
- To help tackle obesity, the LTP states that the NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ *(also outlined in the above link to Chapter 2 of the LTP).*
- These metrics will be encompassed as part of the development of a Health Inequalities, Prevention and Personalised Care dashboard bringing together the agreed deliverables into a single view to track progress against trajectories (Q2 2025)

Who is accountable?

- Prevention SROs in place across the system provider organisations.
- An ICS Health Inequalities, Prevention and Personalised Care Board brings together representation across all the system programme and enabler Boards, with each having a dedicated named individual as the Health Inequality Ambassador. Representation cuts across VCSE, Healthwatch, Primary Care, Providers and includes Directors of Public Health. This Board's function is to ensure the strategic intent of making health inequalities everyone's responsibility is realised through the application of health inequalities lens to all the work that we deliver to realise a close in the gap in healthcare inequalities through targeted prevention work.

Where can you see more detail and get involved?

- Information relating to the Long Term Plan priorities can be found here.
- Data is collated on the Regional Dashboards which can be accessed through the FutureNHS Collaboration Platform.
- Details around Your Health and Talk Wellbeing can be found on the ICS website. Information around what the service entails and upcoming events are included:
- Your Health – Worcestershire
- Talk Wellbeing – Herefordshire

6. Personalised Care

Theme 6

Why is this important?

Personalisation means health and care services delivering what matters most to each individual in a way that meets them where they are at. Engagement with our local population has told us that this relies on people having clear expectations of what is expected of them and what they can expect of their health and care professionals and services. Services are then able to offer support that is appropriate to the individual's level of need, making the best use of resources and getting the individual to the right support at the right time.

The Comprehensive model of Personalised Care outlines a three-tier approach to implementation: Universal (whole population) interventions; interventions targeted at those with Long-Term Conditions (LTCs) (30% of the population) and specialist interventions (5% of people with complex needs) (NHS, 2019). The NHS Long Term Plan outlines six interlinked components which underpin delivery: Shared Decision Making (SDM); Enabling Choice; Social Prescribing; Supported Self-Management (SSM); Personalised Care and Support Plans (PCSPs) and Personal Health Budgets (PHBs).

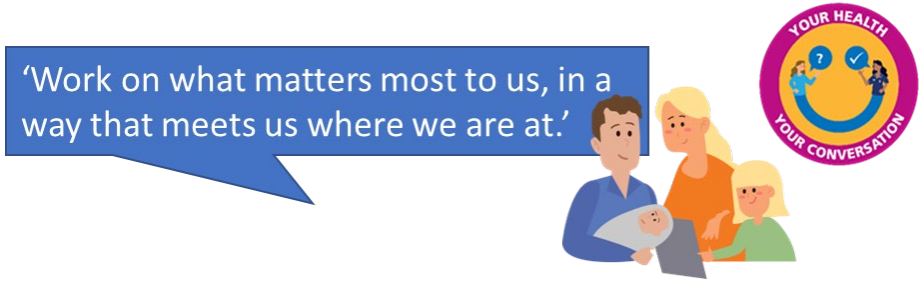
Supporting people with LTCs to self-manage is critical to addressing the rapidly growing demand this population represents . Our approach to supporting people to live well with their LTCs is to to raise awareness of how an individual's knowledge, skills and confidence, also termed activation, impacts on their ability to self-manage.

What have we delivered in 24/25?

- Developed and enhanced our training offer through the ICS Exchange platform. This now includes a Health Literacy training package and more modular and practical training.
- A health literacy network has been established, which is developing system wide health literacy commitments and a self-assessment tools to assess organisational maturity.
- A Personalised Care Toolkit has been developed to support system wide colleagues to implement personalisation approaches.
- There have been multiple examples of patient information improvements across the system, e.g. a Pulmonary Rehabilitation Guide, Endometriosis and Frailty videos.
- We continue to promote and develop our Long Term Condition video library, which provides health literate information on a range of topics.
- We piloted a Family Coaching service for children who are overweight, demonstrating positive outcomes from a whole family approach, the learning from this pilot has informed the children's hubs in Worcestershire and the service has been embedded in Herefordshire.
- We have piloted a service for high intensity users of urgent and emergency care services, SupportingYou. This is demonstrating a reduction in A&E attendances.

What are the priorities going forward?

- Continuation of the Supporting You Service in Worcestershire.
- Continuation of the Health Literacy programme.
- Continued development and delivery of the Health and Wellbeing and LTC video library.
- Promotion of the Peer Support Worker offer.
- Embedding use of Patient Reported Experience and Outcome measures across priority LTC services.



What are we measuring?

The dashboard that is in development is anticipated to measure: numbers of PHBs, number of personalised care and support plans (PCSPs), numbers of ARRS role team members and referrals to their services, the number of people accessing personalised care training and the number of registered carers. There are also specific outcome measures in place for the services that are being piloted and for the video library.

Who is accountable?

The Health Inequalities, Prevention and Personalisation Board is responsible for delivery of Personalised Care. This is a system wide meeting, with membership across health, the local authority and the Voluntary, Community Social Enterprise. The SRO is the ICB Chief Nursing officer.

Where can you see more detail and get involved?

Health Literacy - https://teamnet.clarity.co.uk/Topics/ViewItem/5813997c-1f90-477c-9de9-b10e00e42f56

Personalisation Toolkit - https://teamnet.clarity.co.uk/Topics/ViewItem/1680689e-80fe-4368-898e-b086007d97da

Any queries, please email: hw.personalisedcare@nhs.net

7. Working with Communities

Theme 7

Why is this important?
Our ambition is to place greater emphasis on early engagement and ongoing dialogue and partnerships with people and communities. From these early, open and genuine conversations we can work together with local communities, who are often better placed to create solutions to the health challenges we face.

What have we delivered in 24/25?
During 204/25 we have worked with all of our partners across the system to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This has included supporting people to sustain and improve their health and wellbeing, as well as working with people and communities to develop our plans and priorities, address health inequalities, and co-design services that equitably address the health challenges that our population faces.

Our key deliverables are detailed within the People and Communities Annual Reports and the Insights Reports:

1. People and Communities Annual Report – These reports are published annually and detail how the ICB has worked with ICS partners to engage with people and communities at a system, place and local level.
2. People and Communities Voices Report – Published quarterly, these reports collate soft intelligence and highlight key themes from the feedback garnered from people, communities and ICS partners, from across Herefordshire and Worcestershire. These insights are fed back to the key ICS and ICB decision makers for their consideration and to highlight any cross-cutting themes between services and areas of focus.

Some examples of our work include:

- NHS 10 Year Plan – Facilitated and ran two engagement events on the NHS 10 Year Plan. Representatives from Patient Participation Groups (PPGs) and health services from across Herefordshire and Worcestershire, joined us for two sessions. The interactive and informative sessions focused on national and local health priorities. Attendees had the opportunity to network, have their say on the NHS 10 Year Plan , engage on local plans, share best practices, and learn from each other's experiences. There was a lot of in-depth discussions and feedback generated from the two gatherings. The ICB has fed all the comments generated into the national NHS Change consultation, as well as internally using feedback to improve local health services and work on Integrated Neighbourhoods.
- Palliative and End of Life Care – This engagement exercise sought the views, stories and experiences of people who live, work or receive care in Herefordshire and Worcestershire, specifically targeting people who were receiving palliative or end of life care, those in the last year of life, and including carers. The feedback received was fed back to the programme board and will be used to shape the new Palliative and End of Life Care Strategy.

Priorities going forward
We intend to:

- Listen more and broadcast less, and where engagement is an ongoing and iterative process focused on what matters to people, not something 'done once'
- Hold ongoing conversations with communities about healthcare, built around community groups, forums, networks, social media, and any other place where people come together as a community
- Provide clear and timely feedback to local people about the impact of their involvement
- Develop plans and strategies that are fully informed by engagement with the public and patients
- Use insights and data to improve access to services and support reduction of health inequalities
- Focus on early prevention and supports communities to develop their own solutions to improving their health and wellbeing

Specific programme areas of focus are the NHS Ten Year Plan, Building a Sustainable Future (BSF) Programme and stroke services reconfiguration.

What we're measuring
- The ICB's compliance with undertaking our legal duties to involve the public in decision-making about NHS services.
- The feedback, sentiment and key themes that we have gathered from undertaking engagement with people and communities in Herefordshire and Worcestershire.
- The demographic details of the people and the communities we engage with. This is to ensure that we are listening to a wide and diverse range of people, and to highlight where more engagement needs to be undertaken with specific people, groups and communities.

Who is accountable?
- NHS Herefordshire and Worcestershire Integrated Care Board is responsible for ensuring that the statutory duty to involve are met across the system.
- The ICB is responsible for arranging effective health and care services for the Herefordshire and Worcestershire population; demonstrating that decision-making is clearly informed by insight
- Herefordshire and Worcestershire Integrated Care Partnership Assembly is responsible for ensuring that strategies for health and wellbeing are based on the needs and aspirations of local communities, and open to scrutiny and challenge
- The One Herefordshire Partnership and Worcestershire Executive Committee are responsible for delivering health and care services shaped by local need

Where can you see more detail and get involved?
Please see our strategy 'Working with people and communities in Herefordshire and Worcestershire' or for more information or contact the ICB Engagement Team.

8. Commitment to Carers

Theme 8

Why is this important?

Carers are a diverse group, and every caring situation is unique. Carers are people who care for a family member, a friend, or another person in need of assistance or support with daily living. They include those caring for children who have a disability or additional needs, older people, people living with long-term medical conditions, people with a mental illness, people with a disability, people with addiction, people experiencing substance misuse and those receiving palliative care.

The degree to which a carers own life is impacted by their caring role will vary. Parent carers are most likely to be caring the longest and experience the greatest financial impact. Some carers may find themselves caring for more than one person. The physical demands of caring may be greatest for those whose cared for is disabled or is frail. The emotional demands on carers may be greatest for those caring for someone at end of life or caring for someone with poor mental health.

According to the last Census (2021), there were 16,501 and 52,547 carers in Herefordshire and Worcestershire respectively, of which 7,701 (47%) and 25,171 (48%) care for more than 20 hours a week. This represents a rise in proportion of carers providing higher levels of care than in the previous census (around a third). Carer support organisations are in touch with 5,500 carers in Herefordshire, and 14,547 in Worcestershire. Worcestershire Association for Carers receives around 600 referrals per month, 85% of which result in 1 to 1 support. Local intelligence tells us that the complexity of caring roles is increasing. This includes carers maintaining responsibility for increasingly complex clinical needs against increasingly stretched finances. The number of carers is expected to rise by at least 60% by 2030 (Carers Trust).

By supporting carers, we enable people to remain living well within their communities, reducing the demand on health and social care and improving the health and wellbeing of both the carer and the cared for.

What have we delivered in our second year 2024/25?

1. Continued to support system partners to progress against Commitment to Carers statements.
2. Facilitated regular ICS Carer Reference Group (CRG). Key areas progressed include:
    - Empowering Carers at Discharge – working with pilot inpatient wards as part of the Accelerating Reform Fund project to identify and support carers, capturing learning to share systemwide
    - Improved recording of carer status across system partners.
    - Herefordshire carers strategy refresh and introduction of the Herefordshire Carers Partnership forum
3. Enabled opportunities, through the CRG and place-based forums, for carers to share their views and lived experience, and contribute to co-production of improvements in carer support.
4. Incentivised the following areas in primary care through the 2023/24 CEIF contract:

- Identification of GP practice carers lead.
- Delivery of carer awareness training.
- Drive to increase the number of carers identified and recorded in EMIS.
- Signposting to local carers support.
- Proactive offer of other support to carers, e.g., social prescribing.

What are the priorities going forward?

1. Continue the drive to recognise and support more carers across the system.
2. Capture and share Accelerating Reform Fund learning to enable improvement in carers support across Herefordshire and Worcestershire.
3. Continue to support carers forums across the two counties, strengthening the carer voice in planning and provision of services.
4. Work with system partners to develop carer awareness training package for staff.
5. Work with system partners to ensure carers voices are heard and the profile of work in support of carers is raised.

What are we measuring?

1. The number of carers identified across the system.
2. Qualitative progress towards the system Commitment to Carers by each provider organisation.
3. Feedback on patient and carer experience of services via periodic Healthwatch surveys.

Who is accountable?

The Carers programme is a component of the Personalised Care programme and accountability sits with the Health Inequalities, Prevention and Personalisation Board. The Carers Reference Group was established to develop and enable delivery against our system commitment to carers. These commitments are integral to place-based Carer Strategies held by our County Councils, which are supported by carer partnerships in both Herefordshire and Worcestershire.

Where can you see more detail and get involved?

Visit the ICB carers resource hub: [Resource Hub for Family, Carers and Loved Ones :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)]

9. Supporting the Armed Forces Community

Theme 9

Why is this important?

The Armed Forces community is made up of serving personnel, veterans and their Family's and carers. There are an estimated 2.4 million veterans living in the UK. Within Herefordshire and Worcestershire there are currently approximately 30,000 military veterans. Herefordshire and Worcestershire ICB has a high density of veterans making up about 4.7% of the patient base. The Armed Forces Act 2021 makes it a legal duty on specified public organisations to have due regard to the principles of the Armed Forces Covenant when exercising their functions. These duties apply to ICBs. As an ICB we are working with system partners to give due regard to the health and social care needs of the Armed Forces Community in the planning and commission of services. We are working on building our engagement with this community to build our understanding for how we can support their health and wellbeing.

What have we delivered in our second year 2024/25?

Within the first two years alongside signing the armed forces covenant, the ICB has been an integral part in supporting this cohorts through both primary and secondary care. Leads from the system were invited to an Armed Forces Health Symposium where there were valuable conversations to take away to help deliver the promises to the Armed Forces Community.
With the introduction of the Talk Wellbeing Service in Herefordshire, they have reported a large number of veterans engaging with their services and through the training which has been undertaken by the team has supported clinicians in engaging with this group.
More practices in Worcestershire are signing up to the veteran friendly practice scheme too with compared to the first year we are nearly 10% higher in sign up rates.

What are the priorities going forward?

Within the next year it is key to ensure that we can continue to keep signposting the Armed Forces community to healthcare available within the system and to continue the identification of them within the healthcare system.
We will continue to encourage practices to sign up to the veteran friendly practice scheme.

What are we measuring?

There are two key measurables which we are working towards.

1. Increasing the number of veteran friendly practices across Worcestershire (as Herefordshire are already 100%). This is being collated by the Royal College of General Practioners
2. Increase the number of coded veterans on clinical system, initially in Primary Care. This is being supported by local BI teams to assist in sourcing the data.

Who is accountable?

The Clinical Lead on the project is Dr Jonathan Leach OBE, with project management in place to support. This will be delivered through following the key commitments from the Armed Forces Forward View that ICBs use indicators to measure progress. We will work with partner and provider organisations to develop and deliver objectives and actions to reduce any health inequalities and improve healthcare for this population. We will work closely with the service users to understand their needs and requests within the services.

Where can you see more detail and get involved?

If you have any questions or for more information on how to get involved or how this community could benefit your work, please email: hwicb.partnerships@nhs.net

10. Addressing the specific needs of victims of abuse

Theme 10

Why is this important?

The ICB has a duty to address the particular needs of victims of abuse, including an assessment of need. Working with health, social care and statutory partners to support victims, tackle perpetrators and prevent abuse. This includes reducing the health inequalities faced by victims of abuse.

There are a range of initiatives and services in place that will be built upon over the lifetime of the joint forward plan, these include:

- The Serious Violence Duty (SVD) is based on a public health approach which requires co-operation and collaboration including data across a range of partners. This approach to tackling violence means looking at violence not as isolated incidents or a sole police enforcement problem. It is about taking a multi-agency approach to understanding the causes and consequences of serious violence and focusing on prevention and intervention.
- Training plan to support upskilling of talk wellbeing and your health outreach services to spot those vulnerable to domestic abuse / serious violence etc
- Collaboration between Policing partners and roving vaccination teams in areas of deprivation and inequality.
- Pan West Mercia data group in place – With leadership from Herefordshire Council.
- District collaboratives – working between district councils, primary care networks, community support officers, voluntary sector to identify needs in the local community
- Funding secured by Herefordshire PCN's to collaborate with 3rd sector organisations supporting victims of domestic abuse, exploitation and youth crime.

What have we delivered in our second year 2024/25?

Services have been developed and commissioned responding to identified cohorts or individuals to support prevention and reduction in serious violence, these are listed below:

- Serious violence duty actions including strategic needs assessment to support action.
- SVD - Develop system wide data group in partnership with Police, Local Authority, West Midlands Ambulance Service, CSPs and other relevant organisations.
- Worked with partners in preparation for implementation of the Victims and Prisoners Act (2024).
- Delivered trauma informed care training, supported by the Integrated Care Partnership Assembly.
- Commitment to integrate the Workwell programme, supporting people to get back to and stay in work, with the IRIS programme in 2025/26.
- Supported the White Ribbon Campaign across system partners, seeking to end male violence against women and girls.

West Mercia Rape & Sexual Abuse Support Centre

WEST MERCIA WOMEN'S AID

What are the priorities going forward?

There are a number of services and programmes in place to ensure that we are addressing the needs of victims of abuse, these include:

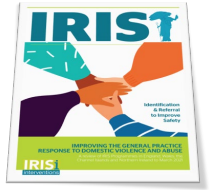
- **Domestic Abuse and Sexual Violence:** Working with the Police and Crime Commissioner as interim convener of the Victims and Prisoners Act 2024, implementing required actions.
- **IRIS:** A specialist domestic violence and abuse training support and referral Programme for General Practices that has been positively evaluated in a randomized controlled trial. Iris is a collaboration between primary care and third sector organisations specialising in domestic abuse. This service will continue in 2025/26 in Herefordshire, supported by Herefordshire Council and NHS Herefordshire and Worcestershire.
- **Climb:** A service which delivers early intervention and prevention for those at risk of criminal exploitation.
- **Purple Leaf and West Mercia Rape and Sexual Abuse Support:** A charity providing specialist front line support independent advocacy counselling and those affected by any form of sexual violence
- **Drive perpetrator programme:** A project which aims to reduce the number of child and adult victims of Domestic Abuse by deterring the perpetrator (in Place).
- **Steer Clear:** Prevention Programme working with young people who have been or could be involved in knife crime, continuing in 2025/26.

What are we measuring?

The overall approach is to ensure that all partners are sharing data and intelligence to build up a comprehensive picture of individuals and communities at risk of serious violence, domestic abuse or sexual violence. Those key hotspots across the system are being looked at and appropriate interventions will be put in place. This will be developed during 2025/26, working with West Merica Police and broader partners through Community Safety Partnerships.

Who is accountable?

The integrated care board (NHS Herefordshire and Worcestershire) has a specific duty to address the particular needs of victims of abuse. This will be delivered at place through the Herefordshire community safety partnership, Worcestershire community safety partnership and the crime reduction board.



11. Digital, Data, Analytics and Technology

Theme 11

Why is this important?

We cannot improve health outcomes and reduce health inequalities without data and technology, which is key to making health and care services more accessible to parts of our communities. This can be via remote and virtual care, better planning of services and enhanced sharing of patient information. Technology and data can play a core role to reduce elective backlogs, mitigating urgent care pressures, continuing to deliver responsive and timely community and primary care. Digital products can enable personalised preventative care by giving people more control over their lives by providing self-assessment, education, motivation and monitoring to help them manage their own health. We must ensure digital services are inclusive and provide for everyone's needs by listening to and designing with communities with seldom heard voices more closely.

What have we delivered in 2024/25?

- Written and published the system's Digital and Cyber Strategies to outline our ambitions and direction of travel.
- Continued the work on optimisation and increasing adoption of the Shared Care Record. This included a comprehensive evaluation of the service to date and taking action on the findings.
- Developed and enhanced our patient facing digital offer and Patient Portal to provide a front door to patients under our care.
- Worked closely with our system partners in work towards levelling up digital maturity.
- Embedded the enhanced BI and analytics service, delivering more aligned and standard performance and BI reporting and tools. Continuing to progress with the capabilities needed for effective population health management.
- Continued to work on refreshed technology to support staff capacity, efficiency and organisational productivity specifically unified communications, telephony and networks.
- Commenced work on Artificial intelligence pilots and initiatives to support productivity.

What are the priorities going forward?

Pillar 1: Getting the right infrastructure in place

- Sourcing and developing the essential operating systems, technology and software to enable us to deliver the best outcomes
- Levelling up the digital maturity and architecture of organisations

Including: Shared Care Record, Electronic Patient Records, Frontline Digitisation.

Pillar 2: Enabling integration of our data sources

- Ensuring systems and applications can talk seamlessly to each other – maximising interoperability
- Improving information to support decision-making

Including: Data Sharing Agreements, Agreed Standards, Data Security/Protection, Groundwork for Population Health Management and Federated Data Platform.

Pillar 3: Creating an environment to enable people to self-serve

- Providing our people with easy-to-use apps and systems, where they can access their information and help manage their own care and needs, closer to home where possible

Including: Patient Portal/NHS App, Patient access to their records, Improved and accessible information

Pillar 4: Supporting the transformation of services 'around the user'

- Ensuring all NHS staff have access to and are trained in the use of the right tools and systems to deliver the best care to and outcomes for our people

Including: AI and Automation Principles, Continuing Health Care, Piloting newer technologies

What are we measuring?

Each project measures outcomes and success. This will include improvements in productivity, efficiency, usability and usage. For example the number of people across our system using the Shared Care Record.

Who is accountable?

One of the ICS Programme Boards focuses on Digital, Data, Analytics and Technology and brings in the ICS Digital Clinical Leads, these two groups will be responsible for setting the digital agenda and collective vision. Their work will be informed by the ICS Analytics Board, Technical Design Authority and Clinical Safety Officer Group on digital transformation and improvement.

There are a number of Groups and Boards focusing on the technicalities of the deliverables including Shared Care Record, Cyber and Data Security and Primary Care. Based on the structures already in place in the NHS Trusts and primary care system in Herefordshire and Worcestershire, the ICB Digital Leaders will work closely with the organisation Boards and Steering Groups. There are strong links to the other five ICS Forums where digital plays a central role and vice versa delivery teams are accountable for the outcomes they are set up to deliver.

Where can you see more detail and get involved?

There is a digital section on the ICB website

Digital innovation :: Herefordshire and Worcestershire Integrated Care System (hwics.org.uk)

12. Research and innovation

Theme 12

Why is this important?
As a system we recognise the importance of promoting research an innovation in the provision of healthcare. The ICB Medical Director holds the responsibility for promoting this, ensuring it is clinically led and underpins the delivery of the Joint Forward plan.

What will we deliver and when?

- **Assets:** ICS Academy, Knowledge and research school, The Herefordshire and Worcestershire research consortium. Worcester University - Allied health professional school. I&I Bid – Engaging underrepresented communities. (Personalised care.) Innovation – Pods. Research network.
- **Resources:** Increase access to funding, ,E.g. NHIR and working in partnership with the academic health science network.
- **2024/25 priorities:** Delivering the new **5 year research and innovation strategy** developed and published last year. This will be led by the Herefordshire and Worcestershire research consortium, reporting into the ICS academy steering group.

Innovation - What are we building on?
To help promote innovation across the system, the ICB has created an Innovation Hub called: The CO-LAB www.icscolab.org.uk We believe this is the first example of an ICB-led Innovation Hub. It exists both virtually and physically, located deliberately in a rural community hospitals (Kidderminster Treatment Centre), where we know innovation traditionally receives less focus, but has real chance of improving health services. Approaching it's first year operating, it has had a number of successful initiatives and adoptions of innovation, including:

New Ways of Working and developing new knowledge:

- In partnership with Warwick University's "West Midlands Health and Wellbeing Innovation Network WMHWIN", The CO-LAB ran a 5-day Agile approach for one of our Trusts to help them co-design a new Heart Failure @ Home pathway with a "User focus". The co-design event included staff, commercial innovators and patients. Outputs included a framework for staff to use if interested in this type of approach, supplemented by education webinars.
- It is regularly used as a space anyone in the ICS can use for free to re-imagine pathways and processes. For example, it's used monthly by one of the trust's Transformation guiding board as part of it's Virginia Mason Programme.

Trial and Adoption of Innovation:

- The CO-LAB hosted certified VR anti-anxiety headsets and approached teams to trial. Following a successful trial on our Pediatric Oncology wards, where they reduced anxiety in children needing cannulas, improving patient experience and reducing clinic time, a number of headsets have been purchased for long-term use on those wards and are being trialed across multiple other wards within two Trusts (one within our ICS and one in a neighboring ICS)
- As the host for the first teleconsultation pod from a French-based innovator, The CO-LAB has worked extensively with the company on feasibility, demoing and real-world testing. The pods are now being used in the South East of England and is being deployed in system as part of an NIHR bid for the ICS.

Partnerships:

- The CO-LAB has partnered with innovative organisations to understand opportunities and art-of-the-possible to highlight to workstream leads, these include:
    - ICS Partnership with Amazon Web services, where the ICB participates in their Global Healthcare Incubator.
    - Satellite Catapult, currently arranging a trial of drone technology
    - IASME, working with a local innovator to train unemployed Neurodiverse young people for employment in cybersecurity
    - Partnership with multiple Universities, including a successful partnership with the University of Manchester on a systematic review of literature on the implementation of AI in health and care

Staff and wellbeing:
Early on in the hub's life it became apparent there was a significant ask for finding and spreading innovation practice for wellbeing of staff. Initiatives have included:

- Partnering with a Hypnotherapy provider, we setup an agreement to offer the hub's use whilst closed in return for free provision of sessions to front-line staff to address anxiety, sleep deprivation and relaxation. Sessions typically have 20 attendees, with great feedback
- The Hub is provided free of charge to ICS groups who want to host staff celebration or wellbeing events. For example, it is used as part of the International staff process, providing an area for them to come together, and celebrate pre-exam.
- NHSE provided sessions for Wellbeing in Leadership Roles, is being hosted at hub for several trusts in and out of the ICS.

Herefordshire and Worcestershire Research consortium

- Is the system wide group overseeing research in the system, we are looking to widen its brief to look at innovation too as part of the strategy refresh.
- It monitors performance / recruitment across the system, but also looks to broaden the scope of our research beyond organisational boundaries, looking at how we work with the local university as it develops
- Will hold oversight of delivery of the new strategy.
- Now reports into the ICS academy steering group, where previously it was not part of any formal governance.

13. Greener NHS

Theme 13

Why is this important?

The climate emergency is also a health emergency.

Poor environmental health contributes to major diseases including cardiac problems, asthma and cancer. Unaddressed, it will disrupt care and affect patients and people at all stages of their lives. Climate change impacts every single person and as such we all have a duty and responsibility to do something about it.

Herefordshire and Worcestershire ICS are committed to embedding environmental and sustainable practices into all areas of our work, as an enabler for better health. We see the work of the green agenda aligned to our principles of delivering high quality care; reducing health inequalities and improving the health and wellbeing for the communities we serve.

Reducing emissions will mean fewer cases of asthma, cancer and heart disease. Many of the drivers of climate change are also the drivers of ill health and health inequalities. In the UK, air pollution is attributable for 1 in 20 deaths, making it the greatest environmental threat to health. We can all play our part in tackling climate change through reducing harmful carbon emissions, which will improve health and save lives.

Environmental health impacts are often unfairly weighted in areas of deprivation and minority ethnic groups. For example, Black, Asian and minority ethnic groups are disproportionately affected by high pollution levels, and children or women exposed to air pollution experience elevated risk of developing health conditions.

What have we done in our second year, 24/25?

- Deepened relationships with public sector partners to support strategic developments and build awareness to our populations
- Continued to embed the system-wide ICS wide Sustainability Impact Assessment (SIA) into decision making.
- Increased the number of virtual appointments and virtual wards available to our patients thereby reducing carbon emissions through travel.
- Continued to reduce the amount of nitrous oxide used through identifying leaks within our system and changes to manifolds.

What are the priorities going forward?

- To refresh the HWICS Green Plan for 2025-8.
- To continue to increase the use of low carbon inhalers.
- To continue to strengthen our networks and connections to create greater impact.
- To strengthen our focus on Clinical Transformation pathway opportunities.
- To support our efficiency and productivity agenda by reducing waste across the system.
- To support delivery of social value

Who is accountable?

- Greener NHS SROs have been identified within ICB and across all provider Trusts
- Responsibility and delivery of Trust Green Plans sit at Trust provider level.
- Collectively agreed ICS Greener NHS actions sit at ICB level, working collaboratively with Providers to deliver through their existing governance groups.
- Engagement is undertaken directly with SROs, and operational working and engagement through a system Sustainability Leads group.

Where can you see more detail and get involved?

- ICS Green plan
- ICB Green Board papers

14. Mental Health Collaborative

Theme 14

Where we are now? – What we have achieved together

The Mental Health Collaborative met the national targets for:

- perinatal mental health
- access to mental health services for children and young people
- access to community mental health services
- recovery and improvement rates for people who have received talking therapies
- health checks for people with severe mental illness

The Collaborative recognised the challenge of Dementia diagnosis in our system, establishing a separate programme board with exclusive focus on Dementia care. A plan to improve dementia diagnosis is now in place that is tackling raising awareness and improving support for people living with Dementia.

A revised model of children and young people's emotional wellbeing and mental health service was procured, resulting in Melo being launched in April 2025.

The Collaborative conducted a governance review in 2024/25 to ensure there was greater focus on programme delivery, clearer accountability to the ICB and stronger collaborative strategic leadership.

Where next? – Areas of focus

The Collaborative will focus on five key delivery areas for 2025/26:

- Improving children and young people's mental health so there is multi-faceted and stratified support offer to children and families. This will include embedding the new Melo service, further expansion of MH in Schools and roll-out of Primary Partnership in Neurodivergence in Schools initiative. Additionally, the Collaborative will commission a support service for neurodivergent children and their families. The Collaborative wants children to be supported in a more timely manner and will focus on bringing down CAMHS waiting times.
- Inpatient care in acute psychiatric units. The Collaborative has put in place financial risk/share arrangements to remove the use of inappropriate out of area beds, so that people are cared for closer to their local communities and their families. Alongside this, length of stay will be reduced so that patients have a better opportunity for timely recovery. This will allow resources to be re-purposed for community mental health.
- The redesign of adult mental health acute and rehabilitation clinical pathways (using the GiRFT approach). This will deliver more modern, sustainable and appropriate recovery pathways, and the design will be undertaken with extensive consultation with patients, staff and wider community.
- Review of Adult Community Mental Health Services. This comprehensive review will ensure services provide the right support at the right time, and where necessary assertively, so that there is no risk of the homicides in Nottinghamshire occurring locally.
- Post-diagnostic dementia support. The offer will be recommissioned and will take account of feedback from Healthwatch consultation.

Strategic Focus:

For 2025/26, the Collaborative's strategic focus will be to:

- Ensure it is ready for the implementation of the Mental Health Bill
- Develop and agree a Mental Health Strategy for the local system. This will take account of the new 10 year NHS strategy and ensure that mental health remains a system priority.
- Review arrangements to ensure they are fit for purpose for the changing operational model for ICBs

15. NHS Trust Collaborations

Theme 15

Where we are now?

- Wye Valley NHS Trust (WVT) has been a full member of The Foundation Trust Group since 2016.
- Worcestershire Acute Trust (WAHT) became a full member of The Foundation Trust Group from July 2023 resulting in a joint Chief Executive and Chair across the four Foundation Group Hospitals.
- From April 2025, both trusts have a joint Acting Chief Executive Officer.
- WAHT and WVT has completed a service sustainability analysis, which influences areas of collaboration between the two trusts. There is continued mutual aid for vulnerable services with WVT being lead provider for dermatology and WAHT for MaxFax. Other areas identified as priority services for collaboration include ophthalmology, haematology and Interventional Radiology.
- WAHT and Herefordshire and Worcestershire Health and Care Trust – A Memorandum of Understanding is in place and a work programme agreed. Current work areas include international nurse recruitment, workforce wellbeing and vaccination, the systemwide stroke pathway and urgent care pathway (including frailty and virtual wards). Practical coordination of services between the two trusts is helped by colocation of the acute trust Single Point of Access team in HWHCT premises alongside their Care Navigation Team.
- WAHT and University Hospitals Birmingham – a range of tertiary services provided for Worcestershire residents including some cancer services, renal services, cardiothoracic and trauma services.
- WAHT and University Hospitals Coventry and Warwickshire – MDT working on clinical services in head & neck cancer, Improvement partner for Virginian Mason methodology.
- WAHT and Birmingham Women's and Children's Hospital- collaborative work around paediatric services and work ongoing to collectively support further delivery of paediatric surgery in-county and the expansion of paediatric High Dependency Care at Worcestershire Royal Hospital.
- South Midlands Pathology Network – board approvals received for LIMs outline business case and SM Pathology network collaborative.
- Continued member West Midlands Cancer Alliance.
- Foundation Group collaboration includes work to consolidate pharmacy aseptic medicines preparation facilities across the Group.
- At Place level in Worcestershire, provider collaborative work also includes services within primary care, with close collaboration managed through the Interface group.
- The West Midlands Mental Health and Learning Disability and Autism Provider Collaborative was informally formed in 2021 bringing together 7 Trusts in the West Midlands, including Herefordshire and Worcestershire Health and Care NHS Trust. The specialist inpatient pathways of forensic, LDA< CAMHS, adult eating disorders and mother and baby services are under this Collaborative arrangement and the collective leadership has also developed a governance structure to work on the greatest challenges in the H and LDA and opportunities to address these through working at scale. This has included supporting local systems (ICSs) to improve population health outcomes, building on best practice and developing a regional approach developing innovative clinical and workforce solutions, horizon scanning to maximise WM PC influence and implementation of changes.

Where next? – Areas of focus

- Shared Executive leadership between Acute Trusts will help to continue to strengthen collaborations during 2025
- Within Worcestershire, it is recognised that there is potential to improve patient pathways through increased collaborative working between the acute and community trust.
- The ICB-led Building a Sustainable Future program has identified key services for collaborative working across the ICS.
- Provider review of areas of opportunity around corporate support functions at Foundation Group, system or Place as appropriate
- Taking forward the review of options for Stroke services across H&W
- Continuing the development of a Pathology Network across the South Midlands

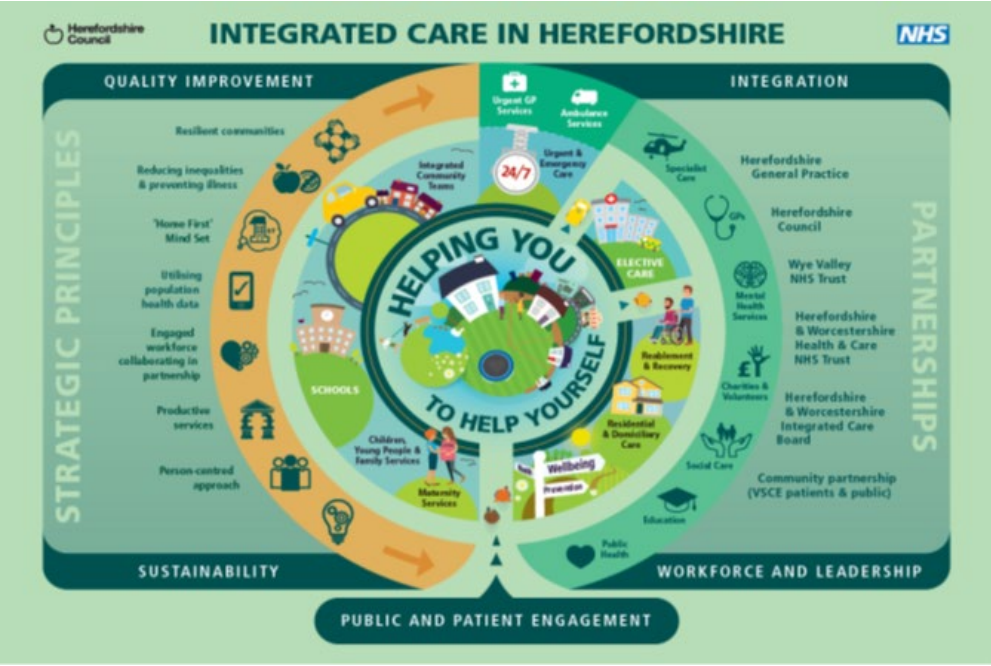
How we will get there? – Development steps

- Stratify provider collaborative arrangements based on service and population needs.
- Progress collaborative working through the Building a Sustainable Future program
- ICB-led methodology for vulnerable services is twofold:
    - At operational level to manage existing or at risk vulnerable clinical services with identified models to support in the short term.
    - Strategically a provider led self-assessment of all clinical services to theme by sustainability / resilience and / or growth domains as part of potential collaborative service model.

16. One Herefordshire Partnership

Theme 16

The One Herefordshire Partnership (1HP) drives the co-ordinated planning and delivery of the Herefordshire health and care system in order to deliver improvements in health and care outcomes through integrated working. 1HP partners share strategic objectives and reviews business cases, provides a forum for discussion on care pathway changes, oversees the Better Care Fund (BCF)and approves the objectives set by the Primary Care networks (PCNs).



Where we are now? What have we delivered in 2024/25

- Making a variety of improvements across the Best Start in Life programme
- Improving the primary/secondary care referral interface with direct access and internal referrals
- Providing improved value for money through the BCF with 22% more D2A purchases in 2024 than in 2023
- Improved collaboration with the Talk Community Healthy Lifestyle Service and delivering Talk Wellbeing Health Checks
- Developed a co-located Community Referral Hub with a SPA and virtual ward, delivering a material increase in WMAS referrals taken from the CAD

Where next? – Areas of focus

1HP 2025/26 priorities will remain as in the previous year.

- **Best Start in Life (HWBB Priority)**
- **Good Mental Wellbeing (HWBB Priority)**
- **Primary/Second Care Interface**
- **Integrated Urgent and Emergency Care**
- **Integrated Neighbourhood Development**
- **Driving Value Through the BCF**
- **Herefordshire Together (supporting VCSE schemes that deliver against 1HP priorities)**

In terms of improvements to outcomes, the partners are finalising a framework based around:

- Prevention and Population Health (HWBB Priorities) including child health, talking therapies and social isolation
- Management of complex community based care, including emergency admission reduction, discharge delay reduction and residential and care home admission reduction
- Improving access to services and early identification, including reduction of elective waiting times and increasing cancer identification

How we will get there? – Development steps

- Develop and agree the outcomes framework that sets out the improvements we will expect to see against the priorities
- Continue to refine the BCF and seek opportunities to improve value for money
- Consider how we might incentivise the urgent and emergency care pathway for general practice in order to prevent acute admissions
- Consider the structure of the partnership in light of the major changes to both the wider NHS structure and local authority boundaries and responsibilities

17. Worcestershire Place Partnership

Theme 17

The Worcestershire system spans many partner organisations and sectors. Whilst many have been working together for years, this is now being extended to deliver even greater collaboration as we strive to fully integrate health, public health and social care.

We recognise the required shift to achieve greater integration and have been working to establish a framework for the culture within which we will work, between key partners, by agreeing and centring on our **shared vision and values** and putting people in our communities at the heart of everything we do. We understand that an **equal partnership** between NHS and health, local government and our VCSE sector is vital, and we have been developing shared health and wellbeing principles as follows:

Together we will:-

- Place equal value and emphasis on the **physical health and mental health** and wellbeing
- **Protect health** and focus on supporting the **conditions for good health**
- **Focus on prevention**; to prevent, reduce or delay need for care and support
- **Improve health disparities** particularly for those who are vulnerable, disadvantaged or living with a disability
- **Listen** to people who use our services and strive to improve, ensuring a **quality experience**
- Deliver **proactive and better coordinated** care to help people to stay healthy and independent**,** based on each person's needs
- Work together in an **evidence-based way** to take to **system wide approaches** to improve health across the life course
- Maximise **shared funding opportunities** to achieve **best value** (including social value)
- Develop and support our **workforce**

District Collaboratives: District Collaboratives bring together statutory health and care services, District Councils, the Voluntary, Community and Social Enterprise (VCSE) and wider partners to deliver against shared priorities with their communities. This is a new way of working and represents a shift in how communities and health and care providers work together. This should see greater local autonomy and resources directed into communities to enable greater control over addressing the underlying causes of ill health through interventions people design for themselves. There is a focus upon building strong, resilient communities, understanding and being able to optimise local assets, whilst articulating gaps and opportunities available to further improve the local offer. We are increasingly seeing that local partnerships are most effective in improving population health and tackling health inequalities.

Where next? – Areas of focus

- Priorities identified by the Worcestershire Health and Wellbeing Board: Good mental health and wellbeing, supported by (1) Healthy living at all ages (2) Safe, thriving and healthy homes, communities and place (3) Quality local jobs and opportunities
- Place based integrated performance report to drive assurance and prioritisation of activities.
- Strong integrated GP leadership across whole county and ensure full support to mature and develop
- Identification and building on local place-based assets to provide foundation for further 'left shift'
- Shared delivery plan across local NHSE Provider Alliance; shared delivery demonstrates maturity of relationship
- Support development and sustainability of VCSE Alliance as an equal partner
- Deliver agreed model of integrated urgent care and frailty action plan, further reducing pressure on ED front door and thereby supporting flow.
- Increasingly looking at shared resources, building on the work of place-based intelligence, engagement and communication cells.
- Support improvements to Stroke pathway to ensure sustainability and high-quality outcomes
- Consider wider integration with other statutory partners eg police, fire

How we will get there? – Development steps

- Developing relationships of trust through working together to deliver place priorities, as listed above.
- Develop systems thinking to enable shared understanding of challenges and solutions across providers.
- Consider implications of adopting Community Paradigm approach and how we can harness local assets to support District Collaborative objectives
- Maximise impact of the reinvigorated Place Leadership, collaboration between HWB and other place-based governance infrastructure to deliver sustainable improvements.

Worcestershire Place Partnership – Progress

The following 3 priorities have been identified and agreed by Worcestershire Place Partnership:

- **Frailty:** move to a systemwide model of care where people identified as living with frailty are proactively and reactively cared for at home, in their local neighbourhoods, and in hospital, by members of the integrated Worcestershire place-based teams.
- **Long Term Conditions:** priority areas of work - heart failure, diabetes and COPD (respiratory).
- **Integrated Neighbourhood Teams/Neighbourhood Health:** prototyping work is progressing in 3 Integrated Neighbourhood Teams Accelerator Sites across Worcestershire. The three sites have identified their priority areas which are to progress proactive care for frail patients in the community (2 sites) and focus on improving the proactive management of diabetes in the community (1 site).

18. Pan system collaboration – The Office of the West Midlands Integrated Care Boards

Theme 18

The six ICBs in the West Midlands are collaborating to form an Office of the West Midlands. NHS Birmingham and Solihull ICB will host the staff performing these functions from 01 April 2023 and staff will transfer to the BSOL ICB in July 2023.

From April 2024 BSOL will also host for the Midlands team supporting all 11 ICBs for the delegated specialised commissioning portfolio.

Herefordshire and Worcestershire ICB will be leading a project on development and delivery of the dental access recovery plan.

The VISION:

Through at scale collaboration and distributive leadership, the Office of WM will add value and benefit to a shared set of common goals and priorities for West Midlands citizens and patients.

Purpose:

The core purpose is to :

- To commission a set of agreed functions at a West Midlands level on behalf of 6 ICBs through shared leadership and joint decision making
- To identify shared priorities and goals and clear projects and work programmes to deliver them
- To bring together in a single host ICB the shared teams and staff supporting the Office of the West Midlands and their ICBs.
- To develop distributive leadership and expertise across an agreed range of functions/teams for the benefit of all ICBs
- To provide a single coherent voice for the West Midlands ICBs where appropriate /a single point of contact/shared voice for change
- To share learning and support improvement across the ICBs
- To achieve best value and efficiency by working at scale where appropriate

Work Programme	Host ICB	Lead CEO
POD / GMaST / Complaints / Secondary Dental – Dental access recovery plan	Herefordshire and Worcestershire	Simon Trickett
Operating Model Development	Coventry and Warwickshire	Phil Johns
Collaboratives		
Integrated Staff Hub and OWN hosting	Birmingham and Solihulll	David Melbourne
Specialised commissioning		
Commissioning Support Service Review	Shropshire, Telford and Wrekin	Simon Whitehouse
NHS 111/999 Services	Black Country	Mark Axcell
West Midlands Combined Authority		
Immunisations and Vaccinations	Staffordshire and Stoke	Peter Axon

NHS
Office of the West Midlands
Partnership of Integrated Care Boards

Herefordshire and Worcestershire Integrated Care System

Joint forward plan – 25/26

Appendix 3: Statutory Requirements checklist

This section includes a **cross reference to the two Health and Wellbeing strategies** for Herefordshire and Worcestershire, to identify the extent to which the JFP addresses the priorities set out therein.

The section also identifies which section of the JPF (or other documents) **show how the ICB will meet its statutory duties** as laid out in Appendix 2 of the mandatory guidance.

Version: 2025 Refresh, May 2025

Mapping to the Herefordshire Health and Wellbeing Strategy

Herefordshire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this
Core Priority Areas	**Best Start in Life For Children**	• **Appendix 1, Theme 1** (Maternity and Neo-natal Care), **Appendix 1, Theme 2** (Early years, children and becoming an adult): The core focus of these two areas is directly aligned to the Health and Wellbeing priority or providing the Best Start in Life for Children.
	Good Mental Wellbeing throughout life	• **Appendix 1, Theme 6** (Learning Disability and Autism Care), **Appendix 1, Theme 7** (Mental Health and Wellbeing), **Appendix 2, Theme 15** (Mental Health Collaborative): The core focus of these three areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life.
Supporting Priorities	**Improving access to local services**	• **Appendix 1, All Themes** – Improving access to core NHS services is a priority running through the work programmes of all core themes, including through the development of virtual wards and an overall ambition to invest more in preventative activities and to provide best value healthcare in the right setting. • **Appendix 1, Themes 11, 12 and 13** (Primary Care Themes): Improving access for primary care services will be a specific focus through implementation of the National Access Recovery Plan. Furthermore, the ICB is responsible for commissioning Dental Services from April '23 and is prioritising work to improve access, particularly for those with greatest need. • **Appendix 2, Theme 11** (Digital data and technology): A key theme of our digital strategy is to enable greater access to service through digital platforms and to support the development of virtual wards.
	Support people to live and age well	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, All Themes** – Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities • **Appendix 2, Theme 5 (Prevention):** This sets out how NHS services will work to support local prevention strategies through specific interventions.
	Good work for everyone	• **Main Document, Workforce Section (page 14)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.
	Support those with complex vulnerabilities	• **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 6** (Learning Disability and Autism Care), These sections outline out work to support people with complex needs. Other services, particularly Primary Care also tailor their approaches to support complex needs. • **Appendix 2, Theme 4** (Health Inequalities), **Appendix 2 Theme 6** (Personalised Care), **Appendix 2 Theme 8** (Commitment to carers), **Appendix 2, Theme 9** (Support to veteran health), **Appendix 2, Theme 10** (Addressing the needs of victims of abuse): These sections outline specific local actions that will ensure that NHS partners support those people with complex vulnerabilities.
	Improve housing, reduce homelessness	• **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes.
	Reduce Carbon Footprint	• **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.

Mapping to the Worcestershire Health and Wellbeing Strategy

Worcestershire Health and Wellbeing Priorities		Where and How the Joint Forward Plan Addresses this	
Core Priority: Good Mental Health and Wellbeing	**Whole Population Approach**	• **Appendix 2, Theme 17** (Worcestershire Place Partnership): This section outlines how partners will work together at county and district collaborative level to put integration at the heart of our service delivery.	The core focus of these areas is directly aligned to the Health and Wellbeing priority of supporting Good Mental Wellbeing throughout life: • **Appendix 1, Theme 6** (Learning Disability and Autism Care) • **Appendix 1, Theme 7** (Mental Health and Wellbeing) • **Appendix 2, Theme 14** (Mental Health Collaborative)
	Align and Support Local Strategies	• **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 11** (Digital, Data and Technology):	
	Commitment to reducing health inequalities	• **Appendix 2, Theme 4** (Health Inequalities), • **Main Document, Population Health Management section (p27)**	
	Engage local communities over the lifetime of the strategy	• **Appendix 2, Theme 7** (Working with Communities) • **Appendix 2, Theme 8** (Commitment to Carers)	
Supporting Priorities	**Healthy Living at All Ages**	• **Main Document, overall theme:** The focus on upstream investment in prevention and providing best value care in the right setting emphasises the central focus of this plan on supporting people to live and age well. • **Appendix 1, Theme 2** (Early years, children and becoming an adult), **Appendix 1, Theme 4** (Frailty), **Appendix 1, Theme 8** (Long term conditions): Improved physical and mental wellbeing is fundamental to all themes in appendix 1, recognising the intent of the overall strategy in the long term to reduce demand on services by investing more time, money and focus on preventative activities. • **Appendix 2, Theme 5** (Prevention)**:** This sets out how NHS services will work to support local prevention strategies through specific interventions.	
	Quality local jobs and opportunities	• **Main Document, Workforce Section (page 14)** – As a direct employer of more than 20,000 people across the ICS area, the NHS has a direct role in providing good work for everyone. The plan sets out our approach to filling our workforce gaps by attracting more people to work in the NHS, particularly in roles that are perfect for local people such as care assistants who can go onto develop a professional career locally.	
	Safe, thriving and healthy communities and places	• **Appendix 2, Theme 7** (Working with Communities): This section outlines how we will listen to our communities and use this intelligence to make sure we focus on doing the right things. • **Main Document, Population Health Management section (page 25),** NHS Partners recognise the inextricable link between poor housing / homelessness and poor health outcomes. A core focus of our population health management work will be to identify specific individuals whose health outcomes are impacted in this way and to implement targeted interventions to improve their outcomes. • **Appendix 2, Theme 13** (Greener NHS), provides an overview of how local NHS partners will contribute to improving the environment and reducing the NHS carbon footprint.	

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Describing the health services for which the ICB proposes to make arrangements.	**Chief Executive**	**Appendix 1, Core Areas of Service** provides an overview of the range of services that the ICB is making arrangements for. The ICB Operating Model and System Development Plan provides more detail on specific areas to demonstrate how services are organised and developed.
Duty to promote integration	**Executive Director of Strategy, Health Inequalities and Integration**	The duty to promote integration is inherent to the **design of the whole local system, as demonstrated in**: Integrated Care Strategy, JPF Main Document, JFP **Appendix 1 (Core areas of focus) and Appendix 2 (Enablers)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. Additionally, there are a myriad of other documents that outline this, including: ICB Operating Model and Organisational Structure, Better Care Fund, ICB Contribution to the Health and Wellbeing Strategies, Place Partnerships and HIPP Board, Fragile Services Framework, Clinical and Care Professional Leadership Networks
Duty to have regard to the wider effect of decisions	**Executive Director of Strategy, Health Inequalities and Integration** **Director of Corporate Services**	**The Four Pillars of Integrated Care Systems**, built up from the Triple Aim were the **basis of the strategic planning framework** that was used to develop the ICS Strategy, the Joint Forward Plan and the linkages they have to the Health and Wellbeing Strategies. The ICB Governance Design, as set out in the ICB Constitution and Governance Handbooks outlines how the Governance Structure of the ICB is designed to ensure that the ICB meets its duty to have regard to the wider effect of its decisions. The main committee for ensuring this happens is the ICB Quality, Resources and Delivery (QRD) Committee, which is supported by the ICB Quality Delivery and Oversight of System Group (QDOS), which pulls together the activities of all the ICS Programme Boards and Forums.
Financial duties	**Chief Finance Officer**	**Main Document, pages 18 - 19** outline the 25/26 Financial Plan. It also outlines arrangements for developing a Medium-Term Financial Strategy, which will be used to set out the plan for returning the system to financial balance. The ICS Finance Forum (chaired by Wye Valley NHS Trust Chairman) is the strategic group that bring finance professionals together to build consensus around the financial plan.
Implementing any Joint Local Health and Wellbeing Strategy	**Executive Director of Strategy, Health Inequalities and Integration**	**The JFP has been developed to specifically demonstrate how NHS partners will contribute to the delivery** of the Integrated Care Strategy and the two Joint Local Health and Wellbeing Strategies. The overall approach to the development of the Integrated Care Strategy and the Operating Model for the system (build around place) has been created to ensure alignment between all strategic plans.
Duty to Improve quality of services	**Executive Chief Nurse**	**Appendix 2, Theme 1 (Quality, Safety and Patient Experience)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to reduce inequalities	**Executive Director of Strategy, Health Inequalities and Integration**	**Appendix 2, Theme 4 (Health Inequalities) and Theme 5 (Prevention)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty to promote the involvement of each patient **Duty to involve the public**	**Director of Operations – System Programmes** **Director of Communications & Engagements**	**Appendix 2, Theme 6 (Personalised Care)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Appendix 2, Theme 7 (Working with Communities)** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas. **Main Document, Population Health Management (page 25),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty as to patient choice	**Managing Director**	**Patient choice is a key focus for the ICB.** There is a plan for an accreditation process for new providers in development that will be ready in late 2023. Addition, there will be revised patient information to promote choice and support patients decisions. Progress against Patient Choice will be reported through the Elective, Diagnostic and Cancer Programme Board through the SRO for patient choice.
Duty to obtain appropriate advice	**Chief Executive, through individual Executive Leads**	**There are a myriad of different arrangements** in place for ensuring that the ICB obtains relevant advice when making decisions. This includes arrangements with a legal firm to provide legal advice, and MOU with public health to provide support for undertaking needs assessments, arrangements with the CSU for provide procurement advice etc.

Mapping of ICB duties to the Joint Forward Plan

The JFP must set out:	Executive Lead	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Duty to promote innovation	**Chief Medical Officer & Director of Workforce and Digital**	The Chief Medical Officer is responsible for coordinating work across the ICB for promoting Innovation and the ICB employs and Officer within the Digital Team to support this work. **Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Duty in respect of research	**Chief Medical Officer / LTC and Personalised Care Lead**	
Duty to promote education and training	**Chief People Officer**	**Main Document Pages 14 to 17** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Duty as to climate change	**Executive Director of Strategy, Health Inequalities and Integration**	**Appendix 2, Theme 13 (Greener NHS)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of children and young people	**Director of Operations – System Programmes**	**Appendix 1, Theme 2 (Early Years, children and becoming an adult)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Addressing the particular needs of victims of abuse	**The Chief Nursing Officer**	**Appendix 2, Theme 10 (Addressing the specific needs of victims of abuse)** The Director of Partnerships and Health Inequalities and Chief Nursing Officer is coordinating work to link in with external partners to ensure that the ICB fulfils across these areas, in addition to the services in place across Herefordshire and Worcestershire.

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Other Recommended Content	Description of approach, governance arrangements and links to other evidence and references to demonstrate the ICB duty.
Workforce	**Main Document Pages 14 to 17** set out the key facets of the ICS System People Plan, which includes details and references to further information on the ICS Academy.
Performance	**Main Document Page 13** sets out the specific short term performance trajectories that are being aimed for. Longer term trajectories will be developed as part of the new approach to Strategic and Operational Planning and will be incorporated in the first refresh of the JFP.
Digital / Data	**Appendix 2, Theme 11 (Digital Data and Technology)**, provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Estates	**The System Development Plan and ICS Operating Model documents** outline more detail on how the ICB and System Partners meet their statutory requirements in these areas.
Procurement / Supply Chain	
Population Health Management	**Main Document, Population Health Management (page 25),** provides an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
System Development	**Appendix 2, Theme 14 to 18** provide an overview of the approach and links to other documents that demonstrate how the ICB and system partners meet their statutory requirements in these areas.
Supporting Wider Social & Economic Development	The ICB fulfils its statutory duties through **membership of the Health and Wellbeing Boards** and engagement and contribution to the two Joint Local Health and Wellbeing Strategies, which both have a focus on tackling the wider determinants to health.
Veteran's Health	**Appendix 2, Theme 9** for detail on our approach to supporting veteran's health

AGENDA ITEM 10

Herefordshire Council

Title of report: Update to the board on the Good Mental Wellbeing throughout lifetime Implementation Plan

Meeting: Health and Wellbeing Board

Meeting date: Monday 9 June 20255

Report by: Public Health Lead: Good Mental Health

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

To provide an update on the progress of the implementation plan for the board's strategic priority of 'Good Mental Wellbeing (GMW) throughout Lifetime', attached as Appendix 1.

Recommendation(s)

That the board considers the report and appendices and notes the progress to date on the Good Mental Wellbeing (GMW) priority.

Alternative options

1. The board could choose not to adopt and acknowledge the challenges to date.

Key considerations

2. The report highlights the progress and challenges in the delivery of the GMW implementation.

3. Strategic leads from internal and partnership organisations are responsible for leading on specific areas in the plan and report quarterly to the Adult Better Mental Health partnership board on progress to date against action.

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

4. The Mental Health Needs Assessment (MHNA) epidemiological findings to date have been considered in the development of the GMW implementation plan. This includes findings from the community wellbeing survey and children and young people survey.

5. The outcomes dashboard (attached as Appendix 2) has been developed with the proposed outcome trajectories for the next few years. The majority of outcomes are taken from the Public Health outcomes framework, which allows for regional and national comparisons, using a RAG rating. However, there is time delay for some of this nationally reported data meaning it is not always current.

6. The most recent health profile data for Herefordshire shows a red RAG rating against the following indicator 'Hospital admissions as a result of self-harm (10-14 years)'. We are currently exploring this data in more detail with our partners.

7. Amber indicators (Herefordshire's performance is not significantly different from England) relate to our suicide rate, emergency admissions for self-harm and smoking prevalence in adults with long term mental health condition.

8. Green areas within the plan include premature mortality in adults with severe mental illness; proportion of clients entering drug treatment identified as having a mental health treatment need, who were receiving treatment for their mental health.

9. Completed actions include becoming a signatory for the prevention concordat for better mental health, development of the local suicide strategy and implementing a local suicide audit group.

10. Whilst the outcomes dashboard provides reliable and robust data, there are other measures and data sources to consider which provide more localised, regular and detailed community information, for example the community wellbeing survey and the children and young people survey.

11. After consulting with partners additional service data and local survey data is being explored and expected to be included to inform real-time information and provide more localised intelligence.

12. As we go into year two of the implementation plan, we are mindful of the need to review, revise and develop new actions to ensure we are effectively meeting our ambitions. We are bringing stakeholders together in early July to review our actions, identify new actions and agree ways of working to take forward the next iteration of the implementation plan covering 2025/27.

13. The mental health needs assessment will help shape the plan and the suicide prevention strategy commitments will also be supported through the action plan.

Community impact

14. The purpose of the GMW implementation plan is to specify the actions and activity that will improve the wellbeing of Herefordshire residents. One of the key principles upon which the Joint Local Health and Wellbeing Strategy (JLHWBS) was developed was that of involving our communities in any actions that are proposed which will be enhanced by the Herefordshire Together initiative. The plan will also support the ambitions of the Council plan.

Environmental impact

15. There are no general implications for the environment arising from this report; however the plan includes support to increase physical activity including through active travel which may have a positive environmental benefit.

Equality duty

16. 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.

17. The principles of equality and the reversal of health inequalities are key strands of the plan. The MHNA provides an assessment of our system need, highlights priority groups and makes recommendations for action. In addition, our ongoing engagement with a wide range of partners will continue to support this. An Equality Impact Assessment was completed in December 2024.

18. To be effective in delivering good population outcomes and helping those most in need, the plan calls for intervention by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale.

Resource implications

19. There are no resource implications associated with this report. However, the resource implications of any recommendations made by the board will need to be considered by the responsible party in response to those recommendations or subsequent decisions.

Legal implications

20. In accordance with Health and Social Care Act 2012, 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.

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

Risk management

22. There are no risk implications identified emerging from the recommendations in this report. However, the delivery of these plans require system and collaborative working across all partners. Where possible, we have identified where activity is funded, but given the fiscal position across partners these will need to be kept under review.

Consultees

23. Consultation on action planning and setting targets undertaken with the Adult Better Mental Health Partnership Board and 1HP and action leads identified.

Appendices

Appendix 1 GMW Implementation Plan 2023-2025

Appendix 2 GMW Outcomes Dashboard

Appendix 3 Healthy Lifestyles group background information

Background papers

None identified.

Glossary of terms, abbreviations and acronyms used in this report

ABMHPB	Adult Better Mental Health Partnership Board
GMW	Good Mental Wellbeing
JLHWBS	Joint Local Health and Wellbeing Strategy
1HP	One Herefordshire Partnership
MHNA	Mental Health Needs Assessment
RAG	Red, Amber, Green

Herefordshire Council

Appendix 1

Good Mental Wellbeing throughout lifetime
Implementation Plan 2023-2025

This draft implementation plan has been developed through engagement with the Adult Better Mental Health Partnership, Health & wellbeing board partners, and the voluntary sector. In addition, the plan considers the Best Start in Life (BSiL) delivery plan, the Herefordshire children and young people's emotional health and wellbeing plan, and H&W mental health collaborative plans. The plan will continue to evolve and develop throughout its life course.

Cross-cutting, collaborative actions, required to underpin all transformational developments:

Actions	Review date	Responsible Service(s)	Indicators/measurements	RAG	Progress
A. Sign up to the National 'Prevention Concordat for Better Mental Health' initiative	June 2025	ABMHPB	Approved as signatory of the Concordat Action plan developed Collaborative actions delivered		Regional review panel taking place 1st May Approved as signatories May 2025
B. Deliver a Mental Health needs assessment	March 2025	Public health	Completed needs assessment		Awaiting publication
C. Create a collaborative 12 month localised comms plan	March 2025	Herefordshire Council	Completed comms plan/ No. of delivered comms		12 month plan developed in collaboration with internal HC comms and aligned with PA comms (WMH day & suicide prev) Comms messaging through Healthy schools

Ambition 1: People feel satisfied with life and have a positive sense of personal wellbeing **Outcome 1.1: Improve individual good mental health and resilience**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
1.1.1 Increase uptake of Mental Health First Aid training in the community	July 2024	Talk Community	No. educational staff completing MHFA training Increase awareness of MH		MHFA (2 day training) – 72 people MH champion (1 day) - 168 MH awareness (½ day) – 15 Last training offered July
1.1.2 Increase uptake of Making Every Contact Count (MECC) training and Solihull offer	Dec 2024	Public Health	No. completing MECC training/ No.taking up Solihull offer Increase knowledge of healthy lifestyle information and signposting support Increase workforce and parental knowledge		MECC e-learning open to all Solihull continued to deliver training, train the trainer and across educational settings Roll out to library staff
1.1.3 Increase completion rate of Making Every Contact Count e-learning (incl. focus on 55+, MH services staff)	Dec 2024	All	No. MH services staff completing MECC e-learning No. people completing MECC e-learning		E-learning link shared across ABMHPB partners to increase reach into MH services Link to frailty plan
1.1.4 Ensure 5 ways to wellbeing is integrated primary care networks and associated care pathways (incl. Frailty focus)	Dec 2024	General practice	Comms to PCNs % residents in contact with family, friends, neighbours % patients signposted to community support		PC representation on BMHPB and discussions underway with PCN areas Link to frailty plan
1.1.5 Support the activity of the Physical activity	March 2025	Public Health	Attendance at Physical activity strategy steering group meetings		PH representation at PA strategy group and PA action plan has been refreshed (July

Ambition 1: People feel satisfied with life and have a positive sense of personal wellbeing **Outcome 1.1: Improve individual good mental health and resilience**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
strategy steering group to enhance wellbeing offer			% physically active adults % physically active children		2024) development includes MW Comms plans coordinated
1.1.6 Support employers to develop a workplace mental wellbeing support offer	Dec 2025	Public health Stride (school settings)	No. employers/ workplaces supported No. employees taking up support offers/engaging with resources		Suicide prevention officer Worcs link CVD workplace NHS Health checks commenced, holistic support offer
1.1.7 Peer mentoring in secondary schools	Dec 2024	Talk Community	No. Schools engaged No. Training sessions delivered Podcast developed Staff CPD delivered		Linked to Healthy schools roll out
1.1.8 Cultural programming work		Culture and leisure lead	5 ways to wellbeing evaluated		Our place delivery

Ambition 1: People feel satisfied with life and have a positive sense of personal wellbeing **Outcome 1.2: Reduce the rates of self-harm amongst young people**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
1.2.1 Distribute Mental wellbeing PSHE resource toolkits to schools	ongoing	CLD	No. schools receiving/ accessing resource toolkits 40 schools represented at PSHE day		Toolkit developed Website launched Linked in to our Healthy tots & Healthy schools programme to continue delivery
1.2.2 Deliver targeted physical activity interventions to improve the mental wellbeing of children and young people e.g. Active Families, Climbing for confidence, school nursing support	July 2026	Stride Active, Wye Valley Trust Culture & Leisure lead	No. interventions delivered/ No. CYP participating CYP physical activity levels Qualitative feedback and impact		PH awarded contract for physical activity intervention Aug 2024-Aug 2026 Our place project delivery
1.2.3 MIND peer support pilot delivery for secondary age pupils	July 2025	MIND/Public Health	No.sessions delivered No. families engaged		1 year pilot complete PH funded further 12 months until July 2025, extend rural offer and school collaboration offer

Ambition 1: People feel satisfied with life and have a positive sense of personal wellbeing **Outcome 1.3: Reduce the rates of suicide**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
1.3.1 Refresh the local suicide strategy	April 2025	Public Health	Completed strategy Stakeholder engagement		Strategy finalised, currently finalsing design

Ambition 1: People feel satisfied with life and have a positive sense of personal wellbeing **Outcome 1.3: Reduce the rates of suicide**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
1.3.2 Implement and roll-out a local Real time suicide surveillance system	ongoing	Commissioning/Public Health	RTSSS in place, partnerships developing		RTSS in place Developing/increasing partnerships within system
1.3.3 Raise awareness of the issue of suicide, its causes and sources of help to those affected by either feeling suicidal or bereaved as a result of suicide.	ongoing	H&W suicide prevention team	No. distributed resources Signposting information Rate of Suicides (PHOF)		The Life Lines campaign and a stand was set up at Plough Lane for World Suicide Prevention Day Successful in our application for the Baton of Hope 2025, which we will host on Thursday 2nd October 2025 Regular HT article provided
1.3.4 Increase uptake of bereaved by suicide support	ongoing	All partners	No. people bereaved by suicide accessing support PH input into new spec		Service at capacity, Attendance at BBS meetings, Development of materials for Healthy schools Close working with BBS and link created from RTSSS, New service commissioning 2025
1.3.5 Implementation of a 'safety plan' tool	Jan 2026	Suicide prevention officer and partners	No. of services using joint 'safety plan' tool Quant & Qual user feedback		Tool created Sharing with safeguarding board early Nov Tool in place
1.3.6 Create a Suicide Audit group	Sept 2024	Public Health	No.group meetings		TofR developed & partner engagement Suicide audit group meets every quarter to review data, 3 meetings so far

Ambition 2: Individuals and families are able to access appropriate Mental Health information and services Outcome 2.1: Improvement in access to Mental Health advice and information					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
2.1.1 Undertake a Children & Young People survey	Jan 2025	Herefordshire Council / Business Intelligence	Survey results		C&YP survey finalised C&YP survey live May, survey completed Sept,
2.1.2 Undertake a Community Wellbeing survey	Survey commence Spring 2026	Public health	Survey results		Scoping underway for survey 2026
2.1.3 Complete the recommissioning of the Talk Community Directory and ensure inclusion of dedicated mental health advice and information	April 2024	Herefordshire council Dementia partnership	Updated Talk Community Directory Dementia RoadMap Dedicated mental health advice and information section		Recommissioning complete Dementia RoadMap resource created TC MH information pages to align with MHNA service mapping
2.1.4 Ensure all schools are aware of and consider applying for the MH lead training grant	July 2025	All	No. applications for the MH lead training grant No. people who have completed MH lead training		78% schools taken up grant Information continues to be shared through various channels
2.1.5 Raise awareness of interventions that address rural isolation and loneliness	Dec 2025	Talk Community	% residents (18+) who say they feel lonely often or always; % of residents in contact with family, friends or neighbours		Included in MW 12 month comms plan Information on Talk Community Herefordshire Together grants distributed Hereford Now article focus Dec 2024
2.1.6 Improve access to advice & information for those with LD	April 2025	Partnership	Uptake of MH services for those with LD		More work to be undertaken, initial discussions, exploring carried out Lumi-nova LD exploration

Ambition 2: Individuals and families are able to access appropriate Mental Health information and services **Outcome 2.2: Increase access to Mental Health services**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
2.2.1 Scope prevalence of Neurodivergent CYP in H&W to understand current and future needs	Dec 2024	ICB	Pathway agreed		Neurodivergent programme to increase capacity & support, new service funding for 0-25 start march 2026 Increased range of options for assessments
2.2.2 Increase provision and uptake of a countywide peer support offer in collaboration with partners	Dec 2025	All	No. of peer support offers		Discussions undertaken, more work required to map offer. There has been some new peer support offers through partners e.g. Stride peer support
2.2.3 Ensure effective signposting to perinatal MH services	June 2025	ICB	No. referrals to perinatal MH services		Discussion with perinatal team, part of MHNA PH part of perinatal H&WB group
2.2.4 Implement relevant actions from C&YP emotional health and wellbeing transformation plan	April 2025	C&YP emotional health and wellbeing group	Review implementation progress of transformation plan actions Ongoing link		Meeting re-implemented Luma Nova implementation introduction of the 0-25 Early Intervention and Preventative Mental Health Service. Objectives 2,3,5 & 6 progressing as planned. Objectives 4 and 8 progressing but delayed. Progress on objectives 1 and 7 unclear – to form part of review of plan to ensure greater clarity going forward.
2.2.5 Mental Health screening outreach for farming communities	June 2025	Talk Wellbeing	No. people referred to talking therapies No. take up screening		Talk wellbeing approach Workplace health (OHID funds) project implemented VCSE offer We are farming minds offer

Ambition 2: Individuals and families are able to access appropriate Mental Health information and services Outcome 2.2: Increase access to Mental Health services					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
2.2.6 Improve access to advice, information and support for veterans	November 2025	Defence Medical Welfare Service Royal British Legion Admiral Nurse Service	No. people supported by DMWS No. of people supported RBL AN Service Help for heroes offer		Improved experiences of healthcare and to support recovery from illness Help veterans and their families to access support in their local area Royal British Legion Admiral Nurse service offers specialist support and advice to families caring for people living with dementia

Ambition 2: Individuals and families are able to access appropriate Mental Health information and services Outcome 2.3: Improve the physical health of individuals with mental illness					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
2.3.1 Increase uptake of physical health checks among those living with serious mental illness (and reduce variation) ensuring appropriate signposting and provision of support to access services	Dec 2026	HLTS Health check provider	% adults with SMI with completed physical health checks		HLTS support for Oakhouse & 27a Outreach pilot ongoing

Ambition 2: Individuals and families are able to access appropriate Mental Health information and services **Outcome 2.3: Improve the physical health of individuals with mental illness**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
2.3.2 Widen the smoking cessation offer and ensure there are close links between providers of MH services and stop smoking services.	Dec 2026	Public Health	% people with a MH condition who smoke/engage services/quit attempt and successfully quit		HLTS new service funding in place Dedicated service offer developed Wellbeing question asked upon assessment
2.3.3 Pilot physical activity interventions for people living with dementia to enable them to get physically active and socialise	June 2025	Public Health/Halo & Herefordshire Dementia Partnership	No. pilot physical activity interventions No. people living with dementia participating in pilots		Pilot completed in Hereford and oversubscribed Further funding of new programmes approved to extend out of city
2.3.4 Review referral management between teams to reduce gap in eligibility and ensure smooth transitions	June 2025 Supported in part by MHNA	Public Health/Service providers MEAM	Referral management review		Referral form for breaking the cycle created Partnership in place (TP &MHNT) Still work to be done around MHNT rejections TC connect referral platform roll-out

Ambition 3: People feel safe from harm in their community **Outcome 3.1: Increase Community Mental Health Support**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
3.1.1 Produce and implement a Comms plan aimed at reducing Mental Health stigma	MH Coms plan developed March 2024	All Comms	Completed Comms plan No. of delivered Comms		12 month comms plan developed, including focus on loneliness, stigma and wellbeing
3.1.2 Pilot Mental Health support in different settings when out of hours	Dec 2026	Community organisations	4 ladies night sessions Monthly well space session		Ladies night ongoing Well space merging with ladies night
3.1.3 Implement relevant actions from BSiL implementation plan	Dec 2024	BSiL / Public Health link	Review implementation progress of transformation plan actions		Continue to liaise with BSiL lead and overlay plans

Ambition 3: People feel safe from harm in their community **Outcome 3.2: Improve partnership working**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
3.2.1 Undertake a review of Talk Community	April 2024	Herefordshire Council	Completed Talk Community review		Review complete
3.2.2 Deliver a range of initiatives through the Safer Communities Fund to support early help and	June 2024	Herefordshire Council Police and Crime	Increase in level 2 early help support How safe or unsafe do people feel when outside in		Safer community initiatives delivered

Ambition 3: People feel safe from harm in their community **Outcome 3.2: Improve partnership working**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
tackle the root causes of crime		Commissioner	their local area after dark? (Community Wellbeing survey)		Linked in to Police rep, next phase of delivery underway (Leominster)
3.2.3 Continue to review approach of the 'most appropriate agency' policy across organisations to deal with problems or concerns	Policy development Dec 2026	ICB	Review and implementation of 'most appropriate agency' policy		Complete
3.2.4 Deliver the priorities of the community safety partnership to keep people safe from harm e.g. violence against women, domestic abuse	Jan 2025	Community Safety Partnership	Community Safety Strategic Assessments		Ongoing - Priorities delivered as held by CSP

Ambition 3: Individuals and families are able to access appropriate Mental Health information and services **Outcome 3.3 : Improvements to surroundings**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**Resource**	**Action targets**
3.3.1 Create a tool which allows policymakers to examine impact of their proposals decision making on mental health	Dec 2026	Public Health / planning	HIA of Local plan HIA framework in place		Updated national planning policy produced. Local approach now approved

Ambition 4: People feel connected in their communities **Outcome 4.1: Increase access and knowledge of community support**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
4.1.1 Invest £75,000 into a community solutions initiatives to create meaningful connections for people to improve their emotional wellbeing	January 2024	Better Mental Health Partnership Children and Young People Partnership	Wellbeing Community networks		Herefordshire together, Grants live (Jan) Grants allocated (April)
4.1.2 Support the youth officer pilot support within diabetes/ epilepsy WVT service	June 2024	WVT (Mark Weston)	No. patients engaged		Recruited to posts, pilot delivery underway, 33 referrals, 1:1 and group sessions underway
4.1.3 Improve signposting and awareness of local community groups (e.g. support groups, activity groups, clubs) via different channels (e.g. social prescribers, town notice boards	December 2025	All	No. people participating in local community groups No. Comms % residents who give unpaid help to any group(s), club(s) % CYP who took part in some form of volunteering outside school/college		Ongoing – Talk community, campaigns/promotions

Ambition 4: People feel connected in their communities Outcome 4.2: Reduce loneliness & social isolation					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
4.2.1 Promote volunteering opportunities available via Herefordshire Wellbeing Ambassadors and Strong Young Minds Champions	December 2024	Community organisations	% residents who give unpaid help to any group(s), club(s) % CYP who took part in some form of volunteering outside school/college		Review current offer
4.2.2 Continue to support the health trainers, wellbeing teams and talk wellbeing to develop community activity and link people into activities	December 2025	Healthy Lifestyle trainer service, Talk wellbeing and PCN wellbeing teams	No. health trainers No. people referred into activities Health trainer feedback		Services currently being delivered
4.2.3 Support the creation of activities and initiatives that enable people to connect with nature and greenspace to improve their wellbeing	December 2025	All	No. Comms promoting local designated wildlife sites/ visits/foot traffic to wildlife sites No.activities available CYP wellbeing scores on the Stirling Children's wellbeing scale (CYP QoL survey)		Herefordshire together grants delivered PA strategy and campaign plan support and collaboration with HWT activity underway Continue to promote activity
4.2.4 Support local befriending schemes to reduce loneliness & social isolation	December 2025	Talk community	No. people participating Proportion of residents who say they feel lonely often or always; Percentage residents in contact with family, friends or neighbours most days		Campaigns/promotion Herefordshire together grant awards Talk Community grants Engaging with primary care

Ambition 4: People feel connected in their communities Outcome 4.2: Reduce loneliness & social isolation					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**RAG**	**Progress**
4.2.5 Implement Rambler wellbeing walks programme	Sept 2025	Public Health	No. Walks registered No. walk leaders		Toolkit purchased, training underway Programme implementation ongoing and website building
4.2.6 Support Rotherwas historic & nature walks	December 2024	Rotherwasth enandnow historic walks Nature walks	Number of walks Number of participants		QR codes in place around Rotherwas to enable self-guided walks by Dec 2024; programme of walks undertaken between April and Dec 2024

Ambition 4: People feel connected in their communities Outcome 4.3: Increase community activity offer					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**Resource**	**Action targets**
4.3.1 Continue to invest in the children and young people's community eating disorder team	June 2024	ICB	No. patients engaged Healthy eating and drinking data (CYP QoL survey)		Investment has continued within CYP ED community services.
4.3.2 Support the Sustainable Food Places approach and the opportunities created by 'food'	December 2024	Public Health	Review implementation of plans		Bronze award achieved Action plan for silver award ongoing
4.3.3 Increase volunteering opportunities	December 2025	All	No. of volunteering opportunities		Herefordshire together grants support this. Ongoing

Ambition 4: People feel connected in their communities **Outcome 4.3: Increase community activity offer**					
Actions	**Target/review date**	**Responsible Service(s) and reporting leads**	**Indicators/measurements**	**Resource**	**Action targets**
4.3.4 Promote and develop existing activities around arts and culture as part of the national creative health initiative	December 2025	Public Health	Leisure and physical activity data (CYP QoL survey)		Herefordshire together grants awarded. Hereford art trail Public Health engagement with leisure
4.3.5 Personalised Support for older people incl. those with complex needs	Dec 2024	Herefordshire Dementia partnership	No. activities for older people with complex needs		Continue to enhance community wellbeing resources to support older people with complex needs including people affected by dementia: 5 Meeting Centres across Herefordshire by June 2025 6 Memory Cafes by June 2025 Increase network of CRISP and Singing for the Brain across the county

RAG Rating Key					
	Not started	On track	Some issues / delay	Attention required / at risk	Complete

Herefordshire Council

Appendix 2

Good Mental Wellbeing throughout lifetime priority (Outcomes dashboard)

Green indicators: Significantly better than England average at the start of the strategy

Outcome Indicator (s)	Data Source	Herefordshire Baseline -year	Herefordshire Baseline	Region Baseline	England Baseline	Herefordshire-2 years since the start of the strategy
Premature mortality in adults with severe mental illness (SMI) (rate per 100,000)	Fingertips - Mental Health Services Data Set (MHSDS)	2020 /22	79.3	110.7	103.6	82.7
The proportion of clients entering drug treatment identified as having a mental health treatment need, who were receiving treatment for their mental health.	Fingertips – National Drug Treatment Monitoring System	2020/21	80.4	67.7	71.0	65.1
Social Isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs)	Fingertips - ASCOF	2022/23	53.2	47.1	44.4	TBC
4.2e Social Isolation: percentage of adult social care users who have as much social contact as they would like (65+ yrs)	Fingertips - ASCOF	2022/23	51.0	44.6	41.5	TBC

Amber indicators: No significant difference with England average at the start of the strategy

Outcome Indicator (s)	Data Source	Herefordshire Baseline -year	Herefordshire Baseline	Region Baseline	England Baseline	Herefordshire- 2 years since the start of the strategy
Suicide rate -all persons (per 100.000)	Fingertips – ONS data	2020/2022	11.7	10.7	10.3	10.9 (2021-2023)
Hospital admissions as a result of self-harm 15-19 years (crude rate- per 100.000)	Fingertips	2022/2023	538		468.2	TBC
Emergency Hospital Admissions for Intentional Self-Harm – all ages rate per 100.000)	Fingertips – HES	2022/2023	95.4	120.2	126.3	125.4
Smoking prevalence in adults with a long-term mental health condition (18+)	Fingertips - GPPS	2022/23	27.8%	24.6	25.1	Next release- TBC
The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health	Fingertips - National drug treatment monitoring system	2021/22	85%	83.4	83.3	82.7%

Proportion of adult in contact with secondary mental health services who live in stable and appropriate accommodation	Fingertips - ASCOF	2020/21	58%	48	58	Next release date-2025
4.2c Social Isolation: percentage of adult carers who have as much social contact as they would like (65+ yrs)	Fingertips - ASCOF	2021/22	32.4	30.3	28.8	Next release date-2025
Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs)	Fingertips - ASCOF	2021/22	27.7	29.4	28.0	28.0

Red indicators: Significantly worse than the England average at the start of the strategy

Outcome Indicator (s)	Data Source	Herefordshire Baseline -year	Herefordshire Baseline	Region baseline	England baseline	Herefordshire-2 years since the start of the strategy
Hospital admissions as a result of self-harm 10-14 years (Crude rate- per 100.000)	Fingertips - HES	2022/23	436.9	288.3	251.2	TBC

Local data

Outcome Indicator (s)	Data Source	Herefordshire Baseline -year	Herefordshire Baseline	Region baseline	England baseline	Herefordshire- 2 years since the start of the strategy
Proportion of adults with good mental wellbeing	Community wellbeing survey	2023	37%	N/A	N/A	Next survey in 2026(TBC)
Proportion of adults with poor mental wellbeing	Community wellbeing survey	2023	8%	N/A	N/A	Next survey in 2026(TBC)
Proportion of adults with high self-reported anxiety	Community wellbeing survey	2023	24%	N/A	N/A	Next survey in 2026(TBC)
Proportion of primary school children with low/medium mental wellbeing score	Herefordshire CYP Quality of Life Survey	2021	25%	N/A	N/A	24%
Proportion of secondary / FE pupils with low/medium mental wellbeing score.	Herefordshire CYP Quality of Life Survey	2021	48% (S) 40% (FE)	N/A	N/A	32% (S) 29%(FE)
Proportion of primary school pupils with low resilience scores	Herefordshire CYP Quality of Life Survey	2021	19%	N/A	N/A	22%
Proportion of secondary school/FE pupils with low resilience scores	Herefordshire CYP Quality of Life Survey	2021	38 % Secondary / 26% FE	N/A	N/A	39% (S) 27% (FE)
Proportion of self-reported self-harm amongst secondary & FE pupils	Herefordshire CYP Quality of Life Survey	2021	10 (S): 3(M)/15 (F) And 10 (FE)	N/A	N/A	TBC

Proportion of secondary school pupils who always or usually feel safe when outside in their local area after dark	Herefordshire CYP Quality of Life Survey	2021	41%	N/A	N/A	44%
Proportion of FE students who always or usually feel safe when outside in their local area after dark	Herefordshire CYP Quality of Life Survey	2021	49%	N/A	N/A	54%
Proportion of primary school pupils who reported that they went to the following in their free time outside school in the last 4 weeks. Top 5: a) parks or open spaces, b) sports club or class (not school lessons or just watching, c) art, craft, dance, drama, film making group, d) swimming e) music group or lessons	Herefordshire CYP Quality of Life Survey	2021	a) 72% b) 48% c) 26% d) 24% e) 22%	N/A	N/A	a) 75% b) 59% c) 29% d) 43% e) 25%
Proportion of secondary school pupils who reported that they went to the following in their free time outside school in the last 4 weeks. Top 5: a) parks or open spaces, b) sports club or class (not school lessons or just watching, c) swimming d) cinema/theatre e) music group or lessons	Herefordshire CYP Quality of Life Survey	2021	a) 73% b) 45% c) 19% d) 16% e) 13%	N/A	N/A	a) 77% b) 50% c) 25% d) 28% e) 13%
Proportion of FE pupils who reported that they went to the following in their free time outside school in the last 4 weeks. Top 4: a) parks or open spaces, b) sports club or class (not school lessons or just watching, c) music group or lessons d) swimming	Herefordshire CYP Quality of Life Survey	2021	a) 61% b) 24% c) 10% d) 8%	N/A	N/A	a) 70% b) 32% c) 10% d) 18%

Appendix 3

Herefordshire and Worcestershire Health and Care NHS Trust

REQUEST EXPENDITURE FROM CHARITABLE FUNDS

Requestor Kate Ford	**Tel no.**	**Date** 18th June 2024	**Site/ Dept.** AOT, 27a St Owens
Payment to: **(Name and address)** Services		**Goods/ Service ordered** • Booking of room at Union Café on a weekly basis (£30 weekly - £1,080 for 3x12 week group programmes) • Physical activities for patients/staff eg cycling track, rock climbing, tennis, gym, tai chi, golf (£900)	
Fund number /name Payment to be made upon receipt of invoices to services		**Requisition Number**	**Total price inc. VAT** £1,980

Details in support of request

Rationale for the Group:

The plan is for the Healthy Lifestyles group to be offered to patients on the Assertive Outreach Team (AOT) caseload. This is to be a joint venture, facilitated by Hereford Healthy Lifestyles Team and supported by staff from the Assertive Outreach Team.

The rationale for offering this group, is that:

1) Patients on the Assertive Outreach Team caseload find it difficult to engage in community activities and require more intensive support to engage in any meaningful activity.
2) Patients on our caseloads' fitness levels, social skills and confidence mean that they face barriers when attempting to access mainstream community and physical activities. This group programme will enable patients to engage in a therapeutic group, in a community setting, with the support of AOT staff.
3) This group will provide a stepping stone, for patients to access mainstream activities in the local community.
4) A large majority of patients on our caseload have poor physical health. Factors influencing this include lifestyle choices, substance misuse, symptoms of illness and anti-psychotic medications. This group will support patients to improve their knowledge around healthy lifestyles and will give them opportunities to improve their physical health.

The group programme will have 2 elements; an educational component and a physical activity component.

The educational component of the group will run for x1 hour, once weekly, for 12 sessions. The group will run in a community setting (Union Café), in Hereford city centre. This is to enable participants to engage in meaningful activity, within their local community. In order for this group to run in a community setting, funding is required for room hire. The Healthy Lifestyles team are available to run the course for free, but they do not have a venue for group sessions at their base.

In addition to the educational component, the plan is for participants of the group to have the

opportunity to try out a range of physical activities in their local community eg cycling at the cycle track, bouldering, tai chi, badminton, swimming, the gym, tennis and other activities as suggested by participants. Some of these activities will have costs involved. In order for all group attendees to have opportunity to try these activities, funding is being requested in order to support patients to be able to attend.

The plan is, for this to be a rolling programme. Between 6-8 patients on our caseload to be offered places on each 12 week course. Patients to be referred onto the course by care co-ordinators. Referrals to be sent to Kate Ford (occupational therapist). Once referrals received, discussion to be had by the team on priorities for each programme.

Evidence base for the need and value of Healthy Lifestyles groups:

There is a wealth of evidence documenting the challenges that individuals with psychosis/general mental health difficulties have, with their physical health and also with engaging in physical health interventions/physical activity. Oliva et al (2023) report that patients with psychosis have a significantly shorter life expectancy of around 10 years compared to the general population (Firth et al., 2017). Oliva et al note that there are several potential reasons behind this mortality gap, for example daily life habits and chronic diseases such as diabetes, metabolic syndrome, and cardiovascular diseases, which frequently co-occur with psychosis, play an important role (Schmitt et al., 2018). Although antipsychotic drugs help with positive symptoms of psychosis, they can also exacerbate chronic medical conditions, making it hard to treat both specific psychotic symptoms and overall health (Fisher et al., 2020).

Psychotic symptoms such as hallucinations and delusions cause significant functional impairment (Segura et al., 2022) across a range of psychotic disorders (Oliver et al., 2019). Physical activity and exercise have been found to help, when used alongside other treatments, by improving the patient's overall health, function and potentially lower symptom levels for psychotic patients (Suen et al., 2021). In a systematic review and meta-analysis by Ziebert et al (2022) aerobic intervention was observed to be effective in reducing negative and general symptoms in patients with schizophrenia.

It is well established that physical activity helps improve mental health. In a recent study of 1.2 million US adults, in which participants were matched across numerous background and demographic factors, individuals who exercised reported better mental health functioning compared to non-exercisers (Chekroud et al 2018). Also in a recent meta-analysis of 49 prospective studies across nearly 267,000 individuals, it was found that higher levels of physical activity was associated with reduced odds of developing depression across age groups. Physical activity also prospectively associated with lower odds of developing elevated anxiety symptoms and anxiety disorders in a recent meta-analysis of more than 80,000 individuals (McDowell et al 2019).

Along with reducing the likelihood of developing physical health diseases, Bellringer (2006) reports that 'physical activity stimulates the production of endorphins, which as a result can improve mood and reduce anxieties'. Bellringer (2006) added 'endorphins are a strong analgesic, and give a pervasive sense of happiness'.

All the evidence above, demonstrates the need for our patients with psychosis/depression/ anxiety to pay careful attention to their physical health and to work on improving their physical health and fitness. This needs to be through a range of strategies – including physical health screenings and work around healthy lifestyles and exercise. Unfortunately, due to the nature of our AOT caseload, many of our patients have a range of functioning difficulties, so find it difficult to assess and work on their physical health independently. Diamond et al (2023) reported that for people with psychosis, the provision of information, resources and practical help to access exercise programmes has often been insufficient to promote behaviour change. Therefore, we need to reach out to our patients and support them to access ways to improve their physical health and fitness levels.

This healthy lifestyles group, will be facilitated in a community setting, meaning that patients will have the opportunity to learn and implement ways to improve their physical health, while integrating with their local community. The group will have an educational component and will offer taster sessions of a variety of different exercise activities. This will enable them to explore what physical activities they feel may benefit them going forward.

Therapeutic Aims of the Group:

- To provide a safe, non-threatening environment for patients to engage in their local community.
- To enable the opportunity for patients to learn about healthy lifestyles in an enjoyable and meaningful way.
- To enable opportunity for patients to maintain and improve their physical health and fitness (particularly important for this client group who are at increased risk of physical health conditions and premature death due to long term use of antipsychotic meds).
- To enable opportunity for patients to maintain and improve their community living skills (ie getting themselves to a venue, organising and planning their time, engaging with the public, using public transport).
- To provide opportunity for patients to increase self-esteem – through improved physical health/fitness/well-being and confidence in a community setting.
- To enable the opportunity for some structure, routine and meaningful activity for the patients' week.
- To enable opportunity for staff to check in with patients re their current functioning (ie motor skills, social interactions, level of motivation, emotional well-being).
- To assess risk in a different environment.
- To provide an enjoyable, social outlet through meaningful activity.
- To enable patients opportunities to develop positive social relationships with staff and fellow peers.
- Develop a hobby and awareness of leisure amenities in the community – patients can then continue to access activities they have enjoyed independently following the group.
- To be available to encourage and signpost patients to physical activities and health lifestyle activities in the local community.

Logistics of the Group:

The cost of room hire is £30 per week. This is for the venue hire for the facilitating the sessions. There will be additional costs for the physical activities that we would like to introduce patients to during the course.

The patients will make their own travel arrangements to the weekly session. AOT staff may be able to support patients to attend, if they are unable.

Patients will be reminded of session times by phone/text, by staff from the AOT.

Patients will be encouraged to wear suitable clothing and bring drinks, when engaging in physical activities as part of the session.

Facilitators will link in with care co-ordinators regarding specific support needs of the patients. Facilitators discuss any issues that arise during sessions with care co-ordinators, so that functioning/health issues can be addressed.

The weekly sessions will be facilitated by staff from Hereford Healthy Lifestyles Team and AOT staff.

The regular time allocated for facilitating this activity will be co-ordinated according to availability of Healthy Lifestyles Team and AOT. This will be a consistent time slot once agreed.

Time will be needed for the setting up of the session, the x1 hour educational slot and then additional time for any community physical activity. There will need to be time for informal interactions and checking in with attendees. Further time will be required for ensuring that clinical notes are documented on Care Notes for the patients attending.

Charitable funds request:

The charitable funds request is for the cost of the room hire and for additional money to put towards the physical activities that we would like to introduce patients to during the course.

Room hire: £30 weekly – programme of 12 weeks: £360.
Requesting money for 3x12 week programmes: £1,080
Physical activity taster session contributions: £900

Total: £1,980

References:

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Proposal prepared by Kate Ford
June 2024

Signature (Fund Manager)	**Date**	**Counter Signature over £2,000 (Chief Operating Officer)**	**Date**

PLEASE NOTE:

1. **All sections on the top part of the form should be completed, signed and dated.**
2. **If ordering goods via supplies an order must be raised through the procurement system. All documentation regarding your request should then be sent to finance with this form.**
3. **The balance of the fund will checked and the bid is passed for approval.**
4. **All bids over £2,000 need to be signed by Chief Operating Officer.**
5. **All requests for expenditure need the appropriate authorisation:**
   - **bids up to £250 – Fund Manager**
   - **bids up to £2,000 – Fund Manager and Director of Finance**
   - **bids £2,000 - £7,500 – Fund Manager and Charitable Funds Committee Chairman**
   - **bids over £7,500 – Charitable Funds Committee**
6. **The order is approved only once approval has been authorised as above.**
7. **Unless specified otherwise within the bid, the order should be placed within 3 months of approval. Failure to do so will result in the bid being void.**

TO BE COMPLETED BY FINANCE

Trust Fund	**Balance**	**Date**	**Order no.**
Approval (Director of Finance)			**Date**
Approval (Chairman/ Trust Fund Committee)			**Date**
Passed for Payment			**Date**

AGENDA ITEM 11

Herefordshire Council

Title of report: Herefordshire Suicide Prevention Strategy

Meeting: Health and Wellbeing Board

Meeting date: Monday 9 June 2025

Report by: Public Health Lead - Mental Health

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

The Herefordshire Suicide Prevention Strategy is brought to the attention of the board for information.

Recommendation(s)

That the board notes the strategy as an action supporting the priority of good mental health across the lifetime.

Alternative options

1. No alternative options considered.

Key considerations

2. During 2024, Public Health along with partners developed a new Suicide Prevention Strategy. Engagement was wide ranging including local statutory, voluntary and community organisations, those with lived experience and the public.

3. A working group led the strategy development to ensure a partnership approach was taken.

4. The working group was keen to ensure the strategy could be useful for all partners, by making it short, keeping the language clear and simple and using real, local case studies.

5. Our strategy considered the new national strategy commitments whilst also being shaped through our own local extensive engagement.

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

6. Local intelligence from the new Herefordshire “real-time suspected suicide surveillance system” informed our strategy. This supported us in identifying our most at risk populations and our priority groups.

7. Our seven commitments will shape a local suicide prevention action plan which will be developed with the working group.

Community impact

8. The suicide prevention strategy is a key action within the Good Mental Health action plan; good mental health being a health and wellbeing strategy priority.

9. This strategy has been supported by the mental health needs assessment data and real time suspected suicide surveillance data.

Environmental impact

10. The development of this project has sought to minimise any adverse environmental impact and will actively seek opportunities to improve and enhance environmental performance.

Equality Impact

11. The mandatory equality impact screening checklist has been completed for this activity and it has been found to have low impact for equality.

12. Due to the potential impact of this project/decision/activity being low, a full Equality Impact Assessment is not required. However, the following equality considerations should be taken into account when making a decision about this activity/project:

    a. Any effect on the public

    b. The needs of people with protected characteristics

    c. Promoting equality of opportunity

Resource implications

13. There is no resource implications associated with this strategy. If resource requirements are identified during the development of the supporting action plan, these will be notified at service level, in the first instance.

Legal implications

14. To be provided by the legal services team following agenda publication.

Risk management

Risk / opportunity	Mitigation
Engagement with the strategy is lower than expected.	The strategy was developed across a wide partnership to create buy-in and expand networks

15. Risks will be managed at a service level.

Consultees

16. Consultation:

- 34 local organisations participated in interviews
- 64 anonymous public questionnaires completed
- 7 lived experience interviews
- a summary of their views can be found in the appendices of the strategy
- the results were themed and informed the development of the commitments within the strategy

Appendices

Appendix 1 Herefordshire Suicide Prevention Strategy 2025 - 2029

Background papers

None identified.

Herefordshire Council

Herefordshire Suicide Prevention Strategy 2025 - 2029

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Our partners	17
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Foreword

We are pleased to publish our new Suicide Prevention Strategy for Herefordshire. This strategy has been developed in collaboration with local partners and highlights our commitments to reduce the number of local lives lost to suicide.

We believe that through collective efforts from individuals, organisations, and communities, we can effectively support our residents. This strategy and associated action plan takes a whole county, all-age approach, aligning with the priorities of the national suicide prevention strategy. Through our local engagement work, we have identified the need to explore suicide in relation to life transitions and events, as well as the unique challenges faced by a rural county, which will be recognised in our ongoing activity.

The Herefordshire Suicide Prevention Working Group will oversee the strategy's action plan, with key actions being delivered by partners within the group. Activity will be reviewed regularly and where appropriate updated to align with changes in local and national intelligence.

Thank you to everyone who has contributed to the development of this strategy and to all those who will continue to support suicide prevention work in Herefordshire, helping to make a difference for our residents.

Suicide can affect any one of us. If you are struggling with your mental health, experiencing suicidal thoughts, supporting someone who is, or have been affected by suicide in any way, there are a number of free services available to offer support:

NHS 111

Urgent 24/7 mental health support.

Call 111, option 2

Samaritans

24/7 listening support for whatever you're going through

Call 116 123 or email jo@samaritans.org

SHOUT

24/7 crisis support via text, if you're struggling to cope and need immediate help.

Text "HERE" to 85258

Papyrus

Confidential support and advice to anyone under the age of 35 struggling with thoughts of suicide and anyone worried about a young person.

Call 0800 068 4141 or text 88247

Hereford Safe Haven

Open 7 days a week from 5pm to 10pm, for anyone over the age of 18, in crisis or in need of support.

Call 01432 372 407

We Are Farming Minds

24/7 support line and counselling to those involved in the agricultural industry.

Call 0808 802 0070 or text 07786 203 130

For further support and signposting please visit the Talk Community Directory website: Suicide prevention, bereavement & support - Talk Community Directory:

www.talkcommunity.co.uk/keeping-well-staying-healthy/mental-health-and-emotional-wellbeing/suicide-prevention-bereavement-support/

If you've seriously harmed yourself or feel you are in crisis, call 999 for an ambulance or go straight to A&E. If you can't do it yourself, please ask someone to help you.

Vision

Our vision is to reduce suicides in Herefordshire and make our county a place where there is hope and community connection. We are committed to ensuring that the right support is available to the right person at the right time.

REACH OUT

FIND HOPE

GET HELP

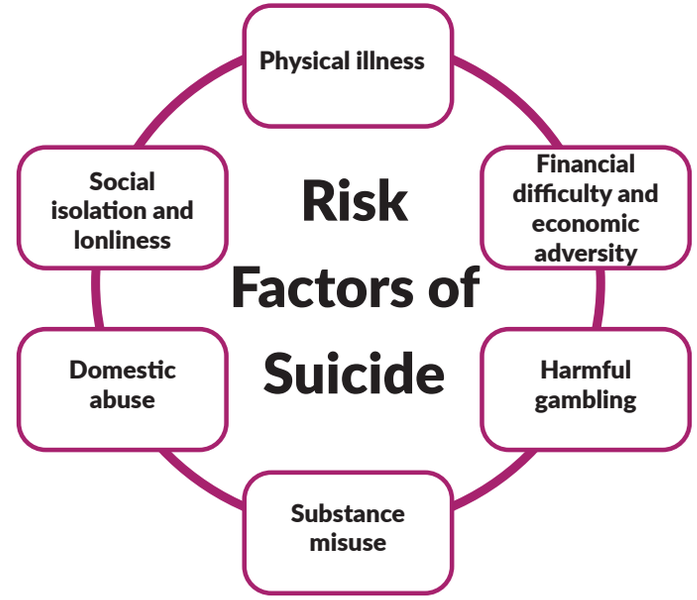
Purpose & Scope

Suicide is a global health priority, with over 720,000 lives lost annually (WHO, 2025)[1]. Despite being preventable, stigma often stops individuals from seeking help. Effective prevention requires coordination across multiple sectors.

Our new strategy has been developed as a result of the 10-year Joint Health & Well-being Strategy, which highlighted suicide prevention as a core priority[2]. The action plan outlines initial steps, including raising awareness, enhancing bereavement support, and improving suicide data in Herefordshire.

The national suicide prevention strategy, published in 2023, has helped shape our approach. The strategy aims to reduce suicide rates over five years, improve support for those who self-harm, as well as those bereaved by suicide. The strategy identifies key focus areas essential for achieving its goals, alongside key priority-groups and risk factors[2].

Local data guides this strategy to address the specific needs of Herefordshire, including data from the Real-Time Suspected Suicide Surveillance System, the Mental Health Needs Assessment, and partnership data.



Department of Health & Social Care (2023) **Suicide prevention in England: 5-year cross-sector strategy - GOV.UK**

Limitations in the current data and intelligence are acknowledged and ways in which to address and fill any gaps will be identified.

In this strategy, suicide is defined as the act of intentionally taking your own life. This strategy does not in capture assisted suicide or euthanasia.

1 WHO, **2025 Suicide**
2 Herefordshire Council, 2023 www.herefordshire.gov.uk/downloads/file/3677/health_and_wellbeing_strategy.pdf

Understanding suicide in Herefordshire

Herefordshire is a rural county with a population of 190,000. It has a strong economy driven by agriculture and manufacturing.

Wages are lower than the national average, whilst housing costs are higher, but residents value the strong sense of community and consider it a good place to live (Herefordshire Joint Local Health and Wellbeing Strategy, 2023)[1].

Suicide data in Herefordshire is informed by national sources, including the Office of National Statistics and the Department of Health & Social Care, which provide insights into confirmed suicides, gender, and age trends. Local data, from the near Real-Time Suspected Suicide Surveillance system (nRTSSS) and the Primary Care Mortality Database, provides further details on methods, locations, and occupations related to suicides.

In 2024, the Real-time Suspected Suicide Surveillance system went live in Herefordshire, the system collects data on suspected suicides before inquest conclusions. This allows for timely bereavement support and targeted prevention efforts and is led by Public Health, West Mercia Police, and the Coroner's Office. To complement this system we established the Herefordshire Suicide Audit Group, comprised of key stakeholders who meet quarterly to share insights and identify trends from the surveillance system. This group works collectively to develop effective prevention and postvention interventions.

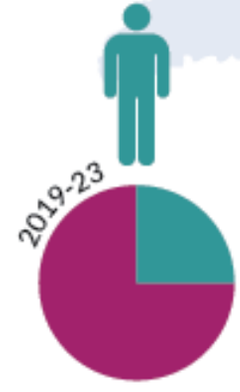
To further contribute to our understanding of suicides in Herefordshire, comprehensive engagement work was undertaken across the county during 2024 to inform the strategy. This work aimed to capture the perspectives of residents, organisations, and individuals with lived experience of suicide. It included discussions with service users, providers, and the local Youth Board through one-on-one conversations, an online survey, and semi-structured interviews. For a detailed breakdown of engagement activities and findings, refer to Appendix (p19).

Monitoring data and gathering intelligence from local sources is essential in informing the work we do to prevent suicides in Herefordshire. It helps us pinpoint underlying factors contributing to suicide risk and enables us to detect early signs of potential suicide clusters and emerging trends.

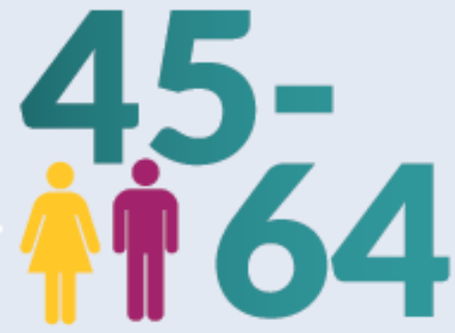
1 Herefordshire Council, 2023 Herefordshire Joint Local Health and Wellbeing Strategy 2023 - 2033

Since 2001 ¾ of suicides in Herefordshire occur in males (the same as National average).

Between a death occurring and its registration in Herefordshire



Suicide has accounted for 1 in 4 deaths in men under 35 in Herefordshire.

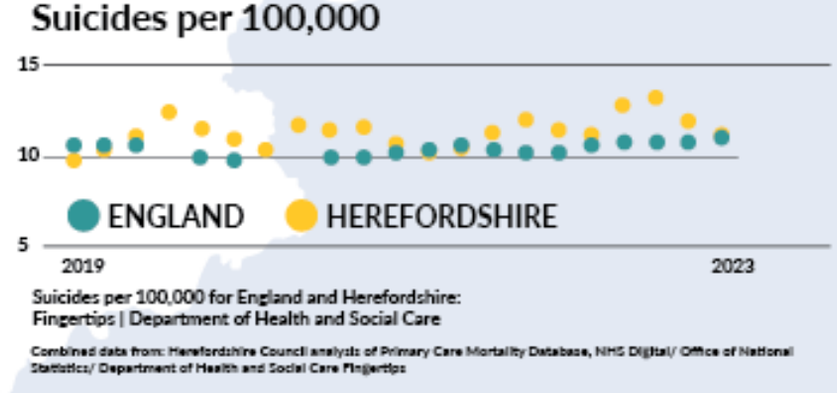


Highest rates of suicides in Herefordshire are in 45-64 year olds (2018-2022)

18

Number of Deaths in Herefordshire: on average

/year since 2001



Suicides per 100,000 for England and Herefordshire: Fingertips | Department of Health and Social Care

Combined data from: Herefordshire Council analysis of Primary Care Mortality Database, NHS Digital/ Office of National Statistics/ Department of Health and Social Care Fingertips

To compare Herefordshire data with that of England and Wales please visit the following website: Suicides in England and Wales - Office for National Statistics

What have we done so far

Since the implementation of the previous Herefordshire Suicide Prevention Strategy (2019-2023) and action plan, there has been significant progress in the following areas:

Partnership Working

A Herefordshire Suicide Prevention Working Group has been formed to create a collaborative, community-based approach involving those with lived experience, expert organisations and those wishing to support preventative work across the county. Additionally, a Herefordshire Suicide Audit Group has been developed, providing professionals with a platform to review local data and coordinate targeted, strategic actions.

Community Offer

Funded Suicide Awareness Training is now available for Herefordshire residents and workers, along with free Workplace Wellbeing sessions for local businesses to enhance their understanding of mental health and suicide prevention and improve their wellbeing offer. The Orange Button Community Scheme has evolved across Herefordshire and Worcestershire to provide community-based suicide prevention support, with over 850 participants wearing the button. Furthermore, voluntary organisations and community groups continue to provide essential support.

Communication

Enhanced communication around suicide prevention has been achieved through the 'Now We're Talking' campaign, a partnership between Herefordshire & Worcestershire Health and Care Trust, Herefordshire Council, Talk Community, Worcestershire County Council, and Stay Connected. Local media coverage has increased for national campaigns and promotion of local mental wellbeing services, while suicide prevention signage and information has been improved across the county.

Resources

New resources have been introduced, including the Real-Time Suspected Suicide Surveillance system, alongside the appointment of a dedicated Suicide Prevention Officer within the Herefordshire Council Public Health team. The Talk Community website has been updated to offer targeted suicide-related information, support, and signposting. Additionally, NHS Mental Health Services have revised patient risk assessments to provide more personalised support.

Postvention Support

Funded suicide bereavement support is available for individuals aged 4 and up, with options for one-on-one or group sessions available in person or via telephone. There is also access to a number of alternative bereavement support groups available across the county for all ages.

Photo credit: WCC

Guiding principles

Suicide is Preventable: Through awareness, education, and timely intervention, we can save lives.

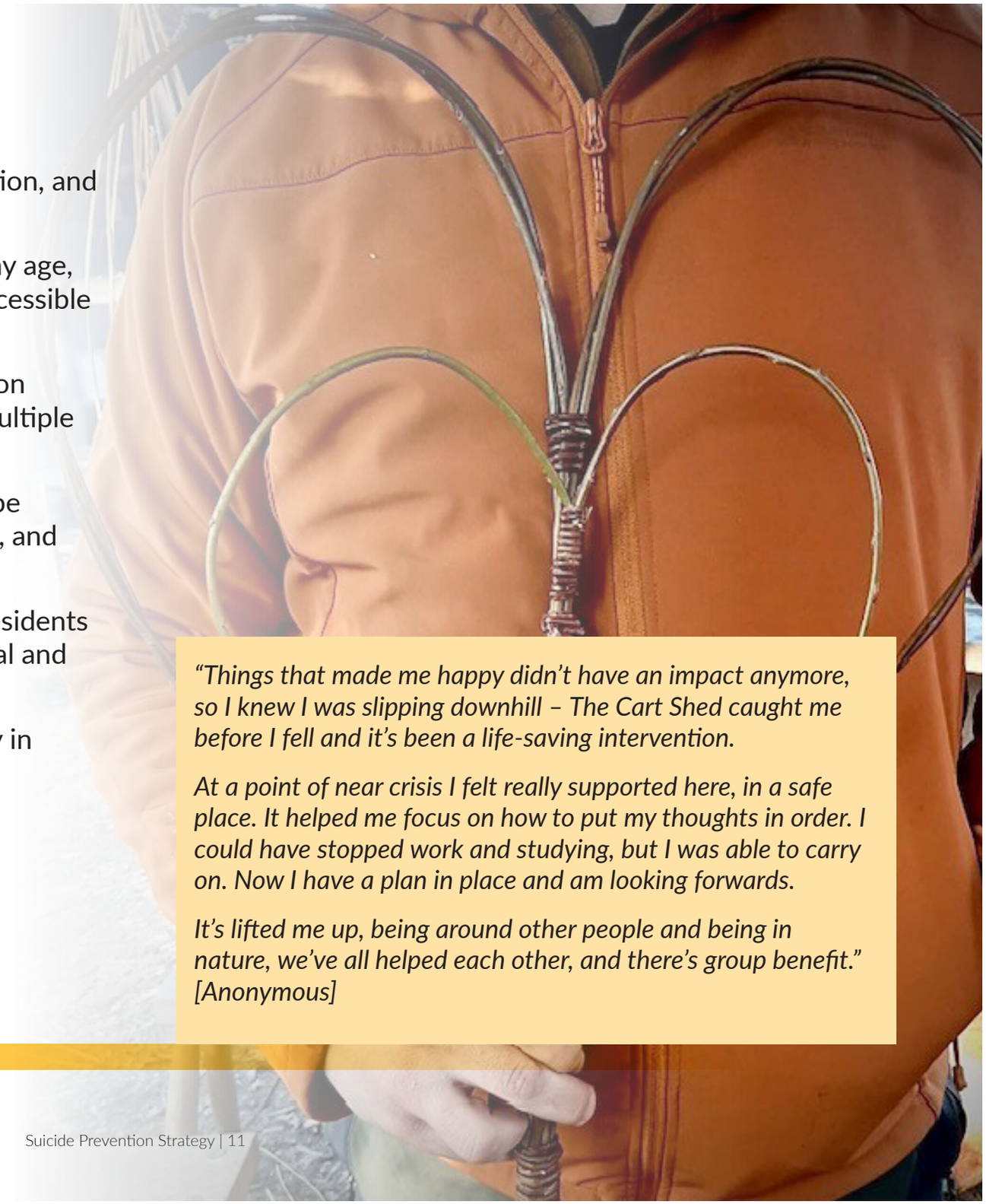
Across All Ages: Suicide can affect individuals of any age, so prevention and postvention support must be accessible to all.

Collaborative Approach: Effective suicide prevention and support requires a coordinated effort across multiple partners and those with lived experience.

Local Needs Matter: Data and intelligence will shape our approach and reflect the unique cultural, social, and demographic needs of Herefordshire.

Relevance: Our strategy should resonate with all residents and workers in Herefordshire, ensuring it is practical and beneficial for everyone.

Shared Responsibility: Everybody has a role to play in suicide prevention.



"Things that made me happy didn't have an impact anymore, so I knew I was slipping downhill – The Cart Shed caught me before I fell and it's been a life-saving intervention.

At a point of near crisis I felt really supported here, in a safe place. It helped me focus on how to put my thoughts in order. I could have stopped work and studying, but I was able to carry on. Now I have a plan in place and am looking forwards.

It's lifted me up, being around other people and being in nature, we've all helped each other, and there's group benefit." [Anonymous]

Our commitments

Making suicide everyone's business

Encourage all partners to play their part in suicide prevention

- Promoting open conversations and better use of language to reduce the stigma of suicide
- Support organisations to provide consistent messaging

Work with local, national and social media outlets

- Promote positive stories about mental health and help-seeking behaviours – help empower individuals
- Work with colleagues to monitor media coverage and use Samaritans guidelines for reporting on suicide

Support a Community approach

- Increase individual's awareness of looking after their own wellbeing and the risk factors of suicide
- Ensuring advice and support is accessible and that people know where they can go

Strengthen mental health and early intervention support

Increase awareness of local support, training and activities

- Offer suicide prevention and mental health training, targeting those high-risk professions
- Support community activities in rural areas, and areas of need
- Create a local offer to include in education settings to target support at a young age

Support use of wellbeing plans for a personalised approach

- Make wellbeing plans, also known as safety plans, more widely recognised
- Work across multiple agencies to ensure use of wellbeing plans
- Provide support and training for professionals on how to create a wellbeing plan

Create innovative ways of supporting our residents

- Explore different ways in which support can be accessed
- Establish Partnerships to consider external funding opportunities to deliver projects

Improving data and evidence

Provide up to date local data

- Maintain and share data from our Real-time Suspected Suicide Surveillance system to stay informed of local trends and demographic characteristics of those at risk
- Regularly review the latest statistics, data and research to identify emerging trends, effective interventions, and areas for improvement
- Collaborate with our multiagency Suicide Audit Group to facilitate the sharing of data, best practice and research findings for informed decision-making

Inform service delivery

- Provide data-driven insights to inform service commissioning decisions, ensuring that allocated resources are targeted toward high-need areas and effective interventions
- Offer data and evidence to support grant applications, funding proposals, and programme evaluations

Use data and evidence to support those at risk

- Facilitate timely and secure exchange of information across partners to ensure effective support and crisis response
- Share relevant research and evidence with practitioners working with those at risk of suicide

Expanding Partnership working

Maintain and build trusted relationships

- Continue to develop and strengthen the multi-agency suicide prevention networks
- Collectively utilise community assets and programmes of work to help reduce risk

Improve accessibility and delivery of services

- Collaborate with commissioners and service providers
- Collectively understand responsibilities and boundaries of services

Create a safer community

- Work with partners to identify, intervene and respond to high-risk locations and means
- Share insights with relevant partners to create protective environments

Use local intelligence

- Continue to monitor suicide data and intelligence to identify priority groups and any emerging issues
- Work with partners to understand our local priority groups and ensure approaches are tailored to their support needs

Identify and support priority groups

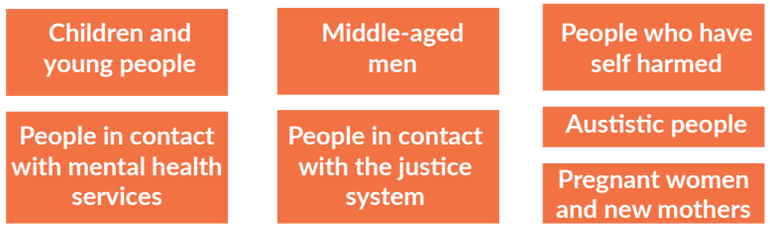
Identify support for priority groups

- Understand what support is already available and identify any gaps
- Ensure that targeted support is effectively promoted and widely publicised

Make support accessible

- Ensure appropriate pathways are in place to access support.
- Consideration should be given to where, when and how support is offered.
- Co-ordinate a countywide prevention campaign aimed at groups identified as higher risk of suicide

National Priority Groups



Our Story: We Are Farming Minds

We Are Farming Minds is a registered charity founded by Sam and Emily Stables, a local farming couple dedicated to breaking the stigma surrounding mental health. We support the farming community of Herefordshire through free counselling, a confidential 24/7 support line, and bespoke mental health awareness training. In the 2022/23 period, we provided 900 counselling sessions and continue to see demand grow.

To reduce isolation that is often felt within farming, we host free social events including 'One Foot in the Grain', a monthly gathering for farmers over 50 to visit different farms across the county, enjoy good food and speak with fellow farmers. As well as 'Woman What Farm' which features varied monthly activities, ranging from paddleboarding to pampering, enabling women in agriculture to connect, recharge, and discover new interests.

Provide effective crisis support

Understand that 'crisis'

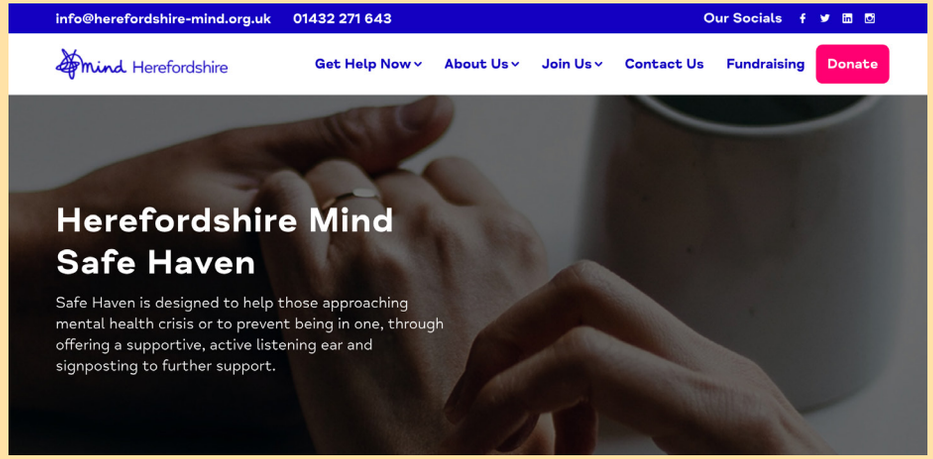
- Recognise 'crisis' can mean a wide range of situations and levels of need
- Partner with key organisations to provide essential training and resources on suicide prevention and postvention for staff and colleagues

Ensure that the right support is available at the right time

- Provide up to date information on available crisis services, outlining their capabilities and how they can assist individuals in need
- Focus on reducing the time it takes for individuals to access crisis support, ensuring a prompt response to urgent needs

Enhancing Accessibility of Crisis Support

- Ensure that crisis support is accessible to all individuals. This includes creating resources and services that cater to diverse populations
- Work across multi-agencies to identify gaps in services and enhance the collective response to crises



Our Story: Herefordshire Safe Haven

Safe Haven at Herefordshire Mind is a no-judgement, active listening service that can help support and signpost adults in Herefordshire who are in mental distress, whatever their situation; our aim is that no-one in Herefordshire should have to face a mental health problem alone. Since opening in March 2020, we've supported almost 1,000 individuals get the help they need during their mental health journey. We are open 365 days a year, 5pm-10pm via telephone (01432 372 407) and can offer face to face support at our HQ on Widemarsh Street by appointment.

Our Story: Bereaved By Suicide Service

Herefordshire Bereaved by Suicide Service offers free and confidential support to individuals aged 4 and over who have experienced the loss of a loved one to suicide. They understand that grief can be a complex journey, and it doesn't matter when the loss occurred, the service is open to anyone who has been affected, including family members, friends, colleagues, and more.

The service provides personalised support tailored to the unique needs of each individual. They provide a flexible approach, offering home visits to create a comfortable and familiar environment for clients. However, recognising that this may not suit everyone, they can also arrange alternative meeting locations or options to best accommodate individual preferences.

Offer of suicide bereavement information and support

Increase awareness of suicide bereavement services and support

- Continue to share information to the community on the services and support available
- Ensure services are providing effective and compassionate support and signposting for those bereaved by suicide

Ensure accessibility of support for all-ages

- Provide support to educational settings with the relevant tools and resources
- Collaborate with employers to develop initiatives that provide support to employees affected by suicide

Improve support and understanding to those affected by suicide

- Explore and develop support options for individuals who have been impacted by suicide, but who may not have directly lost someone to suicide.
- Consider training options for professionals in understanding the unique challenges faced by those affected by suicide.

Our partners

Suicide is everyone's business, and we are committed to working with partners, including those listed below, to strengthen prevention efforts and reduce suicide rates in Herefordshire:

Herefordshire Health & Care Trust	Integrated Care Board	Wye Valley Trust
West Mercia Police	Herefordshire & Worcestershire Fire and Rescue	Adult and Children's Social Care
Coroner's	Officers of Health and Disparities	HM Prison and Probation Service
Transport for Wales	National Highways	Herefordshire Safeguarding Partnership
British Transport Police	Worcestershire County Council	Turning Point
Herefordshire Primary Care Networks	Education Settings	Our Community

We also recognise that prevention efforts begin before the suicide prevention strategy, and we will work alongside other strategies that address key risk factors and priority groups, including but not limited to:

- Herefordshire Joint Health & Wellbeing Strategy
- Herefordshire Carers Strategy
- Herefordshire Community Safety Strategy
- Herefordshire Domestic Abuse Strategy
- Herefordshire Homelessness Prevention and Rough Sleeping Strategy
- Herefordshire and Worcestershire Joint All Age Autism Strategy.

Call to action

Let's change the conversation around suicide.

In 1961, suicide was de-criminalised, but incorrect and stigmatising language persists. Let's choose words that heal and uplift.

Say this...	Instead of this...
"Died by suicide" or "taken their own life"	"Committed suicide," "successful suicide" or "completed suicide"
"Suicide attempt" or 'non -fatal attempt'"	"Failed suicide" or "unsuccessful suicide"
"Increased rates" or "higher rates"	"Suicide epidemic"
"[Name] is having suicidal thoughts"	"[Name] is suicidal"

Our Story: Baton of Hope

In Autumn 2025, Herefordshire will take part in the UK's biggest suicide prevention initiative, Baton of Hope, by hosting a leg of their second UK tour. This event provides an opportunity to 'stand up to suicide', advocate for change, and support those affected by suicide. Education will be at the forefront of the event, aiming to empower supporters with the knowledge and tools to better understand suicide, challenge stigmas, and drive meaningful conversations.

Suicide is a critical issue for rural counties like Herefordshire and the Baton of Hope campaign provides a unique opportunity to highlight this issue, particularly amongst agricultural and rurally-isolated communities, to create a lasting legacy of support. This will be a significant step in changing the conversation about suicide in Herefordshire.

Boost your skills and knowledge by completing the Zero Suicide Alliance's free online courses:

www.zerosuicidealliance.com/suicide-awareness-training-courses

Zero Suicide Alliance | Because ONE life lost is ONE too many

Appendices

Suicide Prevention Strategy – Engagement Analysis

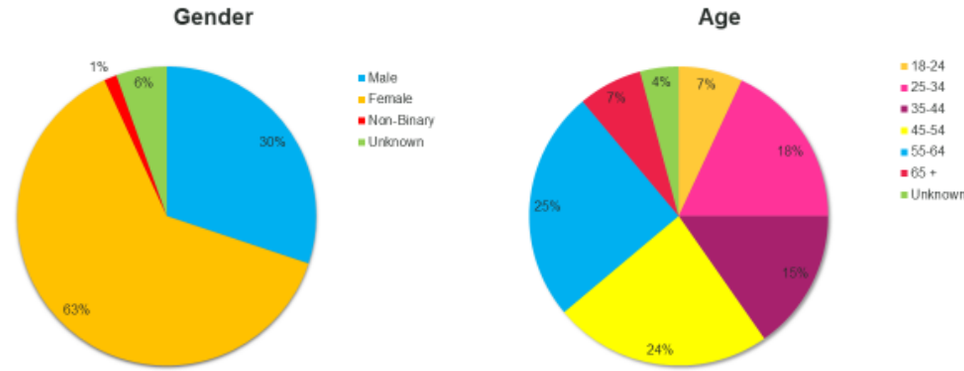
Date: 31/12/2024 Author:
Dr Ryan Davies – Public Health Registrar.

Purpose. Outline to local stakeholders the key issues raised from the thematic analysis of public engagement and actions to guide future strategy, on the topic of suicide prevention.

Background. The engagement was completed on 8th Nov 2024 and comprised 3 key components:

- **Service Providers**. Engaged 34 organisations/services/ partnerships in Herefordshire
- **Service Users**. Comprised a further 2 components:
  - Received responses from 64 participants to the public survey
  - 7 lived-experience interviews, providing greater detail to survey responses
- **Youth Board** – similar to public survey with extra 'solution focused' questions

- Service provider data was largely representative covering most available organisations. However, user surveys and interviews were limited by respondent demographics (fig 1.).



Key points – Qualitative Analysis

The survey questions included reasons for suicidal ideation and reaching crisis, awareness of services (see quantitative below) and experiences of help seeking and use. The youth board survey also included questions on anti-stigma and raising awareness initiatives. The service provider questions related to case-mix, reasons for use, degree of suicidal ideation encountered and pathways used. Finally – what is currently working and not working. These last 2 questions can also be used to analyse user responses to service experiences. Therefore, most actionable analysis may be distilled as follows:

Working	
Service Users	Non-medical / less formalised services Various success stories through: Voluntary sector Community groups Intrinsic support networks Human connections
Service Providers	Ways of working Partnership working and collaboration is frequently mentioned (especially third sector) Training (when available) & Triaging Teams who support each other Quick allocations to key workers Good support (variable by organisation) Innovative ways of working Peer led support (variable by organisation) Improved processes
Not working	
Service Users	Formalised medical services: 'Long Waiting lists', 'Impersonal', 'Overburdened', 'Labelled', 'No space', Lack of options, Crisis point – timing and availability
Service Providers	Wait times & capacity formal service > shift to voluntary All stepping up beyond initial scope – need more training and tangible guidance, risk management, oversight and support and welfare for staff Inappropriate pathways or 'nowhere to go' for patients Key marginalised groups missed – neurodivergent Lack of early intervention/ preventative services Lack of inpatient services (limited escalation measures) Lack of joint working (particularly emergency services with dedicated MH/ medical services) Need for more training at every level

Crisis Factors: Trauma, Relationships, Work/ Educational stress/ Loss, Health, Other.

Youth Survey: Greater openness on MH, hearing lived experiences, teaching in schools.

Key points – Quantitative Analysis

This comprised awareness of services and likelihood of use on a rating scale.

- 91% of people completing the survey had been affected by suicide.
- For each risk factor of suicide, outlined in the National Strategy, over ¾ of participants found these to be contributory. While 27% of participants also listed other factors.
- Samaritans (98%) and Herefordshire Mind (94%) were the most known services, while Border Rural Chaplaincy (10%) and Victim Support (41%) were the least known.
- While a lot of people had heard of a number of services, many had not used them.
- Primary care still remains the majority first choice for help seeking (78%).

Overall, this analysis highlights several clear themes that provide much needed context and can be built upon to guide the subsequent prevention strategy and action plans.

Distilled themes and potential actions to guide strategy

Theme	Potential Action	Impact
Loss of Human Connection	Network Building Utilise existing places & spaces	Enable Social Capital Bonding Bridging & Linking Increase chance of early intervention
Personalisation	Services: something for everyone Delivery: more humanised	Increased preferred service/ options and therefore use by those in need Early intervention
Empowerment	Self-help to improve self-efficacy	Less labelling, more enabling
Increased awareness	2 Strands – Those in need and those in deed. Build trust	Know where to go and know what to say and do. Unburden primary care as first option
Timeliness – Particularly crisis	Availability and escalation prioritised across services	Reduced potential harm
Staff training and support	Risk management oversight Upskill staff – maximise training and awareness opportunities	Improved service delivery Improved staff wellfair Chances for collaborative working
Joined up working	Build upon previous 'Better Together' Template	Help with 'appropraite pathways' Efficiency of cross referral, training and supportive opportunities.

AGENDA ITEM 12

Herefordshire Council

Title of report: Better Care Fund (BCF) reporting 2024-2025

Meeting: Health and Wellbeing Board

Meeting date: Monday 9 June 2025

Report by: Service Director, All Age Commissioning

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

To review and approve the Better Care Fund (BCF) reporting for 2024/2025.

Recommendation(s)

That:

a) the Better Care Fund (BCF) 2024/25 quarterly reports at Appendices 1, 2, 3 and 4, submitted to NHS England, be reviewed and approved by the board; and

b) the ongoing work to support integrated health and care provision that is funded via the BCF is noted by the board.

Alternative options

1. The board could decline to sign off the submission. It is a national requirement that quarterly reports are signed off by the Health and Wellbeing Board (HWB). The content of the returns has already been approved by the council's Corporate Director for Community Wellbeing and Herefordshire and Worcestershire Integrated Care Board (HWICB) accountable officer and submitted prior to the meeting of the board.

2. The HWB does not always align with national deadlines, however this gives the board an opportunity to review and provide feedback.

Further information on the subject of this report is available from
Marie Gallagher, Tel: 01432 260435, email: Marie.Gallagher1@herefordshire.gov.ukl

Key considerations

3. The Better Care Fund provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring/fenced budgets from Herefordshire and Worcestershire Integrated Care Board (HWICB) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Adult Social Care Discharge Fund (ASCDF).

4. The National BCF team determines national reporting requirements on the overall BCF programme, with quarterly reports being submitted to NHS England (NHSE) and Health and Wellbeing Boards.

5. 2024/25 reporting templates require confirmation that the BCF national conditions continued to be met throughout the year, confirmation of actual income and expenditure in BCF section 75 agreements for 2024/25 (covering the whole of the BCF plan including the Adult Social Care Discharge Fund monies), details of significant successes and challenges during the year. There is often a relatively short window of time between NHSE publishing the reporting templates and the national submission dates.

6. Due to timelines not aligning throughout the year, a full year report has been prepared covering all quarters for 2024/25. It is anticipated that future quarterly reports will be presented to the nearest HWB in line with national deadlines and submission.

7. Herefordshire has reported in each quarter that all of the national conditions, as listed below, have been met.

   i) A jointly agreed plan

   ii) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer

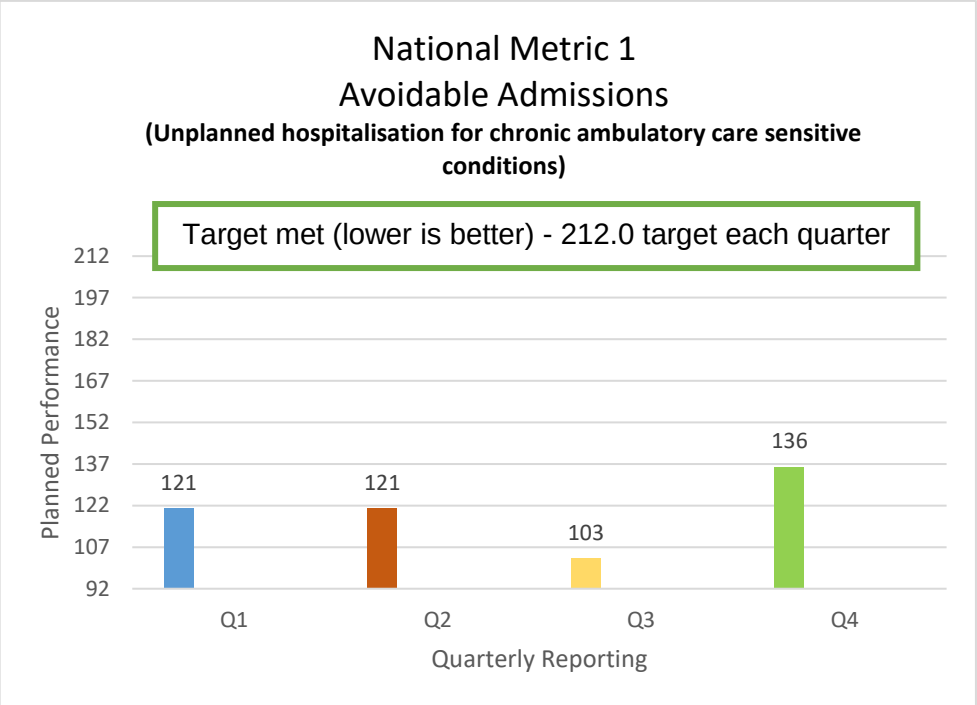
   iii) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

   iv) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.

8. The Quarter 1 2024/25 submission **(Appendix 1)** only required provision of information regarding spend and activity relating to the use of the Local Authority and ICB Discharge Funds, the total for which was £1.096 million.

9. Quarters 2, 3 and end of year reports **(Appendices 2, 3, and 4)** required more detail on metrics, performance and finance. Performance metrics reported are taken from outturn data for the full year 2024/25 as follows:

Performance



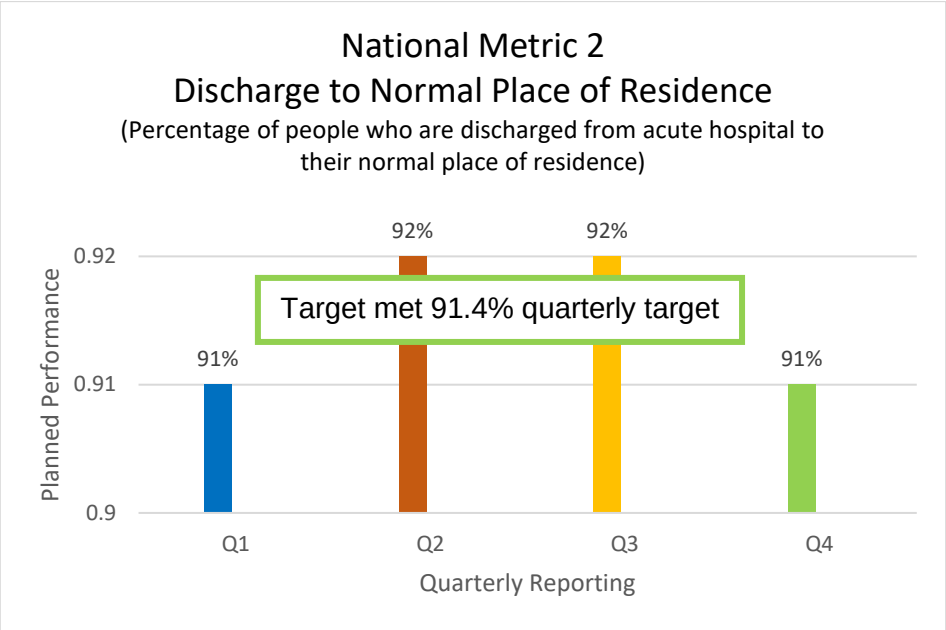
10. The graph for National Metric 1 – Avoidable admissions show the overall target of 212.0 each quarter was met. A lower number is better.

11. Care Home Practitioners have continued to work closely with providers and links between Wye Valley Trust long term condition ACP's via discharge and single point of access continued to develop and improve.

12. Step up virtual ward beds supporting patients with long term care to remain receiving care at home have been introduced utilising the existing Bridging Team Frailty Same Day Emergency Care (FSDEC) to support these beds.

13. Teams continue to work together to achieve the target with specific focus on care home unplanned admissions. A significant improvement has been seen utilising the FSDEC Bridging Team function providing a same day response to those patients seen in FSDEC and able to return home, thus avoiding admission to an acute bed; community support is then planned to enable the person to remain at home. The community referral hub continues to work across the system to support the opportunities for admission avoidance, although there has been an increase in referrals from West Midlands Ambulance Service lately.

14. Access to data to highlight variances can be a challenge across care homes and recruitment continues to be an issue.



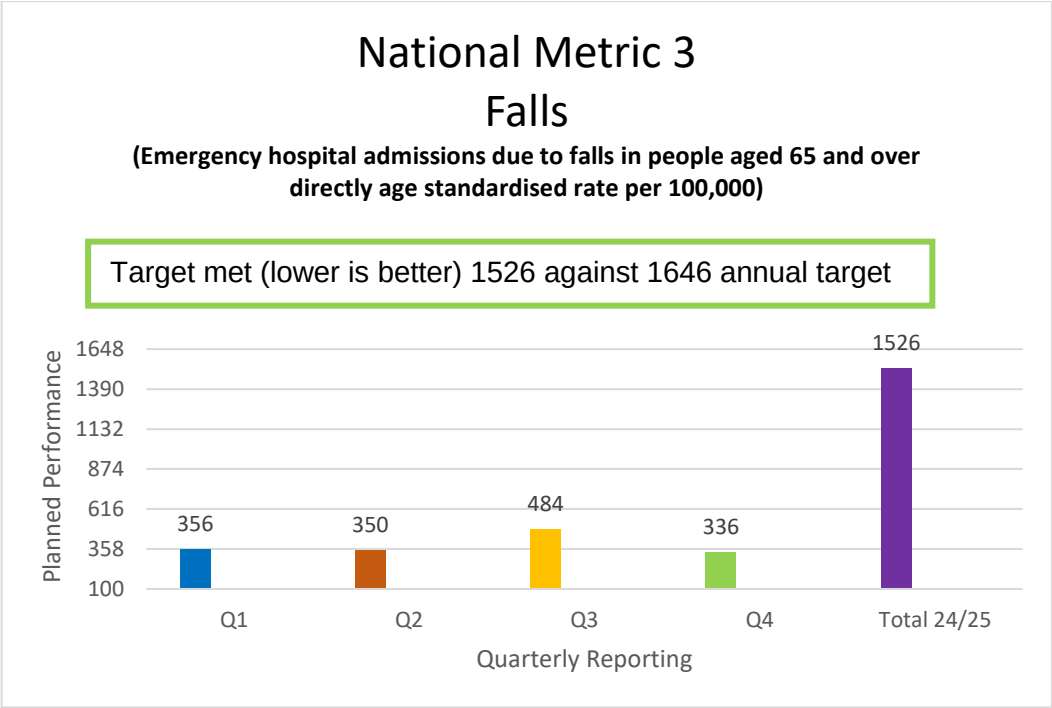
15. The graph for National Metric 2 – Discharge to Normal Place of Residence shows the overall target of 91.4% each quarter was met. With Q2 and Q3 exceeding the target.

16. The bridging team is supporting the improvements related to patients discharged to their usual place of residence on the day that they no longer meet the criteria to reside. The team continue to provide an efficient function with high levels of activity and working seamlessly with reablement provider. Reablement service improvements are having a positive impact on hospital delays for Pathway 1.

17. The availability of capacity in Pathway 1 service to enable discharge to usual place of residence requires daily focus although this has significantly improved recently following system focus. Further work to maximise occupancy of D2A services and reduce LOS in all pathways continues.

18. A full review of therapy resource to ensure reablement offer available will be taking place.

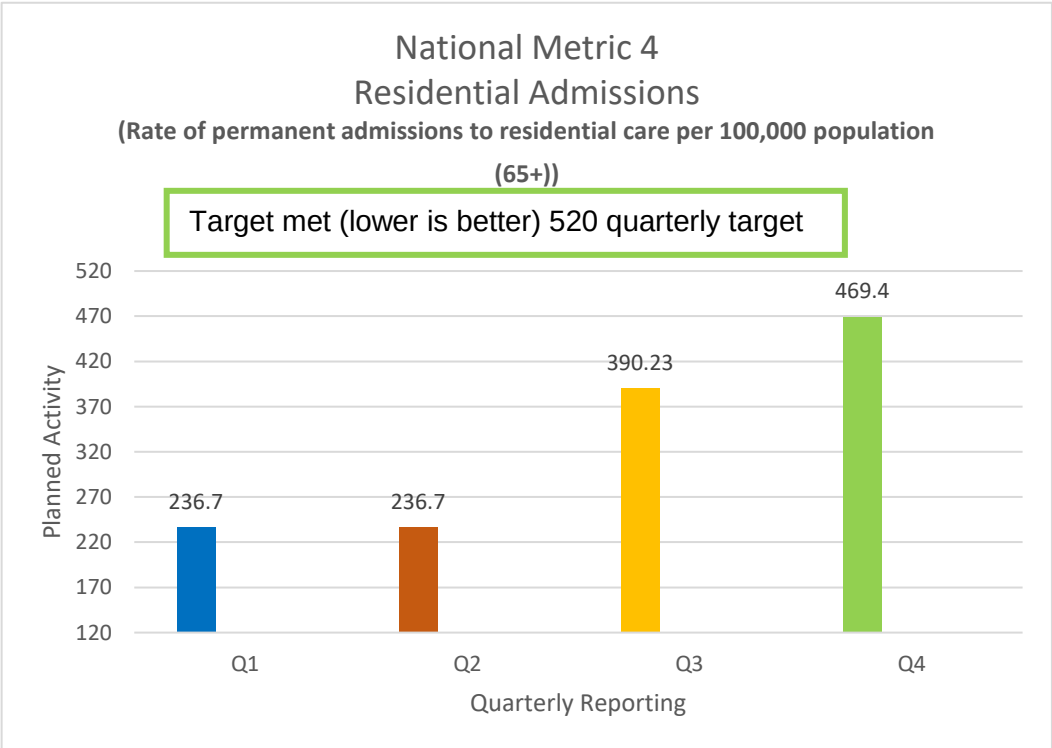
19. Increasing occupancy in D2A bed provision has been a challenge, although improvements continue in pathway 2 beds, commissioned by the council. ICB commissioned D2A beds are currently being reviewed by commissioners to improve occupancy levels.



20. The graph for National Metric 3 – Falls shows the overall target for the year was met with data showing 1526 against the annual target of 1646.

21. Therapy recruitment in Q2 continued to be a challenge to enable capacity for timely access to falls clinics. Q3 saw an improvement with therapy resource for FSDEC to reduce need for inpatient admissions.

22. The service continues to deliver both a timely response and a navigation element to ensure frequent fallers receive appropriate support at year end. The overall target (1646) was met showing 1526 emergency hospital admissions due to falls.



23. The graph for National Metric 4 – Residential Admissions shows the quarterly target of 520 was met in each quarter.

24. The care home market in Herefordshire remains vibrant however this proves challenging in relation to the ability of the council to commission care at or near its standard fee rates. The council is also seeing an increase in the number of self-funders requiring support from the council as a result of their funds having depleted which has a localised impact on number of providers who actively work with the Council.

25. Data in Q3 highlighted high numbers of people being discharged from hospital into bedded care.

26. Despite some challenges, activity in 2024/25 has significantly improved, with levels of permanent admissions each month being lower than in 2023/24. The system continues to work together to address any challenges.

27. A D2A system wide review during 2023/24, increased capacity in the home care market and improvements in delivery of home based D2A support are evidencing improvements in system flow, supporting more people to return home following a hospital episode.

28. Improvements within the Home First service have been made increasing the capacity and improvements in system flow are starting to be realised, supporting more people to return home.

29. Growth in acuity of needs of individuals requiring admissions to care and costs for residential and nursing provision continue to increase and rise. Further work is underway to review pathways and continuously improve commissioned services to support flow.

30. A requirement of the BCF return is to report on intermediate care capacity and demand. Capacity and demand areas are required to reflect on changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans. There are four questions seeking to address the assumptions used in the calculations, changes in the first six months of the year, and any support needs particularly for winter and ongoing data issues.

Question 1 - How have your estimates for capacity and demand changed since the last reporting period?

31. Q1 and Q2 estimates remained unchanged, with efforts focused on reducing demand for Pathway 3 and increasing hospital admission avoidance. In Q3, Pathway 1 grew slightly while Pathways 2 and 3 decreased. The system reviewed data to inform future planning.

32. End of Year (EOY) data shows the productivity of the main D2A providers throughout 2024/25 has progressed and there is further productivity improvements planned for 2025/26. While these enhancements will decrease the need to 'spot-purchase' care provision, they will not eliminate it entirely. The commissioning approach will be reviewed for this winter and consider 'block purchasing' Pathway 2 capacity.

33. Improved data collection has enhanced the understanding of the current position compared to 12 months ago. This knowledge has facilitated the development of a practical plan and will help manage any variations in demand.

Question 2 - How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?

34. There are workstreams for operations and process, pathway 3 discharges, data, commissioning, and communications, each reporting to an integrated system discharge board.

Focus is on hospital admission avoidance in an attempt to reduce demand of D2A once admitted to hospital. Overall capacity is relatively stable.

Question 3 - Do you have any capacity concerns or specific support needs to raise for the winter ahead or for 25/26?

35. System working in Herefordshire means that any actual capacity issues are dealt with as a system and resolved as a priority by using spot purchase for packages of care and care home D2A.

36. On the whole demand does not exceed capacity but the reliance on 'spot-purchase' is a concern. As a system we are working with our main providers to improve productivity (improved length of stay and occupancy). Achieving the desired improvement will materially reduce the need to spot purchase - which potentially could be further reduced by the use of effective 'block-purchasing'.

Question 4 - Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?

37. A system approach to solving any blocks to discharge with local processes in place to support escalation to ensure senior manager involvement of all providers at the right time to prevent longer length of stay (LOS). Use of the Community Response Hub (CRH) to access community urgent response helps with to prevent admissions.

Community impact

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

39. Talk Community brings together community, third sector and statutory services to connect with peers and share ideas and experiences within the local Primary Care Network (PCN) areas; working with communities to identify and address issues that affect them, increase sustainability of communities by facilitating the development of partnerships and collaborative approaches and helping identify any gaps in provision.

Environmental impact

40. 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.

41. Whilst this is a report regarding programme delivery 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

42. Due to the potential impact of this plan being low, a full Equality Impact Assessment is not required. However, the following equality considerations should be taken into account when making a decision about this plan:

    a. The council and HWICB are committed to equality and compliance with the public sector equality duty. 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.

b. Whilst this paper is not seeking any project specific decisions, the year-end report provides an overview of performance in relation to services funded by the BCF. 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.

c. Commissioned services funded by the BCF take into account arrangements to assess and consult on how functions impact on protected characteristics. Services are undertaken in a manner which respects individuality of service users, patients etc. Where appropriate, an Equality Impact Assessment (EIA) is undertaken for separate schemes and services that are within the BCF.

Resource implications

43. In 2024/25 the BCF provided Herefordshire with total funding of £29.508 million.

44. **Better Care Fund – Summary Financial Position 2024/25**

Funding Stream	Approved Plan	Forecast Expenditure	Forecast Variance to Approved Plan
Mandatory Transfer to Adult Social Care	£7,263,296	£7,303,070	£39,774
NHS Commissioned Out of Hospital Services	£9,630,075	£9,654,696	£24,621
Disabled Facilities Grant	£2,024,535	£1,947,167	(£77,368)
Improved Better Care Fund	£6,782,841	£6,042,249	(£740,592)
Additional Discharge Funding	£3,806,849	£4,532,308	£725,459
TOTAL	**£29,507,596**	**£29,479,491**	**(28,105)**

45. The Better Care Fund provides funding to health and social care services including NHS Community Services, Talk Community, social care provision and integrated discharge services. The largest area of spend is on services that support discharge from hospital.

46. Despite considerable variances in some of the individual funding streams, the BCF ended the financial year with a small underspend. The partners agreed to manage the financial outturn through netting-off overspending and underspending between pools, before managing any residual overspend or underspend.

47. The underspending on the Improved Better Care Fund (iBCF) was primarily due to staffing vacancies in operational social work teams and Talk Community, primarily due to an ongoing restructure of the Community Wellbeing directorate. The overspending on Additional Discharge Funding is due to planned improvements in length of stay and occupancy not being realised.

Legal implications

48. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Integrated Care Boards to pool the necessary funding. The council is legally obliged to comply with grant conditions, which have been complied with.

49. 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.

50. 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.

51. Overseeing the deployment of BCF resources locally is a key part of their remit. BCF plans have to be signed off by the health and wellbeing board as well as the HWICB, which represents the NHS side of the equation.

52. 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.

53. The iBCF is paid directly to the council via a Section 31 grant from the Ministry of Housing, Communities and Local Government (MHCLG). 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

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

55. Monitoring the delivery of the Herefordshire BCF Plan is undertaken by the council and HWICB. The Transformation and Improvement Lead monitors any risks, which are managed through the community and wellbeing directorate risk register where necessary.

56. Assurance Statement:

    The risks associated with the delivery of the Better Care Fund Plan 2025–2026 have been identified and are being managed in accordance with the council's Risk Management Strategy. Risks will be monitored through the Community and Wellbeing Directorate risk register and overseen by the Integrated Care Executive (ICE), ensuring appropriate escalation and mitigation throughout the programme.

Risk / Opportunity	Mitigation
Failure to achieve national metrics ambitions.	A robust process for monitoring activity on a monthly basis is in place and will be monitored through the Integrated Care Executive (ICE).

Risk / Opportunity	Mitigation
Increasing demand due to the demography of expected older age population.	A number of the schemes include both areas that support prevention and the urgent care parts of the system to spread the risk. In addition, the council continues to lead on development with communities.
Overspend, particularly on discharge capacity.	The council and HWICB work with One Herefordshire Partnership to revise and improve the service model for Discharge to Assess to be recurrently sustainable.

Consultees

57. The content of the quarterly reports has been provided by partners within One Herefordshire Partnership, HWICB, WVT, Hoople Ltd and appropriate internal Herefordshire Council staff.

Appendices

Appendix 1 Better care fund quarter 1 2024/25 template

Appendix 2 Better care fund quarter 2 2024/25 template

Appendix 3 Better care fund quarter 3 2024/25 template

Appendix 4 Better care fund year-end 2024/25 template

Background papers

None identified

Glossary of terms, abbreviations and acronyms used in this report

Acronym	Description
BCF	Better Care Fund
iBCF	Improved Better Care Fund
1HP	One Herefordshire Partnership
HWICB	Herefordshire & Worcestershire Integrated Commissioning Board
EIA	Equality Impact Assessment
EOY	End of Year
FSDEC	Frailty Same Day Emergency Care
D2A	Discharge to Assess
DHSC	The Department of Health and Social Care
DFG	Disabled Facilities Grant

Acronym	Description
ICE	Integrated Care Executive
LOS	Length of Stay
MHCLG	Ministry of Housing, Communities and Local Government

Appendix 1

HM Government

NHS England

Better Care Fund 2024-25 Quarter 1 Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- 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.griffiths2@herefordshire.gov.uk	
Contact number:	01432 383 809	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 09/12/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

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

	Complete:
2. Cover	Yes
3. Spend and activity	Yes
3.Spend and activity (new schemes)	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2024-25 Quarter 1 Reporting Template

3. Spend and activity (Discharge Fund only)

Add new schemes existing schemes

Selected Health and Wellbeing Board: Herefordshire, County of

Checklist

							Yes		Yes		Yes	Yes
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
401	Support for Hospital Discharge	Integrated Discharge beds @ Hillside Intermediate Care Centre	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with reablement accepting step up and step down users	Local Authority Discharge Funding	£870,977	£303,934	228	45	Number of placements	No	
28	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment	Local Authority Discharge Funding	£193,620	£32,793	-	0		No	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	ICB Discharge Funding	£415,926	£127,068	-	0		No	
43	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management	ICB Discharge Funding	£56,000	£15,251	-	0		No	
33	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)	Local Authority Discharge Funding	£520,309	£152,852	250	30.06	Packages	No	
34	Support for Hospital Discharge	Hospital Discharge Transport	High Impact Change Model for Managing Transfer of Care	Other	ICB Discharge Funding	£235,374	£58,843	-	0		No	
38	Support for Hospital Discharge	Short-term care home beds	Residential Placements	Short term residential care (without rehabilitation or reablement input)	ICB Discharge Funding	£923,931	£262,852	292	99	Number of beds	No	
39	Support for Hospital Discharge	Short-term home care placements	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)	ICB Discharge Funding	£542,712	£134,636	23,874	7850	Hours of care (Unless short-term in which case it is packages)	No	
401	Support for Hospital Discharge	Medical Cover for D2A Care Home Beds	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes	ICB Discharge Funding	£48,000	£8,000	-	0		No	

Appendix 2

Better Care Fund 2024-25 Q2 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data. 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, including the Discharge 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.

DRAFT

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

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the 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

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

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF 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

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met,an outline of the challenge and mitigating actions to support recovery should be outlined. it is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

DRAFT

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2024-25 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- Not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns M and N only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

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

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.
Activity
'For reporting across 24/25 we are asking HWB's to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D H1 Actual Activity".

5.1 C&D Guidance & Assumptions
Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs particularly for winter and ongoing data issues.
5.2 C&D H1 Actual Activity
Please provide actual activity figures for April - September 24, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.
The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation.
Underspend - Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 6a.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

HM Government

NHS England

Better Care Fund 2024-25 Q2 Reporting Template

2. Cover

Version 3.6

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- 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:	Marie Gallalgher and Adrian Griffiths	
E-mail:	Marie.Gallagher1@herefordshire.gov.uk	
Contact number:	01432 260435	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 09/12/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D H1 Actual Activity	Yes
6. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

[<< Link to the Guidance sheet]

^^ Link back to top

Better Care Fund 2024-25 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Herefordshire, County of

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 Q2 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please:* *- describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
		Q1	Q2	Q3	Q4							
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	212.0	212.0	212.0	212.0	117.7	On track to meet target	Ongoing system focus with partners across the system to provide support for the management of long term conditions (LTC) continues to develop.	Q1 - 121 Q2 - 121 Care Home practitioners continue to work closely with providers- links with WVT LTC ACP's via discharge and single point of access continues to improve.			Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.4%	91.4%	91.4%	91.4%	91.48%	On track to meet target	The availability of capacity in Pathway 1 service to enable discharge to usual place of residence requires daily focus - this has significantly improved recently following system focus.	Q1 - 91% Q2 - 92% BCF fund the bridging team which is suporting the improvemnets related to patients discharged to usual place of residence on the day that they no longer meet the criteria to reside.			Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,696.0	317.7	On track to meet target	UEC demand Therapy recruitment to provide capacity for timely access to falls clinics continues to challenge us although improvements have been made in Q2 and we are projecting further improvement is Q3.	Q1 - 356 Q2 - 350 Falls related functions ensure a preventative and responsive elemnt to patinets who have fallen or at risk of falling.			Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				520	not applicable	On track to meet target	Performance at Q2 (260.5) is on track to achieve a level of admissions below target for 2024/25 (520). The Care home market in Herefordshire remains vibrant, with the market significantly geared in relation to self-funders, with the county being a destination for affluent people to move to in later life. This proves challenging in relation to the ability of the council to commission care at or near its standard fee rates resulting in average costs of placements being higher than other Councils in the West Midlands region. The council is also seeing an increase in the number of self-funders requiring support from the council as a result of their funds having depleted. High numbers of people being discharged from hospital in to bedded care remains a challenge.	236.7 - Despite the challenges outlined, activity in 2024/25 has significantly improved, with levels of permanent admissions each month being lower than in 2023/24 D2A system wide review during 2023/24, increased capacity in the home care market and improvements in delivery of home based D2A support are evidencing improvements in system flow, supporting more people to return home following a hospital episode.			Yes

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Herefordshire, County of

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include any learnings from the last 6 months.	
Remain unchanged. Focus on reducing demand for PW3 due to learnings over last six months and increasing use of hospital admission avoidance (CRH)	Yes
2. How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?	
Focus on hospital admission avoidance in an attempt to reduce demand of D2A once admitted to hospital. We have workstreams for operations and process, pathway 3 discharges, data, commissioning, and communications, each reporting to an integrated system discharge board.	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
It is usual to have capacity concerns ahead of the winter due to the unpredictability of demand when heading into winter. Assured that system working in Herefordshire means that any actual capacity issues are dealt with as a system and resolved as a priority by using spot purchase for packages of care and care home D2A.	Yes
4. Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
System approach to solving any blocks to discharge. Local processes in place to support escalation to ensure senior manager involvement of all providers at the right time to prevent longer length of stay (LOS). Use of Community Response Hub (CRH) to access community urgent response to prevent admissions.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6 months of the year
- modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF.. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Herefordshire, County of

Actual activity - Hospital Discharge

Service Area	Metric	Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)						Actual activity through only spot purchasing (doesn't apply to time to service)						Checklist Complete:
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	84	86	81	69	83	80	54	45	37	53	49	26	0	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	3.71	3.71	3.71	2.71	2.71	2.71	5.018518519	5.688888889	4.891891892	6.509433962	4.959183673	5.346153846							Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	8	21	28	34	27	26	0	0	0	0	0	0	16	20	18	10	16	15	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	3.71	3.71	3.71	2.71	2.71	2.71	6.375	6.95	4.888888889	4.5	5.5625	3.928571429							Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	37	47	41	39	50	47	13	14	17	24	12	15	0	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	4.31	4.31	4.31	3.31	3.31	3.31	5	5.5	6.235294118	6.666666667	5.5	5.4							Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	11	10	6	7	5	11	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	8.79	8.79	8.79	6.79	6.79	6.79	0	0	0	0	0	0							Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	18	18	15	22	7	4	0	0	0	0	0	0	21	19	18	8	11	15	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	9.01	9.01	9.01	7.01	7.01	7.01	15.04761905	13.26315789	17.44444444	18.625	15.54545455	15.21428571							Yes

Herefordshire, County ofReablement & Rehabilitation at home (pathway 1)
TTTHerefordshire, County ofReablement & Rehabilitation at home (pathway 1)
Herefordshire, County ofShort term domiciliary care (pathway 1)
TTTHerefordshire, County ofShort term domiciliary care (pathway 1)
Herefordshire, County ofReablement & Rehabilitation in a bedded setting (pathway 2)
TTTHerefordshire, County ofReablement & Rehabilitation in a bedded setting (pathway 2)
Herefordshire, County ofOther short term bedded care (pathway 2)
TTTHerefordshire, County ofOther short term bedded care (pathway 2)
Herefordshire, County ofShort-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)
TTTHerefordshire, County ofShort-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Actual activity - Community

Service Area	Metric	Prepopulated demand from 2024-25 plan						Actual activity:					
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Social support (including VCS)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	Monthly activity. Number of new clients.	17	18	17	14	17	17	0	0	0	0	0	0
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	32	33	31	26	31	30	5	5	3	3	2	4
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	1	2	0	0
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	15	7	9	2	6	2

Herefordshire, County ofSocial support (including VCS) — Yes
Herefordshire, County ofUrgent Community Response — Yes
Herefordshire, County ofReablement & Rehabilitation at home — Yes
Herefordshire, County ofReablement & Rehabilitation in a bedded setting — Yes
Herefordshire, County ofOther short-term social care — Yes

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. 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. Independent Mental Health Advocacy 2. Safeguarding 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 NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. 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 social 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 should 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 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. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. 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 ten 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. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. 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 (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. 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.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	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.
16	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.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 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.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	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.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 Q2 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Herefordshire, County of

<< Link to summary sheet

	2024-25			
Running Balances	Income	Expenditure to date	Percentage spent	Balance
DFG	£2,474,535	£1,033,203	41.75%	£1,441,332
Minimum NHS Contribution	£16,893,372	£8,143,061	48.20%	£8,750,311
iBCF	£6,782,841	£3,012,859	44.42%	£3,769,982
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£1,584,906	£779,914	49.21%	£804,992
ICB Discharge Funding	£2,221,943	£1,303,594	58.67%	£918,349
Total	**£29,957,597**	**£14,272,631**	**47.64%**	**£15,684,966**

Comments if income changed

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25		
	Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,800,617	£4,800,765	£0
Adult Social Care services spend from the minimum ICB allocations	£7,263,293	£3,342,297	£3,920,996

Checklist Column complete: Yes Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder	0	n/a		Social Care		LA			Private Sector	Minimum NHS Contribution	£45,056	£22,528	
51	Community Resilience & Prevention	Community Commissioning	Prevention / Early Intervention	Other	Commissioning & contracting for community-	0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£535,207	£205,455	YTD Underspend is due to vacancies being held pending staffing restructure
52	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		1140	334	Packages	Social Care		LA			Private Sector	Minimum NHS Contribution	£2,321,847	£1,012,870	YTD underspend is due to staffing vacancies
52	Support for Hospital Discharge	Integrated Discharge- Hillside ICC	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		117	29	Number of placements	Social Care		LA			Private Sector	Minimum NHS Contribution	£440,340	£238,758	YTD overspend is due to increased agency costs
52	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£301,226	£125,522	YTD underspend is due to staffing vacancies
52	Support for Hospital Discharge	Brokerage	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£277,027	£143,514	YTD underspend is due to staffing vacancies
52	Support for Hospital Discharge	ART	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£383,330	£102,922	YTD Underspend is due to vacancies being held pending staffing restructure
52	Support for Hospital Discharge	HLT	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£222,379	£108,483	YTD underspend is due to staffing vacancies
53	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£403,855	£177,379	YTD underspend is due to staffing vacancies
54	Social Care Complex Needs	DoLs / AMHPs	Care Act Implementation Related Duties	Independent Mental Health Advocacy		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,001,473	£532,087	YTD overspend is due to increased medical professional costs
54	Social Care Complex Needs	Safeguarding	Care Act Implementation Related Duties	Safeguarding		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£286,395	£130,360	YTD overspend is due to increased agency costs
54	Social Care Complex Needs	Transitions	Integrated Care Planning and Navigation	Care navigation and planning		0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£283,407	£139,842	YTD underspend is due to staffing vacancies
57	Carers Support	Carers Support Contracts	Care Act Implementation Related Duties	Other	Carer support and advice	0	n/a		Social Care		LA			Local Authority	Minimum NHS Contribution	£225,000	£112,500	
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder	0	n/a		Community Health		NHS			Private Sector	Minimum NHS Contribution	£133,306	£66,653	

52	Support for Hospital Discharge	Integrated Discharge- LICU	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		151	34	Number of placements	Community Health		NHS			Private Sector	Minimum NHS Contribution	£1,055,333	£527,667	
57	Carers Support	Acorns Children's Hospice	Carers Services	Respite services		21	11	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£32,995	£16,498	
57	Carers Support	St Michael's Hospice Carer's Support	Carers Services	Respite services		288	144	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£268,177	£134,089	
33	Disabled Facilities Grant	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		174	90	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	£2,474,535	£1,033,203	YTD overspend is due to timing difference in actual spend on projects compared to plan
151	Community Resilience & Prevention	Talk Community Grants	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£91,686	£67,655	YTD overspend is due to small increase in contract costs
151	Community Resilience & Prevention	Talk Community Management	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£248,674	£67,572	YTD Underspend is due to vacancies being held pending staffing restructure
151	Community Resilience & Prevention	Talk Community Brokers	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£142,699	£55,119	YTD Underspend is due to vacancies being held pending staffing restructure
151	Community Resilience & Prevention	Talk Community Development	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£330,234	£182,871	YTD underspend is due to staffing vacancies
151	Community Resilience & Prevention	Talk Community Directory	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£142,656	£27,050	YTD underspend is due to reduction in website costs
151	Community Resilience & Prevention	Talk Community Service Director	Community Based Schemes	Integrated neighbourhood services		0	n/a		Social Care		LA			Local Authority	iBCF	£130,350	£116,000	YTD overspend is due to increased agency costs
151	Community Resilience & Prevention	Care Navigator Frequent Fallers	Prevention / Early Intervention	Other	Falls Prevention & Responder		n/a		Social Care		LA			Local Authority	iBCF	£44,000	£22,000	
151	Community Resilience & Prevention	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy			n/a		Social Care		LA			Local Authority	iBCF	£207,950	£77,542	
152	Support for Hospital Discharge	Trusted Assessors	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	n/a		Social Care		LA			Local Authority	iBCF	£85,457	£42,729	
152	Support for Hospital Discharge	Additional Costs of D2A beds (Ledbury ICU)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		38	9	Number of placements	Social Care		LA			Local Authority	iBCF	£265,484	£132,742	
154	Social Care Services	Locality Social Work Teams	Integrated Care Planning and Navigation	Care navigation and planning		0	n/a		Social Care		LA			Local Authority	iBCF	£4,003,096	£1,669,192	YTD Underspend is due to vacancies being held pending staffing restructure
154	Social Care Services	Social Care Business Delivery & Practice Improvements	Enablers for Integration	Workforce development		0	n/a		Social Care		LA			Local Authority	iBCF	£255,122	£134,197	YTD underspend is due to staffing vacancies
154	Social Care Services	Shared Lives	Residential Placements	Other	Shared Lives	57	57	Number of beds	Social Care		LA			Local Authority	iBCF	£252,827	£123,923	YTD underspend is due to staffing vacancies
401	Support for Hospital Discharge	Integrated Discharge beds @ Hillside Intermediate Care Centre	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		228	57	Number of placements	Social Care		LA			Private Sector	Local Authority Discharge	£870,977	£472,256	YTD overspend is due to increased agency costs
28	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	n/a		Social Care		LA	0.0%		Local Authority	Local Authority Discharge	£193,620	£80,682	YTD underspend is due to staffing vacancies
35	Support for Hospital Discharge	Housing Hospital Discharge Team	High Impact Change Model for Managing Transfer of Care	Housing and related services	0	0	n/a		Social Care		LA	0.0%		Local Authority	iBCF	£98,173	£49,087	
43	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management	0	0	n/a		Social Care		LA	0.0%		Local Authority	Minimum NHS Contribution	£28,546	£12,538	YTD underspend is due to staffing vacancies
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	n/a		Social Care		LA	0.0%		NHS Community Provider	Minimum NHS Contribution	£252,388	£126,194	
56	Care Market Development	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	n/a		Community Health		LA	0.0%		NHS Community Provider	iBCF	£128,681	£64,341	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	n/a		Community Health		NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£8,111,719	£4,055,859	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	n/a		Community Health		NHS	0.0%		NHS Community Provider	ICB Discharge Funding	£415,926	£207,963	
43	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management	0	0	n/a		Community Health		LA	0.0%		NHS	ICB Discharge Funding	£56,000	£30,502	YTD overspend is due to professional costs being higher than expected
33	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)	0	250	75	Packages	Social Care		LA	0.0%		Private Sector	Local Authority Discharge	£520,309	£226,977	YTD underspend is due to staffing vacancies

34	Support for Hospital Discharge	Hospital Discharge Transport	High Impact Change Model for Managing Transfer of Care	Other	Increase in hospital discharge	0	n/a		Acute		NHS	0.0%		Private Sector	ICB Discharge Funding	£235,374	£117,687	
38	Support for Hospital Discharge	Short-term care home beds	Residential Placements	Short term residential care (without rehabilitation or reablement input)	0	292	153	Number of beds	Social Care		LA	0.0%		Private Sector	ICB Discharge Funding	£923,931	£667,046	YTD overspend is due to demand being higher than plan and increased costs of placements
39	Support for Hospital Discharge	Short-term home care placements	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)	0	23874	13818	Hours of care (Unless short-term in which case it is packages)	Social Care		LA	0.0%		Private Sector	ICB Discharge Funding	£542,712	£256,396	YTD underspend is due to demand being slightly lower than planned
52	Social Care Services	Social Care Operations Management	Integrated Care Planning and Navigation	Care navigation and planning	0	0	n/a		Social Care		LA	0.0%		Local Authority	Minimum NHS Contribution	£284,366	£151,346	YTD overspend is due to removal of savings target from service
52	Social Care Services	Social Care Operations Management	Integrated Care Planning and Navigation	Care navigation and planning	0	0	n/a		Social Care		LA	0.0%		Local Authority	iBCF	£92,028	£48,979	YTD overspend is due to removal of savings target from service
55	Residential Placements	Short-term respite care	Residential Placements	Short term residential care (without rehabilitation or reablement input)	0	84	42	Number of beds	Social Care		LA	0.0%		Local Authority	iBCF	£263,724	£131,862	YTD underspend is due to demand being slightly lower than planned
401	Support for Hospital Discharge	Medical Cover for D2A Care Home Beds	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes	0	0	n/a		Primary Care		NHS	0.0%		Private Sector	ICB Discharge Funding	£48,000	£24,000	

Appendix 3

Better Care Fund 2024-25 Q3 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

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, including the Discharge 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.

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

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In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Please submit this template by 14 February 2025

Note on entering information into this template

Please do not copy and paste into the 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

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

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF 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

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

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4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.

Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2024-25 has been pre-populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- On track to meet the ambition
- Not on track to meet the ambition
- Data not available to assess progress

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You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns M and N only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

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

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.

Activity
For reporting across 24/25 we are asking HWBs to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D H1 Actual Activity".

5.1 C&D Guidance & Assumptions
Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the quarter, and any support needs particularly for managing winter demand and ongoing data issues.

5.2 C&D H1 Actual Activity
Please provide actual activity figures for this quarter, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.
The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure from all 3 quarters to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation.
Underspend - Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 6a.

Please use the Discontinue column to indicate if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent.

If you would like to amend a scheme, you can first 'discontinue' said scheme, then re-enter the scheme new data into the 'add new schemes' section.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

Better Care Fund 2024-25 Q3 Reporting Template

2. Cover

Version 1.0

Please Note:

- *The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.*
- *At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.*
- *All information will be supplied to BCF partners to inform policy development.*
- *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:	Marie Gallagher/Adrian Griffiths	
E-mail:	Marie.Gallagher1@herefordshire.gov.uk	
Contact number:	01432 260435	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Thu 13/03/2025	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

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

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D H1 Actual Activity	Yes
6b. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

<< Link to the Guidance sheet

Better Care Fund 2024-25 Q3 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Herefordshire, County of

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 Q3 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q2 (For Q3 data,please refer to data pack on BCX)	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans - ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan*	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	212.0	212.0	212.0	212.0	122.6	On track to meet target	Access to data to highlight variances across care homes	(103) Introduction of Step up Virtual Ward beds to support patients with long term care to remain receiving care at home. Utilising Bridging Team Frailty Same Day Emergency Care (FSDEC) (BCF funded) to support these ward beds. Trial of Care Home Practitioners based in Single Point of Access to supppprt unplanned care home admission reduction. Full review of Care Home Practitioner role planned, including utilising data to support targeted focus.	N/A	N/A	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.4%	91.4%	91.4%	91.4%	92.6%	On track to meet target	Therapy resource limited- demand and capcity completed and has identified funding gap	(92%) Maintaining the improvement for Pathway 1 as Bridging Team and Home First funded by BCF- aiming to reduce Bridging Team as capacity and length of stay (LOS) improves in Home First service. Further work to maximise occupancy of D2A services and reduce LOS in all pathways. Full review of therapy resource to ensure reablement offfer available.	N/A	N/A	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,696.0	374.9	On track to meet target	Therapy resource for FSDEC (Frailty Same Day Emergency Care) to reduce need for inpatient admission	(484) Falls responder and navigator linked in with Single Point of Access- Discussions underway with current provider and potential changes which should see further improvements. Waiting list for falls clinics (non BCF funded) improving which should see preventative offer improve and therefore reduce admissions. Review of falls responder offer currently taking place.	N/A	N/A	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				520	not applicable	On track to meet target	The Care home market in Herefordshire remains vibrant however, it remains challenging for the Council to commission care at or near standard fee rates, the Council currently commissions around 34% of care home beds, with the majority of the remainder being purchased by self funders. There has also been an increase in numbers of people being discharged from hospital during Q3, with high numbers being discharged into bedded care.	Performance at Q3 (390.23) is on track to achieve a level of admissions below target for 2024/25 (520). The system continues to work together to address the challenges. Improvements within the HomeFirst service have been made increasing the capacity and improvements in system flow are starting to be realised, supporting more people to return home. Further work is underway to review pathways and continuously improve commissioned services to support flow.	N/A	N/A	Yes

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5. Capacity & Demand

Selected Health and Wellbeing Board: Herefordshire, County of

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
Real time tracking of capacity and demand remains a real challenge and makes understanding growth and/or seasonal variation very diffcult. We have seen growth in pathway 1 and some slight reduction in P2 and P3. We do not fully understand this and have spent some time as a wide system reviewing the data to understand how this should be reflected in our planning for the remainder of this year and into next year; the work will be completed in the coming weeks.	Yes
2. Do you have any capacity concerns for Q4? Please consider both your community capacity and hospital discharge capacity.	
Overall capacity remains relatively stable and is not a major concern for Quarter 4.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
On the whole demand does not exceed capacity but the reliance on 'spot-purchase' is a concern. As a system we are working with our main providrs to improve productivity (improved length of stay and occupancy). Achieving the desired improvement will materially reduce the need to spot purchase - which potentially could be further reduced by the use of effective 'block-purchasing'.	Yes
4. Do you have any specific support needs to raise for Q4? Please consider any priorities for planning readiness for 25/26.	
No suppport needs at this time	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- Actual demand in the first 9 months of the year
- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Complete:

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5. Capacity & Demand

Selected Health and Wellbeing Board: Herefordshire, County of

Checklist

Complete:

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan			Actual activity (not including spot purchased capacity)			Actual activity through only spot purchasing (doesn't apply to time to service)			Checklist
Service Area	Metric	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	90	96	86	57	40	30	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	1.71	1.71	1.71	5.47	4.75	3.93				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	30	47	53	0	0	0	31	32	44	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1.71	1.71	1.71	0	0	0				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	47	56	44	19	13	17	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2.31	2.31	2.31	4.05	4.46	5.47				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	11	12	11	0	0	0	5	9	2	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	4.79	4.79	4.79	0	0	0				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	13	8	16	0	0	0	21	23	21	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	5.01	5.01	5.01	0	0	0				Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan			Actual activity:			
Service Area	Metric	Oct-24	Nov-24	Dec-24	Oct-24	Nov-24	Dec-24	
Social support (including VCS)	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes
Urgent Community Response	Monthly activity. Number of new clients.	18.59	19.89	17.68	0	0	0	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	34.32	36.72	32.64	3	9	11	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	7	11	13	Yes

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. 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. Independent Mental Health Advocacy 2. Safeguarding 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 NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. 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 social 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 should 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 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. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. 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 ten 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. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. 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 (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. 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.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.

14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	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.
16	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.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 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.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	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.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

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6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Herefordshire, County of

	2024-25			
Running Balances	Income	Expenditure to date	Percentage spent	Balance
DFG	£2,474,535	£1,486,363	60.07%	£988,172
Minimum NHS Contribution	£16,893,372	£12,357,178	73.15%	£4,536,194
iBCF	£6,782,841	£4,677,936	68.97%	£2,104,905
Additional LA Contribution	£0	£0		£0
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£1,584,906	£1,182,795	74.63%	£402,111
ICB Discharge Funding	£2,221,943	£2,041,179	91.86%	£180,764
Total	**£29,957,597**	**£21,745,451**	**72.59%**	**£8,212,146**

Comments if income changed

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25		
	Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,800,617	£7,201,147	£0
Adult Social Care services spend from the minimum ICB allocations	£7,263,293	£5,156,031	£2,107,262

Checklist Column complete: Yes Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent)	Comments
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder	0	NA		Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 45,056	£33,792		
51	Community Resilience & Prevention	Community Commissioning	Prevention / Early Intervention	Other	Commissioning & contracting for community-	0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 535,207	£265,188		
52	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		1140	438	Packages	Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 2,321,847	£1,529,397		
52	Support for Hospital Discharge	Integrated Discharge- Hillside ICC	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		117	45	Number of placements	Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 440,340	£346,227		
52	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 301,226	£241,521		
52	Support for Hospital Discharge	Brokerage	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 277,027	£230,054		
52	Support for Hospital Discharge	ART	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 383,330	£185,121		
52	Support for Hospital Discharge	HLT	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 222,379	£178,830		
53	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management		0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 403,855	£271,404		
54	Social Care Complex Needs	DoLs / AMHPs	Care Act Implementation Related Duties	Independent Mental Health Advocacy		0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 1,001,473	£862,160		
54	Social Care Complex Needs	Safeguarding	Care Act Implementation Related Duties	Safeguarding		0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 286,395	£203,161		
54	Social Care Complex Needs	Transitions	Integrated Care Planning and Navigation	Care navigation and planning		0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 283,407	£217,607		
57	Carers Support	Carers Support Contracts	Care Act Implementation Related Duties	Other	Carer support and advice	0	NA		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 225,000	£168,750		
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder	0	NA		Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 133,306	£99,980		

52	Support for Hospital Discharge	Integrated Discharge- LICU	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		151	75	Number of placements	Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 1,055,333	£791,500	
57	Carers Support	Acorns Children's Hospice	Carers Services	Respite services		21	16	Beneficiaries	Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 32,995	£24,746	
57	Carers Support	St Michael's Hospice Carer's Support	Carers Services	Respite services		288	216	Beneficiaries	Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 268,177	£201,133	
33	Disabled Facilities Grant	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		174	131	Number of adaptations funded/people supported	Social Care	0	LA			Local Authority	DFG	£ 2,474,535	£1,486,363	
151	Community Resilience & Prevention	Talk Community Grants	Community Based Schemes	Integrated neighbourhood services		0	NA		Social Care	0	LA			Local Authority	iBCF	£ 91,686	£100,357	
151	Community Resilience & Prevention	Talk Community Management	Community Based Schemes	Integrated neighbourhood services		0	NA		Social Care	0	LA			Local Authority	iBCF	£ 248,674	£71,533	
151	Community Resilience & Prevention	Talk Community Brokers	Community Based Schemes	Integrated neighbourhood services		0	NA		Social Care	0	LA			Local Authority	iBCF	£ 142,699	£89,323	
151	Community Resilience & Prevention	Talk Community Development	Community Based Schemes	Integrated neighbourhood services		0	NA		Social Care	0	LA			Local Authority	iBCF	£ 330,234	£278,518	
151	Community Resilience & Prevention	Talk Community Directory	Community Based Schemes	Integrated neighbourhood services		0	NA		Social Care	0	LA			Local Authority	iBCF	£ 142,656	£45,994	
151	Community Resilience & Prevention	Talk Community Service Director	Community Based Schemes	Integrated neighbourhood services		0	NA		Social Care	0	LA			Local Authority	iBCF	£ 130,350	£235,707	
151	Community Resilience & Prevention	Care Navigator Frequent Fallers	Prevention / Early Intervention	Other	Falls Prevention & Responder		NA		Social Care	0	LA			Local Authority	iBCF	£ 44,000	£33,000	
151	Community Resilience & Prevention	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy			NA		Social Care	0	LA			Local Authority	iBCF	£ 207,950	£116,313	
152	Support for Hospital Discharge	Trusted Assessors	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	NA		Social Care	0	LA			Local Authority	iBCF	£ 85,457	£64,093	
152	Support for Hospital Discharge	Additional Costs of D2A beds (Ledbury ICU)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		38	20	Number of placements	Social Care	0	LA			Local Authority	iBCF	£ 265,484	£199,113	
154	Social Care Services	Locality Social Work Teams	Integrated Care Planning and Navigation	Care navigation and planning		0	NA		Social Care	0	LA			Local Authority	iBCF	£ 4,003,096	£2,537,429	
154	Social Care Services	Social Care Business Delivery & Practice Improvements	Enablers for Integration	Workforce development		0	NA		Social Care	0	LA			Local Authority	iBCF	£ 255,122	£270,399	
154	Social Care Services	Shared Lives	Residential Placements	Other	Shared Lives	57	57	Number of beds	Social Care	0	LA			Local Authority	iBCF	£ 252,827	£198,855	
401	Support for Hospital Discharge	Integrated Discharge beds @ Hillside Intermediate Care Centre	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		228	89	Number of placements	Social Care	0	LA			Private Sector	Local Authority Discharge	£ 870,977	£684,825	
28	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	NA		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 193,620	£155,243	
35	Support for Hospital Discharge	Housing Hospital Discharge Team	High Impact Change Model for Managing Transfer of Care	Housing and related services	0	0	NA		Social Care	0	LA	0		Local Authority	iBCF	£ 98,173	£73,630	
43	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management	0	0	NA		Social Care	0	LA	0		Local Authority	Minimum NHS Contribution	£ 28,546	£19,184	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	NA		Social Care	0	LA	0		NHS Community Provider	Minimum NHS Contribution	£ 252,388	£189,291	
56	Care Market Development	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	NA		Community Health	0	LA	0		NHS Community Provider	iBCF	£ 128,681	£96,511	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	Minimum NHS Contribution	£ 8,111,719	£6,083,789	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	NA		Community Health	0	NHS	0		NHS Community Provider	ICB Discharge Funding	£ 415,926	£311,945	
43	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management	0	0	NA		Community Health	0	LA	0		NHS	ICB Discharge Funding	£ 56,000	£43,024	
33	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)	0	250	98	Packages	Social Care	0	LA	0		Private Sector	Local Authority Discharge	£ 520,309	£342,727	
34	Support for Hospital Discharge	Hospital Discharge Transport	High Impact Change Model for Managing Transfer of Care	Other	Increase in hospital discharge	0	NA		Acute	0	NHS	0		Private Sector	ICB Discharge Funding	£ 235,374	£176,531	
38	Support for Hospital Discharge	Short-term care home beds	Residential Placements	Short term residential care (without rehabilitation or reablement input)	0	292	234	Number of beds	Social Care	0	LA	0		Private Sector	ICB Discharge Funding	£ 923,931	£1,052,159	

39	Support for Hospital Discharge	Short-term home care placements	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess	0	23874	23832	Hours of care (Unless short-term in which case it is packages)	Social Care	0	LA	0		Private Sector	ICB Discharge Funding	£ 542,712	£421,522		
52	Social Care Services	Social Care Operations Management	Integrated Care Planning and Navigation	Care navigation and planning	0	0	NA		Social Care	0	LA	0		Local Authority	Minimum NHS Contribution	£ 284,366	£214,344		
52	Social Care Services	Social Care Operations Management	Integrated Care Planning and Navigation	Care navigation and planning	0	0	NA		Social Care	0	LA	0		Local Authority	iBCF	£ 92,028	£69,367		
55	Residential Placements	Short-term respite care	Residential Placements	Short term residential care (without rehabilitation or reablement input)	0	84	63	Number of beds	Social Care	0	LA	0		Local Authority	iBCF	£ 263,724	£197,793		
401	Support for Hospital Discharge	Medical Cover for D2A Care Home Beds	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes	0	0	NA		Primary Care	0	NHS	0		Private Sector	ICB Discharge Funding	£ 48,000	£36,000		

Appendix 4

Better Care Fund 2024-25 EOY Reporting Template

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1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

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, including the Discharge 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.

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

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In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the 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

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

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

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

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF 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

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2024-25 will pre-populate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the second quarter of 2024-25 has been pre-populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- Target met
- Target not met
- Data not available to assess progress

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You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns L and M only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

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

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.

Activity
For reporting across 24/25 we are asking HWBs to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D Actual Activity".

5.1 C&D Guidance & Assumptions
Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the quarter, and any support needs particularly for managing winter demand and ongoing data issues.
5.2 C&D Actual Activity
Please provide actual activity figures for this quarter, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

6. Income

This section require confirmation of actual income received in 2024-25 across each fund.

- Please confirm the total HWB level actual BCF pooled income for 2024-25 by reporting any changes to the planned additional contributions by LAs and NHS as reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ADF via LA and ICB if this has changed.
- The template will automatically pre-populate the planned income in 2024-25 from BCF plans, including additional contributions.

7. Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.

The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation. Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation. This shouldn't include spend which has already been allocated in-year and should be the net position.

Underspend - Where there is an underspend please provide details as to the reasons for the underspend.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 7a.

8. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2024-25 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.

The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of yes/no responses:

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2024-25
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

DRAFT

https://www.scie.org.uk/integrated-care/logic-model-for-integrated-care/#enablers

Please highlight:

4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2024-25.

5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2024-25.

Please provide narrative for the above 2 questions.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

HM Government

NHS England

Better Care Fund 2024-25 EOY Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- 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:	Marie Gallagher and Adrian Griffiths	
E-mail:	Marie.Gallagher1@herefordshire.gov.uk	
Contact number:	01432 260435	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 09/06/2025	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

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

Complete

	Complete:	
2. Cover	Yes	For further guidance on requirements please refer back to guidance sheet - tab 1.
3. National Conditions	Yes	
4. Metrics	Yes	
5.1 C&D Guidance & Assumptions	Yes	
5.2 C&D Actual Activity	Yes	
6. Income actual	Yes	
7b. Expenditure	Yes	Expenditure Underspent or Overspent
8. Year End Feedback	Yes	

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2024-25 EOY Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Herefordshire, County of

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 EOY Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q3 (For Q4 data,please refer to data pack on BCX)	Assessment of whether ambitions have been met	Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	212.0	212.0	212.0	212.0	93.1	Target met	The teams continue to work together to achieve the target utilising appropriate functions to deliver. Specific focus on care home unplanned admissions has commenced this year and will continue through 25/26 Recruitment continues to be a challenge particularly around the bridging team utilised to support admission avoidance.	(136) A significant improvement has been the FSDEC Bridging team function- providing a same day response to those patients seen in FSDEC and able to return home. Thus avoiding admission to an acute bed- community support is then planned to enable the person to remain at home. The Community Referral Hub continues to work in an integrtaed way across the system to support the opportunities for Admission Avoidance- record numbers of referrals and a significant increase in referrals from West Midlands Ambulance Service.	N/A	N/A	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.4%	91.4%	91.4%	91.4%	92.03%	Target met	Increasing occupancy in D2A bed provision has been challenging- although improvements continue in our Pathway 2 beds, commissioned by Local Authority ICB commissioned D2A beds are currently being reveiwed by commissioning team to improve occupancy levels Therapy capacity has a direct impact on this target- business case in development to close the assessed gap in resource	(91%) Discharge bridging team continue to provide an efficient function with high levels of activity and working seamlessly with reablemen provider Reablement service improvements are having a positive impact on hospital delays for Pathway 1	N/A	N/A	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,696.0	178.4	Target met	No challenges	(336) Falls response service continues to deliver both a timely response and a navigation element to ensure frequEnt fallers receive appropriate support	N/A	N/A	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				520	not applicable	Target met	Growth in acquity of needs of individuals requiring admissions to care and costs for residential and nursing provision continue to increase and rise. Within Herefordshire, there continues to be significant proportion of the market that is purchased by self-funders, which has a localised impact on number of providers who actively work with the Council.	469.4 - level of admissions below target and we continue to be able to ensure timely access to residential care to meet eligible care and support needs.	N/A	N/A	Yes

Better Care Fund 2024-25 EOY Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Herefordshire, County of

5.1 Assumptions

	Checklist
1. How have your estimates for capacity and demand changed since the last reporting period? Please describe how you are building on your learning across the year where any changes were needed.	
We have made some progress through 2024-2025 on the productivity of our main D2A providers and have planned for further productivity improvements in 2025/26. Whist these improvements will reduce our need to 'spot-purchase' care provision it will not remove this need entirely. We will review our commisioning approach for this winter and look to 'block purchase' P2 capacity. We have improved our data collection and understand our position better than we did 12 months ago and this learning has allowed us to develop a credible plan and will allow us to mitigate any variation in demand.	Yes
2. Do you have any capacity concerns for 25-26? Please consider both your community capacity and hospital discharge capacity.	
Overall capacity remains relativey stable and is not a major concern.	Yes
3. Where actual demand exceeds capacity, what is your approach to ensuring that people are supported to avoid admission or to enable discharge? Please describe how this improves on your approach for the last reporting period.	
On the whole demand does not exceed capacity but our continued relaince on 'spot-purchase' is an ongoing concern. As a system we are working with our main providers to improve productivity (improved length of stay and occupancy). Achieving the desired improvement will materially reduce the need to spot purchase - which potentailly will be further reduced by the use of effective 'block-purchasing'	Yes
4. Do you have any specific support needs to raise? Please consider any priorities for planning readiness for 25/26.	
We do not gave any specific support needs at this time.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- Modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF.. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Complete:

Better Care Fund 2024-25 EOY Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Herefordshire, County of

Actual activity - Hospital Discharge

Service Area	Metric	Prepopulated demand from 2024-25 plan Jan-25	Feb-25	Mar-25	Actual activity (not including spot purchased capacity) Jan-25	Feb-25	Mar-25	Actual activity through only spot purchasing (doesn't apply to time to service) Jan-25	Feb-25	Mar-25	Checklist Complete:
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	89	89	100	50	31	26	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	1.71	1.71	1.71	4.49	3.52	3.96				Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	50	35	32	0	0	0	37	31	23	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1.71	1.71	1.71	3.97	5.13	6.57				Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	45	40	41	16	16	17	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2.31	2.31	2.31	5.07	6.06	8.35				Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	9	23	17	0	0	0	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	4.79	4.79	4.79	0	0	0				Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	17	8	13	0	0	0	24	9	21	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	5.01	5.01	5.01	0	0	0				Yes

Actual activity - Community

Service Area	Metric	Prepopulated demand from 2024-25 plan Jan-25	Feb-25	Mar-25	Actual activity: Jan-25	Feb-25	Mar-25	Checklist Complete:
Social support (including VCS)	Monthly activity. Number of new clients.	0	0	0	0	0	0	Yes
Urgent Community Response	Monthly activity. Number of new clients.	18.33	18.33	20.54	0	0	0	Yes
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	33.84	33.84	37.92	11	10	7	Yes
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	0	0	0	1	0	1	Yes
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	4	9	15	Yes

Better Care Fund 2024-25 EOY Reporting Template

6. Income actual

Selected Health and Wellbeing Board: Herefordshire, County of

	2024-25				
Source of Funding	Planned Income	Actual income	Carried from previous year (23-24)	Actual total income (Column D + E)	**Checklist** Complete:
DFG	£2,474,535	£2,474,535	£0	£2,474,535	Yes
Minimum NHS Contribution	£16,893,372	£16,893,372		£16,893,372	Yes
iBCF	£6,782,841	£6,782,841		£6,782,841	Yes
Additional LA Contribution	£0	£0		£0	Yes
Additional NHS Contribution	£0	£0		£0	Yes
Local Authority Discharge Funding	£1,584,906	£1,584,906		£1,584,906	Yes
ICB Discharge Funding	£2,221,943	£2,221,943		£2,221,943	Yes
Total	**£29,957,597**			**£29,957,597**	

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. 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. Independent Mental Health Advocacy 2. Safeguarding 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 NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. 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 social 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 should 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 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. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. 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 ten 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. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. 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 (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. 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.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	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.
16	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.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 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.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	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.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 EOY Reporting Template

7b. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Herefordshire, County of

	2024-25					
Running Balances	Income	Expenditure to date	Percentage spent	Balance		**If underspent, please provide reasons**
DFG	£2,474,535	£2,397,167	96.87%	£77,368	Underspent!	Adaptations approved but not started at end of year
Minimum NHS Contribution	£16,893,372	£16,957,766	100.38%	-£64,394	Overspent!	
iBCF	£6,782,841	£6,042,249	89.08%	£740,592	Underspent!	Staffing restructure and vacancies
Additional LA Contribution	£0	£0		£0		
Additional NHS Contribution	£0	£0		£0		
Local Authority Discharge Funding	£1,584,906	£1,695,862	107.00%	-£110,956	Overspent!	
ICB Discharge Funding	£2,221,943	£2,836,446	127.66%	-£614,503	Overspent!	
Total	**£29,957,597**	**£29,929,490**	**99.91%**	**£28,107**	Underspent!	Net impact of overspends and underspends above

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25		
	Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,800,617	£9,629,144	£0
Adult Social Care services spend from the minimum ICB allocations	£7,263,293	£7,328,622	£0

Checklist Column complete: Yes Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Actual Spend (£)	Discontinue (if scheme is no longer being carried out in 24-25, i.e. no money has been spent and will be spent)	Comments
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder	0	0		Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 45,056	£44,952		
51	Community Resilience & Prevention	Community Commissioning	Prevention / Early Intervention	Other	Commissioning & contracting for community-	0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 535,207	£460,458		
52	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		1140	497	Packages	Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 2,321,847	£2,088,560		
52	Support for Hospital Discharge	Integrated Discharge- Hillside ICC	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		117	52	Number of placements	Social Care	0	LA			Private Sector	Minimum NHS Contribution	£ 440,340	£518,530		
52	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 301,226	£314,569		
52	Support for Hospital Discharge	Brokerage	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 277,027	£309,960		
52	Support for Hospital Discharge	ART	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 383,330	£260,937		
52	Support for Hospital Discharge	HLT	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 222,379	£249,744		
53	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management		0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 403,855	£361,495		
54	Social Care Complex Needs	DoLs / AMHPs	Care Act Implementation Related Duties	Independent Mental Health Advocacy		0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 1,001,473	£1,221,481		
54	Social Care Complex Needs	Safeguarding	Care Act Implementation Related Duties	Safeguarding		0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 286,395	£284,999		
54	Social Care Complex Needs	Transitions	Integrated Care Planning and Navigation	Care navigation and planning		0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 283,407	£289,848		
57	Carers Support	Carers Support Contracts	Care Act Implementation Related Duties	Other	Carer support and advice	0	0		Social Care	0	LA			Local Authority	Minimum NHS Contribution	£ 225,000	£225,000		
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder	0	0		Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 133,306	£132,999		

52	Support for Hospital Discharge	Integrated Discharge- LICU	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		151	68	Number of placements	Community Health	0	NHS			Private Sector	Minimum NHS Contribution	£ 1,055,333	£1,083,255	
57	Carers Support	Acorns Children's Hospice	Carers Services	Respite services		21	21	Beneficiaries	Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 32,995	£32,995	
57	Carers Support	St Michael's Hospice Carer's Support	Carers Services	Respite services		288	288	Beneficiaries	Community Health	0	NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£ 268,177	£268,177	
33	Disabled Facilities Grant	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		174	174	Number of adaptations funded/people supported	Social Care	0	LA			Local Authority	DFG	£ 2,474,535	£2,397,167	
151	Community Resilience & Prevention	Talk Community Grants	Community Based Schemes	Integrated neighbourhood services		0	0		Social Care	0	LA			Local Authority	iBCF	£ 91,686	£99,404	
151	Community Resilience & Prevention	Talk Community Management	Community Based Schemes	Integrated neighbourhood services		0	0		Social Care	0	LA			Local Authority	iBCF	£ 248,674	£80,828	
151	Community Resilience & Prevention	Talk Community Brokers	Community Based Schemes	Integrated neighbourhood services		0	0		Social Care	0	LA			Local Authority	iBCF	£ 142,699	£120,893	
151	Community Resilience & Prevention	Talk Community Development	Community Based Schemes	Integrated neighbourhood services		0	0		Social Care	0	LA			Local Authority	iBCF	£ 330,234	£373,458	
151	Community Resilience & Prevention	Talk Community Directory	Community Based Schemes	Integrated neighbourhood services		0	0		Social Care	0	LA			Local Authority	iBCF	£ 142,656	£55,432	
151	Community Resilience & Prevention	Talk Community Service Director	Community Based Schemes	Integrated neighbourhood services		0	0		Social Care	0	LA			Local Authority	iBCF	£ 130,350	£164,067	
151	Community Resilience & Prevention	Care Navigator Frequent Fallers	Prevention / Early Intervention	Other	Falls Prevention & Responder		0		Social Care	0	LA			Local Authority	iBCF	£ 44,000	£58,667	
151	Community Resilience & Prevention	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy			0		Social Care	0	LA			Local Authority	iBCF	£ 207,950	£155,960	
152	Support for Hospital Discharge	Trusted Assessors	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care	0	LA			Local Authority	iBCF	£ 85,457	£85,457	
152	Support for Hospital Discharge	Additional Costs of D2A beds (Ledbury ICU)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		38	17	Number of placements	Social Care	0	LA			Local Authority	iBCF	£ 265,484	£272,508	
154	Social Care Services	Locality Social Work Teams	Integrated Care Planning and Navigation	Care navigation and planning		0	0		Social Care	0	LA			Local Authority	iBCF	£ 4,003,096	£3,338,066	
154	Social Care Services	Social Care Business Delivery & Practice Improvements	Enablers for Integration	Workforce development		0	0		Social Care	0	LA			Local Authority	iBCF	£ 255,122	£334,361	
154	Social Care Services	Shared Lives	Residential Placements	Other	Shared Lives	57	57	Number of beds	Social Care	0	LA			Local Authority	iBCF	£ 252,827	£272,447	
401	Support for Hospital Discharge	Integrated Discharge beds @ Hillside Intermediate Care Centre	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		228	101	Number of placements	Social Care	0	LA			Private Sector	Local Authority Discharge	£ 870,977	£1,025,634	
28	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	0		Social Care	0	LA	0		Local Authority	Local Authority Discharge	£ 193,620	£202,197	
35	Support for Hospital Discharge	Housing Hospital Discharge Team	High Impact Change Model for Managing Transfer of Care	Housing and related services	0	0	0		Social Care	0	LA	0		Local Authority	iBCF	£ 98,173	£102,326	
43	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management	0	0	0		Social Care	0	LA	0		Local Authority	Minimum NHS Contribution	£ 28,546	£25,552	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care	0	LA	0		NHS Community Provider	Minimum NHS Contribution	£ 252,388	£252,388	
56	Care Market Development	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Community Health	0	LA	0		NHS Community Provider	iBCF	£ 128,681	£128,681	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Community Health	0	NHS	0		NHS Community Provider	Minimum NHS Contribution	£ 8,111,719	£8,111,718	
56	Support for Hospital Discharge	WVT Integrated Care Services	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Community Health	0	NHS	0		NHS Community Provider	ICB Discharge Funding	£ 415,926	£415,926	
43	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management	0	0	0		Community Health	0	LA	0		NHS	ICB Discharge Funding	£ 56,000	£56,962	
33	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)	0	250	109	Packages	Social Care	0	LA	0		Private Sector	Local Authority Discharge	£ 520,309	£468,031	
34	Support for Hospital Discharge	Hospital Discharge Transport	High Impact Change Model for Managing Transfer of Care	Other	Increase in hospital discharge	0	0		Acute	0	NHS	0		Private Sector	ICB Discharge Funding	£ 235,374	£235,374	
38	Support for Hospital Discharge	Short-term care home beds	Residential Placements	Short term residential care (without rehabilitation or reablement input)	0	292	267	Number of beds	Social Care	0	LA	0		Private Sector	ICB Discharge Funding	£ 923,931	£1,392,168	

39	Support for Hospital Discharge	Short-term home care placements	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)	0	23874	32842	Hours of care (Unless short-term in which case it is packages)	Social Care	0	LA	0		Private Sector	ICB Discharge Funding	£ 542,712	£688,016		
52	Social Care Services	Social Care Operations Management	Integrated Care Planning and Navigation	Care navigation and planning	0	0	0		Social Care	0	LA	0		Local Authority	Minimum NHS Contribution	£ 284,366	£420,149		
52	Social Care Services	Social Care Operations Management	Integrated Care Planning and Navigation	Care navigation and planning	0	0	0		Social Care	0	LA	0		Local Authority	iBCF	£ 92,028	£135,971		
55	Residential Placements	Short-term respite care	Residential Placements	Short term residential care (without rehabilitation or reablement input)	0	84	84	Number of beds	Social Care	0	LA	0		Local Authority	iBCF	£ 263,724	£263,724		
401	Support for Hospital Discharge	Medical Cover for D2A Care Home Beds	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes	0	0	0		Primary Care	0	NHS	0		Private Sector	ICB Discharge Funding	£ 48,000	£48,000		

Better Care Fund 2024-25 EOY Reporting Template

8. Year End Impact Summary

Selected Health and Wellbeing Board: Herefordshire, County of

Confirmation of Statements			Checklist Complete:
Question statements	**Confirmation**	**If the answer is "No" please provide an explanation:**	
Overall delivery of BCF has improved joint working between health and social care	Yes		Yes
Our BCF schemes were implemented as planned in 2024-25	Yes		Yes
The delivery of our BCF plan 2024-25 has had a positive impact on the integration of health and social care in our locality.	Yes		Yes

Highlight success and challenges within reference to the most relevant enablers from SCIE logic model:		
Logic model for integrated care - SCIE		
Success and Challenges	**Narrative**	
2 key successes observed towards driving the enablers for integration	Discharge to Assess Board has provided a much needed opportunity for the system to join together to achieve. This allows the various organisations to plan, deliver and understand financial implications for decisions made related to the services within the BCF. Commitment from all Partners to review and co-produce our specifications for delivery of our commissioned Enablement services has ensured a high quality specification with mutual understanding across all Partners of service delivery and has enhanced opportunities for integration and further development of the existing model.	Yes
2 key challenges observed towards driving the enablers for integration	Increased demand for discharge to assess services has created capacity issues across our teams- however the system has been able to work through demand and capacity planning to ascertain where resource is required to support our residents. Increased demand across services associated with discharge to assess will also result in increases in cost and expenditure that have been unforseen, we have ensured people are discharged timely through demand and capacity planning however we have seen an increase in costs associated with spot purchasing.	Yes

Herefordshire Council

Title of report: Herefordshire's Better Care Fund (BCF) plan 2025-26

Meeting: Health and Wellbeing Board

Meeting date: Monday 9 June 2025

Report by: Service Director - All Age Commissioning, Transformation and Improvement Lead

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

To update Health and Wellbeing Board members on Herefordshire's Better Care Fund (BCF) Plan 2025/26 and seek formal Health and Wellbeing Board approval.

Recommendation(s)

That:

a) The Herefordshire Better Care Fund 2025/26 Narrative Plan (Appendix 1), Planning Template (Appendix 2) and the Capacity and Demand Template (Appendix 3), submitted to NHS England, be reviewed and approved; and

b) the ongoing work to support integrated health and care provision that is funded via the BCF is noted by the board.

Alternative options

1. The board could decline to sign off the submission. It is a national requirement that the BCF Plan is signed off by the Health and Wellbeing Board (HWB). The content of the return has already been approved by Hilary Hall, Corporate Director for Community Wellbeing by way of delegated authority and submitted prior to the meeting of the board, in accordance with national deadlines.

Further information on the subject of this report is available from
Hayley Doyle, Marie Gallagher, Tel: 01432 260832, Tel: 01432 260435, email:
Hayley.Doyle@herefordshire.gov.uk, Marie.Gallagher1@herefordshire.gov.ukl

2. The BCF Plan was signed off by Simon Trickett, Chief Executive of Herefordshire and Worcestershire Integrated Care Board (HWICB).

3. The HWB does not always align with national deadlines, however this gives the board an opportunity to review and provide feedback.

Key considerations

4. The Better Care Fund provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Herefordshire and Worcestershire Integrated Care Board (HWICB) allocations, and funding paid directly to local government.

5. The national BCF team determines national reporting requirements on the overall BCF programme, with quarterly reports being submitted to NHS England (NHSE) and Health and Wellbeing Boards.

6. The Better Care Fund Policy Framework and Planning Requirements for 2025/26 were published on 30 January 2025. Similar to previous years, the Better Care Fund Policy Framework for 2025/26, requires that BCF plans consist of:

   a. BCF Narrative Plan (**Appendix 1**);

   b. BCF planning template including planned expenditure, confirmation that national conditions are met, ambitions for national metrics and additional contributions to BCF section 75 agreements, revised ambitions and plans for performance against four BCF national metrics based on 2024/25 performance. (**Appendix 2**);

   c. A separate intermediate care and short term Capacity and Demand plan (**Appendix 3**).

7. The deadline for submission of the updated BCF plan to NHS England was 31 March 2025.

8. There was a delay in submitting the Herefordshire plan this year due to financial pressures on partners making it difficult to agree an expenditure plan. System colleagues worked together to resolve this, and the national team were kept updated. The approved plan was submitted 7 May 2025.

New BCF objectives for 2025/26

9. **Objective 1:** reform to support the shift from sickness to prevention local areas must agree plans that help people remain independent for longer and prevent escalation of health and care needs, including:

   a. timely, proactive and joined up support for people with more complex health and care needs

   b. use of home adaptations and technology

   c. support for unpaid carers

10. **Objective 2:** reform to support people living independently and the shift from hospital to home Local areas must agree plans that:

    a. help prevent avoidable hospitable admissions

    b. achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)

    c. reduce the proportion of people who need long-term residential or nursing home care

Key changes from previous years

11. **Consolidating discharge funding**: To give local areas greater flexibility in how they meet the objectives of the BCF, the previously ring-fenced Discharge Fund has been consolidated within the BCF. While discharge funding is now consolidated, reducing discharge delays remains a critical shared priority across the NHS and local authorities.

12. **Planning:** The introduction of a more proportionate and risk-based approach to reviewing local BCF plans, and progress against those plans, with strong accountability that focuses on outcomes rather than inputs. Where local partners are not achieving improvements, an enhanced level of support and oversight and work will be provided, with local partners to agree how they will raise performance.

13. **Metrics:** New metrics focused on outcomes rather than inputs, with locally agreed goals against these metrics.

Planning for 2025 to 2026

14. As set out in the BCF policy framework, HWB's must ensure plans meet four national conditions for 2025/26:

National condition 1: Plans to be jointly agreed

a. Local authorities and ICBs must agree a joint plan, signed off by the HWB, to support the policy objectives of the BCF for 2025/26.

b. The development of these plans must involve joint working with local NHS trusts, social care providers, voluntary and community service partners and local housing authorities.

National condition 2: Implementing the objectives of the BCF

Local authorities and ICBs must show how health and social care services will support improved outcomes against the two national policy objectives.

National condition 3: Complying with the grant conditions and the BCF funding conditions including maintaining the NHS minimum contribution to adult social care

a. The NHS minimum contribution to adult social care is met and maintained by the ICB and must increase by at least 3.9%.

b. Local authorities comply with the grant conditions of the Local Authority Better Care Grant and the Disabled Facilities Grant (DFG).

c. Plans will also be subject to a minimum expectation of spending on adult social care.

National condition 4: Complying with the oversight and support processes

This requires ICBs and HWBs to engage with national BCF oversight and support processes.

15. Compliance with the national conditions is confirmed through the BCF Planning template. Spend applicable to these national conditions is calculated in the planning template based on scheme level expenditure data.

Metrics

16. The BCF policy framework sets out three national metrics for the BCF 2025/26, as follows:

1) Emergency admissions to hospital for people aged over 65 per 100,000 population.

2) Average length of discharge delay for all acute adult patients, derived from a combination of:

   - proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)
   - for those adult patients not discharged on their DRD, average number of days from the DRD to discharge

3) Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population

17. These metrics have been designed to help local areas to focus on impact and outcomes. Data on these metrics will be centrally collected by the national team and made available to HWB's on a new BCF dashboard.

Intermediate care capacity and demand plans

18. As part of national condition 1, HWBs are required to agree and submit a plan showing projected demand and planned capacity for intermediate care services (and other short-term care) to help people to remain independent, or regain independence, at home (including support aimed at avoiding unnecessary hospital admissions and support following discharge from hospital).

19. NHSE Timetable for Assurance

Assurance Milestone	**Date**
Draft headline HWB submissions to be made to regional better care managers for feedback and discussion	3 March 2025
Full HWB submission to be made to the national Better Care Fund team and regional better care managers	31 March 2025 (12 noon)
Outcome letters to HWB areas	May 2025
All section 75 agreements to be signed and in place	30 September 2025

Community impact

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

21. Talk Community brings together community, third sector and statutory services to connect with peers and share ideas and experiences within the local Primary Care Network (PCN) areas; working with communities to identify and address issues that affect them, increase sustainability of communities by facilitating the development of partnerships and collaborative approaches and helping identify any gaps in provision.

Environmental impact

22. 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.

23. Whilst this is a report on programme delivery 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

24. Due to the potential impact of this plan being low, a full Equality Impact Assessment is not required. However, the following equality considerations should be taken into account when making a decision about this plan:

    a. The council and HWICB are committed to equality and compliance with the public sector equality duty. 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.

    b. Whilst this paper is not seeking any project specific decisions, the year-end report provides an overview of performance in relation to services funded by the BCF. 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.

    c. Commissioned services funded by the BCF take into account arrangements to assess and consult on how functions impact on protected characteristics. Services are undertaken in a manner which respects individuality of service users, patients etc. Where appropriate, an Equality Impact Assessment (EIA) is undertaken for separate schemes and services that are within the BCF.

Resource implications

25. Funding for the Better Care Fund has increased by £0.673m for 2025/26, of which £0.341m relates to Disabled Facilities Grant.

26. **Better Care Fund Financial Plan 2025/26 – Summary by Funding Stream**

Better Care Fund Financial Plan 2025/26	2024/25 Funding Values £	2025/26 Increase in Funding Allocation £	2025/26 Total Allocation £
NHS Minimum Contribution (transfer to ASC)	£7,263,293	£285,092	£7,548,385
NHS Minimum Contribution (retained by ICB)	£11,852,022	£47,448	£11,899,470
Total NHS Minimum Contribution	£19,115,315	**£332,540**	**£19,447,855**
Disabled Facilities Grant	**£2,474,535**	**£340,496**	**£2,815,031**
Local Authority Better Care Grant	**£8,367,747**	**£0**	**£8,367,747**
TOTAL BETTER CARE FUND	**£29,957,597**	**£673,036**	**£30,630,633**

27. The main changes from 2024/25 are:

    a. Removing ASC operational teams from the plan. The ongoing restructure of ASC staffing made financial reporting difficult in 2024/25, and performance management of these teams is not the responsibility of One Herefordshire, so they have been removed from the BCF to be funded by the council's own budgets.

b. Removing Talk Community from the plan. Responsibility for the Talk Community programme has moved to Public Health within Herefordshire Council, so it has been removed from the BCF to be funded from the council's own budgets.

c. Replacing Talk Community and ASC Operational Teams with a new scheme: ASC long-term placements. The £7.5million expenditure in the BCF will be a contribution to the council's overall net budget for ASC placements of £86.7million.

28. **2025/26 BCF Summary Financial Plan**

	Scheme Name	2024/25 Planned Expenditure	Total Changes	2025/26 Planned Expenditure
1	Acorns Children's Hospice	£32,995	£1,947	£34,942
2	Advocacy	£207,950	(£52,866)	£155,084
3	*ASC Long-term Placements*	£0	£7,552,056	£7,552,056
4	Brokerage	£277,027	£49,762	£326,789
5	Carers Support	£225,000	£0	£225,000
6	Disabled Facilities Grant	£2,474,535	£340,496	£2,815,031
7	Discharge to Assess	£8,039,706	£286,399	£8,326,105
8	DoLS/AMHPs	£1,001,473	£14,091	£1,015,564
9	Falls Response and Prevention	£222,362	£3,835	£226,197
10	Partnerships and Integration Staffing	£488,400	(2,56,867)	£231,533
11	Safeguarding	£286,395	£9,327	£295,722
12	St Michael's Hospice Carer's Support	£268,177	£15,821	£283,998
13	Trusted Assessors	£85,457	£2,564	£88,021
14	WVT Integrated Care Services	£8.908.713	£145,877	£9,054,590
	Operational Social Work Teams	*£6,353,107*	*(£6,353,107)*	*£0*
	Talk Community	*£1,086,299*	*(£1,086,299)*	*£0*
	PLAN TOTAL	**£29,957,596**	**£673,037**	**£30,630,633**

29. Limited increases in BCF revenue allocations, coupled with inflationary pressures and projected levels of demand for services mean that a balanced BCF plan for 2025/26 could only be achieved by including planned savings in BCF services.

30. Planned savings are summarised below; they focus mainly on discharge services to recover the overspending seen in 2024/25. There is a high risk of overspending against BCF funding if the planned improvements to occupancy and length of stay are not achieved.

2025/26 Planned Savings	**£**
Reduction in Strategic Finance Manager FTE	(£55,306)
Rapid review of VFM in BCF funded services	(£181,808)
Improvement in occupancy at Hillside and LICU	(£178,713)
Improvement in capacity of Home First	(£58,632)
Likely underspend in Home First staffing	(£150,708)
Reduce Also in D2A	(£199,017)
Total Proposed Reduction	**(£824,084)**

Legal implications

31. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Integrated Care Boards to pool the necessary funding. The council is legally obliged to comply with grant conditions, which have been complied with.

32. 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.

33. 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.

34. Overseeing the deployment of BCF resources locally is a key part of their remit. BCF plans have to be signed off by the health and wellbeing board as well as the HWICB, which represents the NHS side of the equation.

35. 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.

36. The iBCF is paid directly to the council via a Section 31 grant from the MHCLG. 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 is legally obliged to comply with the grant conditions set.

Risk management

37. Monitoring the delivery of the Herefordshire BCF Plan is undertaken by the council and HWICB. The Transformation and Improvement Lead monitors any risks, which are managed through the community and wellbeing directorate risk register where necessary.

38. The One Herefordshire Integrated Care Executive (ICE) undertakes scrutiny of performance monitoring of BCF by:

    a. Building consensus between partners and setting objectives beyond the nationally determined outcomes as part of the annual planning of the Better Care Fund, including the BCF Plan.

    b. Development and implementation of new and/or revised services or care pathways.

    c. Monitoring, delivery and reporting of performance and outcomes.

    d. Budget management and ensuring spending lives within the resources allocated, identifying remedial actions where spending is off trajectory.

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/national assurance process	The council and HWICB have worked through the national guidance and requirements to ensure a robust response, and a comprehensive, detailed plan is submitted.
Failure to achieve national metric ambitions	A robust process for monitoring activity monthly is in place and will be monitored through the Integrated Care Executive (ICE).
Overspending, particularly on discharge capacity	The council and HWICB are working with One Herefordshire Partnership to revise and improve the service model for Discharge to Assess to be recurrently sustainable.
Increasing demand due to the demography of expected older age population.	Several of the schemes include both areas that support prevention and the urgent care parts of the system to spread the risk. In addition, the council continues to lead on development with communities.

Consultees

39. The content of the report has been provided by partners within One Herefordshire Partnership, HWICB, WVT, Hoople Ltd and appropriate internal Herefordshire Council staff.

Appendices

Appendix 1 Herefordshire's BCF 2025-26 Narrative Plan Template

Appendix 2 Herefordshire's BCF 2025-2026 Planning Template

Appendix 3 Herefordshire's BCF Capacity and Demand Template 2025-26

Background papers

None identified.

Glossary of terms, abbreviations and acronyms used in this report

Acronym	Description
AHMP	Approved Mental Health Practitioner
BCF	Better Care Fund

Acronym	Description
AHMP	Approved Mental Health Practitioner
iBCF	Improved Better Care Fund
HWICB	Herefordshire and Worcestershire Integrated Care Board
HWB	Health and Wellbeing Board
DFG	Disabled Facilities Grant
D2A	Discharge to Assess
DHSC	Department of Health and Social Care
DoLS	Deprivation of Liberty and Safeguarding
DRD	Discharge Ready Date
EIA	Equality Impact Assessment
FTE	Full Time Equivalent
MHCLG	Ministry of Housing, Communities and Local Government
NHSE	NHS England
1HP	One Herefordshire Partnership
ICE	Integrated Care Executive
PCN	Primary Care Network
LICU	Leominster Intermediate Care Unit (Shaw Healthcare)
VFM	Value for Money

Integration and Better Care Fund

Appendix 1

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1	
HWB	Herefordshire	
ICB	Herefordshire & Worcestershire	

Section 1: Overview of BCF Plan

This should include:

- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process.
- Specifically, alignment with plans for improving flow in urgent and emergency care services.
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

Executive Summary

This document sets out Herefordshire's Better Care Fund Plan for 2025/26. It aligns with the BCF Planning Template and the Demand and Capacity Template which will be submitted together with this narrative.

The BCF has been a key contributor for a number of years towards building partnerships and integration between partners and stakeholders of health and social care.

Despite system pressures, partners continue to make a difference to the way services are organised and delivered.

Priorities for 2025/26

Herefordshire's Better Care Fund (BCF) Plan for 2025-26 will continue to support our long-term vision and build on previous system priorities to strengthen what has been achieved so far. Our plan sets out the work we need to do to further develop the way we work together on our shared priorities to deliver key outcomes for local people. Herefordshire's priorities for the BCF 2025-26 include:

- Hospital Discharge Support
- Adult Social Care Services
- Community Health Services

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Key changes since previous BCF Plan

Our BCF plan for 2025/26 has a number of changes compared to the 2023/25 plan. Some of these changes are driven by changes in priorities, others by the need to make difficult financial choices due to the real-terms reduction in BCF funding, particularly in relation to discharge services. In order to maintain discharge flow and consolidate the progress we have made in integrating discharge services, partners have tried to maintain levels of spending on hospital discharge. The lack of any increase in discharge funding for 2025/26, coupled with costs of care that have increased by more than 10% in each of the last three financial years, means that maintaining funding for hospital discharge leads to funding reductions in other areas, and some services funded by BCF will have to be decommissioned.

The most significant changes made in this year's plan are:

- Removal of all operational social work teams from BCF- these services will be funded by adult social care base budget, with the BCF funding repurposed towards long-term ASC placements.
- Removal of Talk Community services - these services are focussed on community resilience and prevention. Responsibility for them has transferred to public health and they will be funded by base budget, with the BCF funding repurposed towards long-term ASC placements.
- No funding available to increase investment in prevention, community resilience or admission avoidance.

A rapid review will focus on identifying cost-effective schemes to achieve any savings.

Patients overstaying the 6-week BCF funded reablement period in one of the 'contracted' D2A providers (Home First, Hillside or LICU) continue to be the financial responsibility of the BCF rather than financially contributing themselves or funded by the council or health.

This does lead to a material financial pressure on the BCF and accordingly this issue needs to be resolved this financial year. This issue will not be easily resolved by cross charging those deemed responsible for the delay and will ultimately create a financial pressure for one or more of the One Herefordshire partners. It is important that partners work together to prevent overstays in the first place and by doing so reduce the overall financial burden on the BCF and release capacity of others to access in a timely way.

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Approach to development of plan and of joint system governance to support delivery (and where required engage with BCF oversight and support process).

The Herefordshire Health and Wellbeing Board is responsible for agreeing the BCF plan and for overseeing delivery through quarterly reporting.

The responsibility for the BCF is embedded within the Senior Leadership Teams of both the Community Wellbeing Directorate of the council and the Herefordshire and Worcestershire Integrated Care Board (ICB). In each organisation, chief officers, and their senior leadership teams, 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 council's County Plan. Ongoing provider forums and engagement also feed into future intentions.

Programme governance arrangements are in place to support joint working and to enable a move to increasing alignment of commissioning arrangements, including the 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 Better Care Fund has the engagement of the One Herefordshire Partnership (1HP) to support the delivery of the plan. One Herefordshire Partnership is the vehicle by which Herefordshire Place partners work together at a strategic level and is a key enabler of the BCF plan delivery.

The establishment of a Memorandum of Understanding (MOU) was agreed for 23-25 plan and has been approved and agreed to continue for the 25-26 plan. Signed by the four partners this will continue to provide a formal basis for the collaboration and working arrangements between organisations involved in the 1HP specifically to detail the collaborative approach to delivery and oversight of integrated health and care delivery in Herefordshire. The MOU sets out a framework of roles and responsibilities for the participants engaged in Place collaboration.

The four partners are Herefordshire Council, Herefordshire General Practice, Herefordshire and Worcestershire Health and Care NHS Trust and Wye Valley Trust. Herefordshire Healthwatch, and Herefordshire and Worcestershire ICB are invited members of the partnership.

The primary purposes of the 1HP are to:

- set the strategy for Herefordshire's health and care services;
- approve priorities, programmes, plans and objectives;

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- receive updates on progress against the objectives and performance of integrated services; and
- ensure that appropriate engagement with the public, service users and staff has taken place.

One Herefordshire Partnership will report to Herefordshire and Worcestershire ICB for the day to day delivery of the Better Care Fund. A MOU has been established setting out the roles and responsibilities of local partners with the ICB. This has been developed to facilitate the objectives set out above.

Partners have agreed the 2025-26 BCF Plan, metrics and capacity & demand data following approval at relevant leadership and committee meetings.

Governance decisions regarding the BCF for Herefordshire are endorsed by Herefordshire Council and Herefordshire and Worcestershire ICB (HWICB) with final accountability for signing off BCF commitments made by Herefordshire Health and Wellbeing Board.

The successful recruitment has taken place for a new role, Partnerships and BCF Manager, to support collaborative practice and system-wide working which will be supported through matrix management agreements.

Alignment with plans for improving flow in urgent and emergency care services.

Integration of discharge services are a key priority of the One Herefordshire Partnership. We have chosen to maintain levels of investment in discharge services to continue the progress made in previous years.

Priorities for developing intermediate care (and other short-term care).

Working with our strategic partners, we plan to further develop Home First services to build on the improvements we have made in pathway one. We will seek to increase capacity by increasing more reablement workers and improve flow by reducing lengths of stay.

We have plans to restructure operational social care to increase capacity for assessments under the Care Act, and to increase capacity in community therapy.

We also plan to improve capacity in our strategic partners for pathway two beds, to reduce reliance on the care market for discharge placements.

We have made great strides in improving our data around discharge services and plan to build on that work to fully understand the whole patient journey from prior to admission to after exit from intermediate care, using the information and learning to improve efficiency and effectiveness throughout the pathway.

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Section 2: National Condition 2: Implementing the objectives of the BCF.

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money.
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans.
- Demonstrating a “home first” approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care.
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

Objective 1: reform to support the shift from sickness to prevention.

Local areas must agree plans that help people remain independent for longer and prevent escalation of health and care needs, including:

- timely, proactive and joined-up support for people with more complex health and care needs
- use of home adaptations and technology
- support for unpaid carers

Herefordshire Council is embarking on a joint piece of work to develop an accommodation and care at home strategy. The strategy will be a signal to the housing and social care markets on requirements in the coming 15-20 years for people with a range of needs. The guiding principle of this work is to ensure in-county accommodation is available for vulnerable people, so funding is retained within the Herefordshire system.

Accommodation is purpose built with design features that support the growth and maintenance of independence for as long as possible, and where digital technologies enhance the built environment. This work is being arranged to include systems partners and is directly related

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to several other pieces of work; Herefordshire Council and Herefordshire and Worcester ICB are collaborating to jointly commission new care facilities tailored for children and adults with complex needs. This initiative is designed to offer a comprehensive support system that integrates both social care and health wrap-around services, along with digital technologies in the built environment which will significantly enhance the quality of care and delivery on-site for individuals with the highest levels of need.

This joint effort aims to ensure that the support provided is seamless and holistic, addressing not only the social care requirements but also the health-related needs of the individuals we serve. By working together, we can create a more cohesive and effective support structure that will greatly benefit those in our community who require the most intensive care and prevent further escalation of need.

This joint work is being done in the context of the development of an accommodation and care at home strategy and a review of supported living, both areas of work involving a multiagency approach which provides a positive foundation for BCF initiative to support.

In addition to the development of additional capacity in the system, reviews are being carried out with systems partners on existing accommodation-based services i.e. supported living and respite to ensure both the accommodation and service models are fit for current and future needs to support timely and safe discharge from hospital and the changing needs of existing residents.

The Carers Partnership Board is overseeing the delivery of the Carers Strategy Action Plan with multiple stakeholders, including health and social care professionals. The action plan seeks to understand the carers population and support them to continue providing services to the Cared for by the collection of robust data sets.

Health, Public Health and other preventative services play a key role in identifying carers who may not yet be known to social care and whose needs for social care could be delayed if the right interventions are made available in a timely way and by ensuring sources of information, advice and guidance are readily available across systems partners.

The ICB supports carer breaks through the BCF, including respite care for people with life-limiting conditions in clinical settings. The NHS contribution will continue to support the Care Act by providing assessment, advice, and support to carers. Carer engagement and support are integral to the strengths-based reablement approach, ensuring carers are informed, supported, and have access to equipment and aids. Additionally, addressing social isolation, fuel poverty, and carers' wellbeing remains critical.

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Re-commissioning has recently taken place on Herefordshire's telecare contract, the new service which commences on 1 April 2025, focuses on improved integration between delivery of the service and service monitoring. An aim throughout 2025/26 is to expand a small scale pilot that took place within 2024/25 of proactive and preventative monitoring, enhancing the preventative approach within Herefordshire. The Partnership continues to work proactively to embed technologies as a system first approach alongside home first. The system-wide Integrated Community Equipment Contract (known as ICES) as has also recently been re-commissioned, following expiry. The new service will commence on 1 April 2025 and the existing contract has been developed and streamlined to provide enhanced outcomes for individuals and greater monitoring capabilities within the system.

Throughout 2025/26, commissioners will be working closely with providers of care services to further develop the care market within Herefordshire. Timely and proactive engagement with providers to build relationships, understand the workforce and provider challenges will enable us to further ensure we are best placed to facilitate timely, proactive and joined-up support. The possibility of further joint commissioning and contracting across the wider provision of care outside of BCF will be fully explored where there are opportunities that arise from contract expiry, to ensure integration is central across the Partnership.

Objective 2: reform to support people living independently and the shift from hospital to home.

Local areas must agree plans that:

- help prevent avoidable hospital admissions
- achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
- reduce the proportion of people who need long-term residential or nursing home care

The system utilises a primary provider where possible to provide the Home First Service, this service also supports the wider discharge to assess process. A service review of delivery of this support for Pathway 1 has recently taken place, with an aim to improving and increasing capacity working collaboratively with the service provider through robust key performance indicators that embed the principles of the home first approach. The review has explored all parts of the patient journey through pathway 1 and a number of improvements to the service specification and to system processes have been made. Through these improvements the

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Service has increased capacity without further financial investment and significantly reduced the number of bed days lost to pathway 1.

We will continue ongoing arrangements for Home First and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the government's hospital discharge and community support guidance.

A system wide Discharge to Assess Board has been developed to support the review of all pathways and to work collaboratively with providers to ensure improvements are sustained.

The system will continue to support the contract to provide a range of advocacy services for adults is via Onside Advocacy (Scheme 151). The provision of adult advocacy promotes individual autonomy, protects against abuse/exploitation, empowers decision-making, supports individuals in understanding their rights, and ensures fair treatment and continuity of care for those who may require additional support in mental health or decision-making processes.

The council has a statutory duty to provide independent advocacy under the Care Act 2014, Mental Health Act 2007, Mental Capacity Act 2005 and the Health and Social Care Act 2012. This requires the provision of;

- Independent Mental Capacity Advocate (IMCA)
- Independent Mental Health Advocate (IMHA)
- Care Act Advocacy
- NHS Complaints Advocacy

The advocacy contract ensures that individuals have the right support to make decisions and the most appropriate care solution.

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Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans.

The table below shows the metrics for 2025-26 and associated targets with explanatory notes on the ambitions.

Metric	Ambition	Comments
Emergency admissions to hospital for people aged 65+ per 100,000 population.	To reduce admissions of this cohort by 5% over the financial year	Provide increased support to those with long term conditions to prevent avoidable admissions and a more responsive health and/or care service to provide a safe alternative to hospital admission.
Average length of discharge delay for all acute adult patients, derived from a combination of: - proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) - for those adult patients not discharged on DRD, average number of days from DRD to discharge.	To reduce the number of discharge delay days by 5% over the year	This will be achieved by working with main providers and removing common causes of delay.
Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population.	The ambition will remain as previous year.	2024/25 admissions are forecast to be much lower than planned. 2025/26 plan is to maintain that improved performance despite demographic pressures and increasing complexity of service users.

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System partners are ensuring robust metrics are in place and working collaboratively to maintain performance in each area. The Integrated Care Executive (ICE) is responsible for monitoring performance against these metrics throughout the year. ICE will set and assess local metrics, such as falls outcomes, D2A capacity utilisation, Length of Stay targets, and the impact of DFGs and expenditure.

Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care.

We will continue to utilise the discharge bridging team to support patients to be discharged, if there are any delays with our Home First service starting.

There has been a review of contract process with the Home First provider and newly established contract management processes will now also include partners from health. The arrangements will ensure that the improvements in the service are sustainable and consider further improvements.

Benchmarking on Home First services is underway in order to identify if further improvements can be made within our Home First delivery.

A full review of therapy resource is underway to ensure reablement offer is available and supports the relevant pathways. Findings will be presented to the D2A Board for discussion on agreement on next steps.

Our aim is to continue to improve our position related to patients being discharged home on the day that they become medically stable for discharge. Our discharge to assess pathways have been reviewed and amended to further improve us achieving this aim.

Service reviews of commissioned services across the D2A pathway have taken place to ensure that the services are aligned to key performance indicators and that improved outcomes for D2A are overseen and monitored closely to reduce delays to discharge.

In 2024/25 the Right Care, Right Place, Right Time programme within which discharge from hospital and improved alignment of community-based resources and responses is a core feature. Partners, we have embedded a home first approach in line with the government's hospital discharge and community support guidance, and ongoing actions continue to support recruitment and retention of staff working within discharge pathways. Ward discharge coordinators are now in place at the acute hospital to support the multi-disciplinary clinical teams' decision making with a focus on Pathway 0.

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Adult social care has wrapped significant support around hospital discharge and D2A including:

- The establishment of the Care Act and Assessment Team (CAAsT) who are responsible for assessing all patients discharged under D2A to pathways 1 2 and 3.
- The appointment of a hospital discharge worker in Housing Solutions to address the challenges faced by individuals and partners when people are discharged from hospital and their accommodation is no longer suitable for them.
- The establishment of a new post of Hospital Team Manager to manage the existing hospital team, as part of the Integrated Discharge Team, to ensure timely escalation regarding delays and immediate actions required

Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

The consolidated local authority discharge fund will continue to support the same activity as previous years.

Our Frailty Same Day Emergency Care (FSDEC) bridging team will continue to provide rapid support to those patients seen in FSDEC who could be cared for at home to prevent admission to an acute bed.

We will continue to maintain strong links with our Virtual Ward (VW) to ensure, where appropriate, patients can remain at home. In addition, step up VW beds are now available for primary care to access, and the system works closely with the team to provide care and support where needed including care support via bridging team and our reablement provider. 2025/26 will see us building on this pathway to maximise opportunity.

The Care Home Practitioner role is currently being reviewed to ensure we are maximising the opportunity for avoiding admission or to reduce discharge delays. This team have developed strong links with our care home providers over previous years, and our aim is to involve these staff directly in liaising with providers to ensure patients can remain in their home unless necessary to receive secondary care.

We will continue to review provision of the trusted assessors system throughout 2025/26, focused on where they add value across the system to reduce discharge delays.

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Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

How 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)

The 2025/26 plan is based on 2024/25 demand and capacity actuals. Activity for the 12 months to January 2025 were used as the baseline for the 2025/26 plan; January 2025 being the most recent completed month available when planning began.

The 2024/25 actual demand has been adjusted for expected increases in demand for discharge to assess, based on experience of 2024/25, tempered by expected reductions in emergency admissions to Hereford County Hospital due to planned actions by members of One Herefordshire partnership.

Capacity plans have been adjusted from 2024/25 levels to reflect improved performance in key strategic partners which both introduce further capacity, improve occupancy levels, and reduce length of stay in pathways one and two. These improvements will reduce but not eliminate spot purchase of discharge capacity in the social care market. This reduction generates savings which partly offset the cost pressures caused by the there being real terms cut in funding for the BCF for 2025/26.

How capacity plans take into account therapy capacity for rehabilitation and reablement interventions

A recent demand and capacity review around therapy support has taken place and has highlighted a significant gap related to therapy roles. Our aim is to ascertain how, by investing in additional therapists will not only support financial savings elsewhere in the system but will provide better outcomes for our residents.

The system will also review reablement training across the system to ensure that all services required to provide high level of reablement are up to date with the latest principles, to ensure we provide our residents with the best opportunity to maintain independence.

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Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

All partners remain dedicated to upholding equality and diversity as outlined by the Equality Act 2010, ensuring that due regard is given in decision making concerning the design and delivery of services. It is essential that individuals are placed at the centre of all activities and services. Partners continue to strive towards enabling universal access to services, particularly for those requiring additional support due to conditions such as learning disabilities and/or autism, ensuring these individuals have equal access to services and are supported to achieve maximum independence within the community wherever possible.

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. 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. 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 (in employment only), pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Through the partnerships with Public Health, Voluntary Community Social Enterprise (VCSE) and trusted local voices, we can connect with our communities to improve relationships with those who experience the greatest health inequalities. Organisational development is required to build awareness, knowledge, skills and clearly set out the relevance to everyone's role on how they can reduce health inequalities.

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In relation to proposed plans to review some of the existing schemes within the BCF, consultations will take place with affected staff groups and stakeholders and service users where appropriate.

In addition, Herefordshire Council Community Wellbeing Directorate are developing the approach around co-production. Initial work has been completed and includes guidance for staff and teams on implementing co-production into commissioning and adult social care and has introduced a payment system to recognise the valuable time contribution of people with lived experience. There are plans to develop this approach further, but recent examples include lived experience panels for recruitment to key commissioning posts.

The system also has a range of forums and boards to consult and gain views of patients and people with live experience. One such example is the Making It Real Board hosted by the Council, which is a board of lived experience individuals with which the system can regularly engage. Senior leaders from the system participate in the Board and the agenda is set by those with lived experience.

Our Person's Voice questionnaire, co-produced with people with lived experience, provides individuals with the opportunity to tell us more about their recent experience with Adult Social Care. Feedback is shared with staff members and is used to inform and improve our services.

The Joint Strategic Needs Assessment (JSNA) has just been refreshed in 2024 and reflects the position for Herefordshire. The system continues to use the JSNA to inform the evidence base for commissioned services and service improvements. Further strategic work is planned to consider the needs of the county in future years considering the ageing population.

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Appendix 2

HM Government

NHS England

Better Care Fund 2025-26 Planning Template

2. Cover

Version 2.0

Please Note:
- The BCF planning template is categorised as 'Management information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners (MHCLG, DHSC, NHS England) to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Governance and Sign off

			Complete:
Health and Wellbeing Board:	Herefordshire, County of		Yes
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	No		Yes
If no indicate the reasons for the delay.	Due to national deadlines not aligning with HWB		Yes
If no please indicate when the HWB is expected to sign off the plan:	Mon 09/06/2025	<< Please enter using the format, DD/MM/YYYY	Yes

Submitted by:	Marie Gallagher / Adrian Griffiths	Yes
Role and organisation:	Transformation and Improvement Lead	Yes
E-mail:	Marie.Gallagher1@herefordshire.gov.uk	Yes
Contact number:	01432 260435	Yes
Documents Submitted (please select from drop down) In addition to this template the HWB are submitting the following:	Narrative	Yes
	C&D National Template	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation	
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Cllr	Carole	Gandy	carole.gandy@herefordshire.gov.uk		Yes
	Health and Wellbeing Board Chair						
Named Accountable person	Local Authority Chief Executive	Mr	Paul	Walker	paul.walker@herefordshire.gov.uk		Yes
	ICB Chief Executive 1	Mr	Simon	Trickett	simon.trickett@nhs.net	HWICB	Yes
	ICB Chief Executive 2 (where required)						
	ICB Chief Executive 3 (where required)						
Finance sign off	LA Section 151 Officer	Mrs	Rachael	Sanders	rachael.sanders@herefordshire.gov.uk		Yes
	ICB Finance Director 1	Mr	Mark	Dutton	Mark.Dutton@nhs.net	HWICB	Yes
	ICB Finance Director 2 (where required)						
	ICB Finance Director 3 (where required)						
Area assurance contacts	Local Authority Director of Adult Social Services	Mrs	Hilary	Hall	hilary.hall@herefordshire.gov.uk		Yes
	DFG Lead	Mrs	Hayley	Crane	hayley.crane@herefordshire.gov.uk		Yes
	ICB Place Director 1	Mr	Jon	Barnes	jon.barnes2@nhs.net	One Herefordshire Partnership	Yes
Please add any additional key contacts who have been responsible for completing the plan	ICB Place Director 2 (where required)						
	ICB Place Director 3 (where required)						

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response	
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	Yes		Yes
National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	Yes		Yes
National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	Yes		Yes
	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	Yes		Yes
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	Yes		Yes

Data Quality Issues - Please outline any data quality issues that have impacted on planning and on the completion of the plan

N/A — Yes

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
5. Expenditure	Yes
6. Metrics	Yes
7. National Conditions	Yes

<< Link to the Guidance sheet

Better Care Fund 2025-26 Planning Template

3. Summary

Selected Health and Wellbeing Board: Herefordshire, County of

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,815,031	£2,815,031	£0
NHS Minimum Contribution	£19,447,855	£19,447,855	£0
Local Authority Better Care Grant	£8,367,748	£8,367,748	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£30,630,634**	**£30,630,634**	**£0**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26
Minimum required spend	£7,548,385
Planned spend	£8,306,335

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	1,301	1,348	1,301	1,195	1,232	1,132	1,278	1,182	1,190	1,139	1,139	1,139

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	0.81	0.61	0.62	0.47	0.70	0.52	0.45	0.37	0.41	0.41	0.53	0.27

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	504.0	130.0	130.2	130.2	130.2

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: Herefordshire, County of

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Herefordshire, County of	£2,815,031
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£2,815,031**

Complete:

Local Authority Better Care Grant	Contribution
Herefordshire, County of	£8,367,748
Total Local Authority Better Care Grant	**£8,367,748**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	No	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding	Yes
Total Additional Local Authority Contribution	**£0**		

NHS Minimum Contribution	Contribution
NHS Herefordshire and Worcestershire ICB	£19,447,855
Total NHS Minimum Contribution	**£19,447,855**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	No	Yes

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding	Yes
Total Additional NHS Contribution	**£0**		
Total NHS Contribution	**£19,447,855**		

	2025-26
Total BCF Pooled Budget	**£30,630,634**

Funding Contributions Comments Optional for any useful detail	Yes

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Herefordshire, County of

<< Link to summary sheet

	2025-26		
Running Balances	Income	Expenditure	Balance
DFG	£2,815,031	£2,815,031	£0
NHS Minimum Contribution	£19,447,855	£19,447,855	£0
Local Authority Better Care Grant	£8,367,748	£8,367,748	£0
Additional LA contribution	£0	£0	£0
Additional NHS contribution	£0	£0	£0
Total	**£30,630,634**	**£30,630,634**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26		
	Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£7,548,385	£8,306,335	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Support to carers, including unpaid carers	Acorns Children's Hospice	3. Supporting unpaid carers	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 34,942	
2	Other	Advocacy	1. Proactive care to those with complex needs	Social Care	Charity / Voluntary Sector	Local Authority Better Care Grant	£ 155,084	
3	Long-term residential/nursing home care	ASC Long-Term Placements	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	NHS Minimum Contribution	£ 1,763,778	
3	Long-term residential/nursing home care	ASC Long-Term Placements	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	Local Authority Better Care Grant	£ 5,788,279	
4	Discharge support and infrastructure	Brokerage	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 326,789	
5	Support to carers, including unpaid carers	Carers Support	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 160,000	
5	Support to carers, including unpaid carers	Carers Support	3. Supporting unpaid carers	Social Care	Local Authority	NHS Minimum Contribution	£ 65,000	
6	Disabled Facilities Grant related schemes	Disabled Facilities Grant	2. Home adaptations and tech	Social Care	Local Authority	DFG	£ 2,815,031	
7	Discharge support and infrastructure	Care Act Assessment Team	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 322,945	
7	Discharge support and infrastructure	Care Act Assessment Team	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 207,581	
7	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Hillside	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 464,559	
7	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Hillside	5. Timely discharge from hospital	Community Health	Private Sector	Local Authority Better Care Grant	£ 918,880	
7	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	LICU	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 1,104,447	
7	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	LICU	5. Timely discharge from hospital	Community Health	Private Sector	Local Authority Better Care Grant	£ 138,915	
7	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home First	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 2,317,745	
7	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home First	5. Timely discharge from hospital	Social Care	Private Sector	Local Authority Better Care Grant	£ 530,022	
7	Discharge support and infrastructure	Hospital Discharge Transport	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 236,534	
7	Discharge support and infrastructure	Hospital Liaison Team	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 281,025	
7	Discharge support and infrastructure	Housiing Hospital Discharge	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 106,579	
7	Discharge support and infrastructure	Medical Cover for D2A Beds	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 48,236	
7	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Short-term Care Home Beds	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 817,722	
7	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Short-term Care Home Beds	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 304,600	
7	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Short-term Home Care	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 526,315	
8	Other	DoLs / AMHPs	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 1,015,564	
9	Wider local support to promote prevention and independence	Falls Response & Prevention	4. Preventing unnecessary hospital admissions	Social Care	NHS Community Provider	NHS Minimum Contribution	£ 182,197	
9	Wider local support to promote prevention and independence	Falls Response & Prevention	4. Preventing unnecessary hospital admissions	Social Care	NHS Community Provider	Local Authority Better Care Grant	£ 44,000	
10	Evaluation and enabling integration	Partnerships & integration Staffing	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 231,533	
11	Other	Safeguarding	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 295,722	
12	Support to carers, including unpaid carers	St Michael's Hospice	3. Supporting unpaid carers	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 283,998	
13	Discharge support and infrastructure	Trusted Assessors	5. Timely discharge from hospital	Social Care	Private Sector	Local Authority Better Care Grant	£ 88,021	
14	Discharge support and infrastructure	WVT Integrated Care Services	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 1,261,452	
14	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	WVT Integrated Care Services	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 7,707,352	
14	Support to carers, including unpaid carers	WVT Integrated Care Services	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	Local Authority Better Care Grant	£ 85,788	

5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS minimum:

- **Area of spend** selected as 'Social Care' and **Source of funding** selected as 'NHS Minimum Contribution'

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:
1. Scheme ID:
- Please enter an ID 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. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. Description of Scheme:
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.
4. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
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.
6. Provider:
- Please select the type of 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.
7. 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 NHS or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:
Any further information that may help the reader of the plan. You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description
1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	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	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	DFG related schemes	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.
4	Wider support to promote prevention and independence	Prevention/early intervention	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 wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes 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
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term 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.
7	Long-term home-based social care services	Personalised care at home	Long-term 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 or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	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 should be recorded under the specific scheme type 'Reablement in a person's own home'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	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.
10	Long-term residential or nursing home care	Residential placements	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.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	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.
14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, 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. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.
15	Urgent Community Response	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: Herefordshire, County of

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Complete:
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,352	1,401	1,352	1,292	1,332	1,223	1,440	1,332	n/a	n/a	n/a	n/a	To reduce admissions of this cohort by 5% over the financial year. Provide increased support to those with long term conditions to prevent avoidable admissions and a more responsive health and/or care service to provide a safe alternative to hospital admission.	Yes
	Number of Admissions 65+	685	710	685	655	675	620	730	675	n/a	n/a	n/a	n/a		
	Population of 65+*	50,683	50,683	50,683	50,683	50,683	50,683	50,683	50,683	n/a	n/a	n/a	n/a		
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
	Rate	1,301	1,348	1,301	1,195	1,232	1,132	1,278	1,182	1,190	1,139	1,139	1,139		
	Number of Admissions 65+	659.3125	683.375	659.3125	605.875	624.375	573.5	647.875	599.0625	602.94531	577.46875	577.46875	577.46875		Yes
	Population of 65+	50,683	50,683	50,683	50,683	50,683	50,683	50,683	50,683	50,683	50,683	50,683	50,683		

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	No	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	No	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.76	0.87	0.77	n/a	n/a	n/a	n/a	To reduce the number of discharge delay days by 5% over the year. This will be achieved by working with main providers and removing common causes of delay.	Yes
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	87.5%	86.6%	86.2%	n/a	n/a	n/a	n/a		
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	6.1	6.5	5.6	n/a	n/a	n/a	n/a		
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
Average length of discharge delay for all acute adult patients	0.81	0.61	0.62	0.47	0.70	0.52	0.45	0.37	0.41	0.41	0.53	0.27		
Proportion of adult patients discharged from acute hospitals on their discharge ready date	88.0%	88.4%	88.1%	90.7%	89.9%	91.1%	92.5%	92.8%	93.3%	93.4%	93.0%	95.4%		Yes
For those adult patients not discharged on DRD, average number of days from DRD to discharge	6.77	5.28	5.19	5.01	6.88	5.88	5.96	5.12	6.12	6.21	7.59	5.72		Yes

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	No	Yes
Local data on average length of delay by discharge pathway.	Number of days	No	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	355.1	540.6	504.0	130.0	130.2	130.2	130.2		2024/25 admissions are forecast to be much lower than planned. 2025/26 plan is to maintain that improved performance adjusted for demographic pressures and increasing complexity of service users presenting for assessment	Yes
	Number of admissions	180	274	255	66	66	66	66			Yes
	Population of 65+*	50,683	50,683	50,683	50,683	50,683	50,683	50,683			

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	No	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	No	Yes

HM Government

NHS England

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: Herefordshire, County of

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes			Yes
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	No	National timescales do not align with HWB meetings in Herefordshire. Local Authority and ICB chief executives have signed	09/06/2025	Yes
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes			Yes
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care					
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes

BCF Capacity & Demand Template 2025-26

1. Guidance

Overview

This template has been unlocked to allow editing as required. It is optional to submit capacity & demand figures as per this template format and a customised format of this will be accepted.

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 can be input into the cell
Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. You should select your HWB from the top of the sheet which will also reveal pre-populated trusts for your area.

2. Once you are satisfied with the information entered the template should be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

3. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

This template follows the same format as last year and so contains all the previously asked for data points including demand (referrals), block and spot capacity, average duration of treatment and time from referral to treat all split by pathway. It is however only required that some form of data points are submitted to show projected demand (disaggregated by step-up and step-down) and capacity for intermediate care and other short term care. The additional data points on average treatment time, time to treat and spot/block capacity split are optional but have remained in case you may find these data points useful.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

List of data points in template:

3.1 C&D Step-down

Estimates of available capacity for each month of the year for each pathway.
Estimated average time between referral and commencement of service.
Expected discharges per pathway for each month, broken down by referral source.
Estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways.

3.2 C&D Step-up

Estimated capacity and demand per month for each service type.
Estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

Better Care Fund 2025-26 Capacity & Demand Template

2. Cover

Version 1.1

Health and Wellbeing Board:	Herefordshire, County of
Completed by:	Adrian Griffiths
E-mail:	adrian.griffiths2@herefordshire.gov.uk
Contact number:	1432383809
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes

Once complete please send this template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'C&D - Name HWB' for example 'C&D - County Durham HWB'. Please also copy in your Better Care Manager.

<< Link to the Guidance sheet

Better Care Fund 2025-26 Capacity & Demand Template

3.1. C&D Step-down

Selected Health and Wellbeing Board: Herefordshire, County of

Step-down

Capacity - Demand (positive is Surplus)	Capacity surplus (not including spot purchasing)												Capacity surplus (including spot puchasing)											
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	-19.4283	-19.6685	-14.6728	-11.3207	-12.4196	-12.3087	-34.8217	-35.062	-39.5315	-17.5261	-16.7413	-10.388	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-13.8453	-10.1966	-5.90541	0	-3.40405	-3.59527	-9.55405	-13.8453	-2.83041	-10.8392	-15.773	-10.7703	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-7.89674	-8.56087	-4.82174	-7.89674	-5.26449	-9.94674	-8.47899	-11.7754	-14.0467	-9.94674	-6.65036	-10.529	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
43.5	Contact Hours per package
	Contact Hours per package
38	Average LoS (days)
	Average LoS (days)
44	Average LoS (days)

Capacity - Step-down		Refreshed planned capacity (not including spot purchased capacity)												Capacity that you expect to secure through spot purchasing											
Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	60.52174	46.95652	39.65217	55.30435	51.13043	57.3913	59.47826	45.91304	25.04348	52.17391	38.6087	50.08696	19.42826	19.66848	14.67283	11.32065	12.41957	12.3087	34.82174	35.061957	39.531522	17.526087	16.741304	10.388043
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	5.9	4.8	5.4	4.3	5.8	4.6	4.2	4.8	5	4.3	4.1	4.2												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.																								
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)																								
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	9.72973	13.37838	14.59459	18.45	10.94595	9.72973	10.94595	9.72973	14.59459	15.81081	17.02703	9.72973	13.84527	10.19662	5.905405	0	3.404054	3.59527	9.554054	13.84527	2.8304054	10.839189	15.772973	10.77027
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	5.2	4.8	5	5.6	5.9	5	4.9	4	4.2	4.9	5.8	5.5												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.																								
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)																								
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	7.478261	3.73913	7.478261	7.478261	4.985507	7.478261	9.971014	8.724638	7.478261	7.478261	8.724638	9.971014	7.896739	8.56087	4.821739	7.896739	5.264493	9.946739	8.478986	11.775362	14.046739	9.9467391	6.6503623	10.528986
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	8.2	11.5	10	13.3	14.3	10.5	10.7	6.6	6.7	7.6	7.7	8												

Demand - Step-down		Please enter refreshed expected no. of referrals:											
Pathway	Trust Referral Source	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Expected Step-down:	Total Step-down	**118.9**	**102.5**	**87.125**	**100.45**	**88.15**	**100.45**	**133.25**	**125.05**	**103.525**	**113.775**	**103.525**	**101.475**
Reablement & Rehabilitation at home (pathway 1)	Total	**79.95**	**66.625**	**54.325**	**66.625**	**63.55**	**69.7**	**94.3**	**80.975**	**64.575**	**69.7**	**55.35**	**60.475**
	WYE VALLEY NHS TRUST	79.95	66.625	54.325	66.625	63.55	69.7	94.3	80.975	64.575	69.7	55.35	60.475
	OTHER												
Short term domiciliary care (pathway 1)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	WYE VALLEY NHS TRUST												
	OTHER												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**23.575**	**23.575**	**20.5**	**18.45**	**14.35**	**13.325**	**20.5**	**23.575**	**17.425**	**26.65**	**32.8**	**20.5**
	WYE VALLEY NHS TRUST	23.575	23.575	20.5	18.45	14.35	13.325	20.5	23.575	17.425	26.65	32.8	20.5
	OTHER												
Other short term bedded care (pathway 2)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	WYE VALLEY NHS TRUST												
	OTHER												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**15.375**	**12.3**	**12.3**	**15.375**	**10.25**	**17.425**	**18.45**	**20.5**	**21.525**	**17.425**	**15.375**	**20.5**
	WYE VALLEY NHS TRUST	15.375	12.3	12.3	15.375	10.25	17.425	18.45	20.5	21.525	17.425	15.375	20.5
	OTHER												

Better Care Fund 2025-26 Capacity & Demand Template

3.2. C&D Step-up

Selected Health and Wellbeing Board: Herefordshire, County of

Step-up **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours

Full Year	Units
	Contact Hours
38	Contact Hours
42	Average LoS
43	Contact Hours

Capacity - Step-up

Please enter refreshed expected capacity:

Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	Monthly capacity. Number of new clients.												
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	23	18	15	19	16	13	21	11	12	15	11	9
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	1	1	2	1	2	1	3	1	1	2	1	0
Other short-term social care	Monthly capacity. Number of new clients.	14	10	7	5	8	9	5	6	10	13	4	9

Demand - Step-up

Please enter refreshed expected no. of referrals:

Service Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)												
Reablement & Rehabilitation at home	23	18	15	19	16	13	21	11	12	15	11	9
Reablement & Rehabilitation in a bedded setting	1	1	2	1	2	1	3	1	1	2	1	0
Other short-term social care	14	10	7	5	8	9	5	6	10	13	4	9

Health and Wellbeing Board Work Programme 2024/25 – 2025/26

Agenda item	Report from	Frequency	Purpose	Notes
Mon 10 June 2024, 2.00 pm – Board meeting in public				
HWB Delivery Plans: Mental Health and Mental Health Needs Assessment	Public Health	Quarterly	Information	
Autism Strategy	Sally Wilson	Ad-hoc	Information	
DPH Annual Report	Matt Pearce	Annually	Information	
Better Care Fund Annual Report	Marie Gallagher	Annually	Information	
Wed 17 July 2024 – Herefordshire Health and Wellbeing Board Conference Event				
Mon 16 September 2024, 2.00 pm – Board meeting in public				
Better Care Fund Integration Plan 2024-25	Marie Gallagher	Ad-hoc	Information	
HWB Delivery Plans: Best Start in Life	Julia Stephens	Quarterly	Information	
Tobacco Control	Luke Bennett / Natalie Johnson-Stanley	Ad-hoc	Information	
Community Safety Partnership Update – including priorities	Helen Wain	Ad-hoc	Information	
Herefordshire Safeguarding Adults Board Annual Report	Kevin Crompton	Annually	Information	
Mon 21 October 2024 - Private workshop: Health and Wellbeing Strategy				
Mon 9 December 2024, 2.00 pm – Board meeting in public				**[Agenda publication: Fri 29 November 2024]**
[HWB Delivery Plans: Mental Health] Update to the board on the Good Mental Wellbeing throughout lifetime Implementation Plan	Kristan Pritchard	Quarterly	Information	
Update on Inequalities Strategy 2023-26	Harpal Aujla	Ad-hoc	Information	
Health Protection Assurance Forum Annual Report 2024	Rob Davies / Sophie Hay	Annually	Information	
Mon 3 February 2025, 2.00 pm - Private workshop: Health and Wellbeing Strategy				
Mon 17 March 2025, 2.00 pm - Board meeting in public				**[Agenda publication: Fri 7 March 2025]**
HWB Delivery Plans: Progress on the Best Start in Life Action Plan	Julia Stephens	Quarterly	Information	
Tobacco Control Plan	Isobel Adams / Luke Bennett	Ad-hoc	Information	
Update to the board on the implementation of the Physical Activity Strategy	Luke Bennett	Ad-hoc	Information	
Mon 9 June 2025, 2.00 pm – Board meeting in public				**[Agenda publication: Fri 30 May 2025]**
Joint Strategic Needs Summary Assessment Summary 2024	Charlotte Worthy / Badri Padmanabhan	Annually	Information	
NHS Five Year Joint Forward Plan update for 2025/26	David Mehaffey, HWICB	Annually	Endorsement	*New item*
Verbal update on national changes of Integrated Care Boards	David Mehaffey, HWICB	Ad-hoc	Information	*New item*
[HWB Delivery Plans: Mental Health] Update to the board on the Good Mental Wellbeing throughout lifetime Implementation Plan	Lindsay MacHardy / Kristan Pritchard	Quarterly	Information	
Herefordshire Suicide Prevention Strategy	Lindsay MacHardy / Kristan Pritchard	Ad-hoc	Information	
Better Care Fund (BCF) reporting 2024/2025	Marie Gallagher / Nicola Williams	Quarterly	Information	
Herefordshire's Better Care Fund (BCF) plan 2025-26	Marie Gallagher / Nicola Williams	Annually	Information	

Agenda item	Report from	Frequency	Purpose	Notes
Friday 4 July 2025, 9.30 am - Private workshop: The aim is to shape the new strategic direction of the Best Start in Life (BSIL) and Good Mental Wellbeing Throughout Life (GMWTL) action plans (2025-2027).				
Mon 15 September 2025, 2.00 pm – Board meeting in public				**[Agenda publication: Fri 5 September 2025]**
HWB Delivery Plans: Best Start in Life	Julia Stephens	Quarterly	Information	
Domestic Abuse Strategy	Kayte Thompson-Dixon / Elliott Nixon	Ad-hoc	Information	*Moved from March and June 2025; The strategy is due to be signed off by Cabinet in July 2025.*
Director of Public Health Annual Report	Director of Public Health	Annually	Information	*Moved from June 2025*
Work and health / WorkWell Project	David Mehaffey, HWICB	Ad-hoc	Information	*Suggested at board meeting 17 March 2025, potentially for September or December 2025.*
Mon 15 December 2025, 2.00 pm – Board meeting in public				**[Agenda publication: Fri 5 December 2025]**
[HWB Delivery Plans: Mental Health] Update to the board on the Good Mental Wellbeing throughout lifetime Implementation Plan	Lindsay MacHardy / Kristan Pritchard	Quarterly	Information	
Oral Health Improvement Board Update	Harpal Aujla	Annually	Information	*2024/25 skipped; see scrutiny item, 27 January 2025:* Dental services in Herefordshire
(date tbc) March 2026, 2.00 pm – Board meeting in public				
Herefordshire Safeguarding Adults Board Annual Report	Kevin Crompton	Annual	Information	
HWB Delivery Plans: Best Start in Life	Julia Stephens	Quarterly	Information	
Better Care Fund progress update	Marie Gallagher / Nicola Williams	Ad-hoc	Information	
(date tbc) June 2026, 2.00 pm – Board meeting in public				
[HWB Delivery Plans: Mental Health] Update to the board on the Good Mental Wellbeing throughout lifetime Implementation Plan	Lindsay MacHardy / Kristan Pritchard	Quarterly	Information	
Tobacco Alliance Annual Report	Harpal Aujla / Isobel Adams	Annual	Information	*Arising from Tobacco Control Plan item at board meeting 17 March 2025.*