Herefordshire Council

NHS Herefordshire Clinical Commissioning Group

Herefordshire Better Care Fund Plan

2016-17

Submission Four

27 June 2016

TABLE OF CONTENTS

1. INTRODUCTION

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

Within Herefordshire a Redesign Management Group has been established to lead and implement a transformational change across all services and to develop a 'One Herefordshire' alliance. The One Herefordshire Plan has been developed through an alliance of all the Herefordshire health partners[1] and the council working in partnership to address the fundamental issues facing the county. It provides the fundamental context and approach that underpins this BCF plan.

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

The Herefordshire BCF plan 2016/17 demonstrates the progress made on the 2015/16 intentions, details key milestones for 2016/17 and describes the future vision for the county. This plan is a key component of, and wholly consistent with, the system wide transformation of Herefordshire's health and social care economy. In addition the BCF also supports the delivery of the Sustainability and Transformation Plan (STP) common objective: *Collaboration and joint working on a scale not achieved before to deliver transformational change that closes the triple aim gap and supports a financially sustainable health and social care economy.*

[1] The partners are: Herefordshire Council, Herefordshire CCG, Wye Valley NHS Trust, 2gether NHS Foundation Trust and Taurus Healthcare

2. LOCAL VISION FOR HEALTH AND SOCIAL CARE SERVICES

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

One Herefordshire, January 2016 (B.1.i)

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

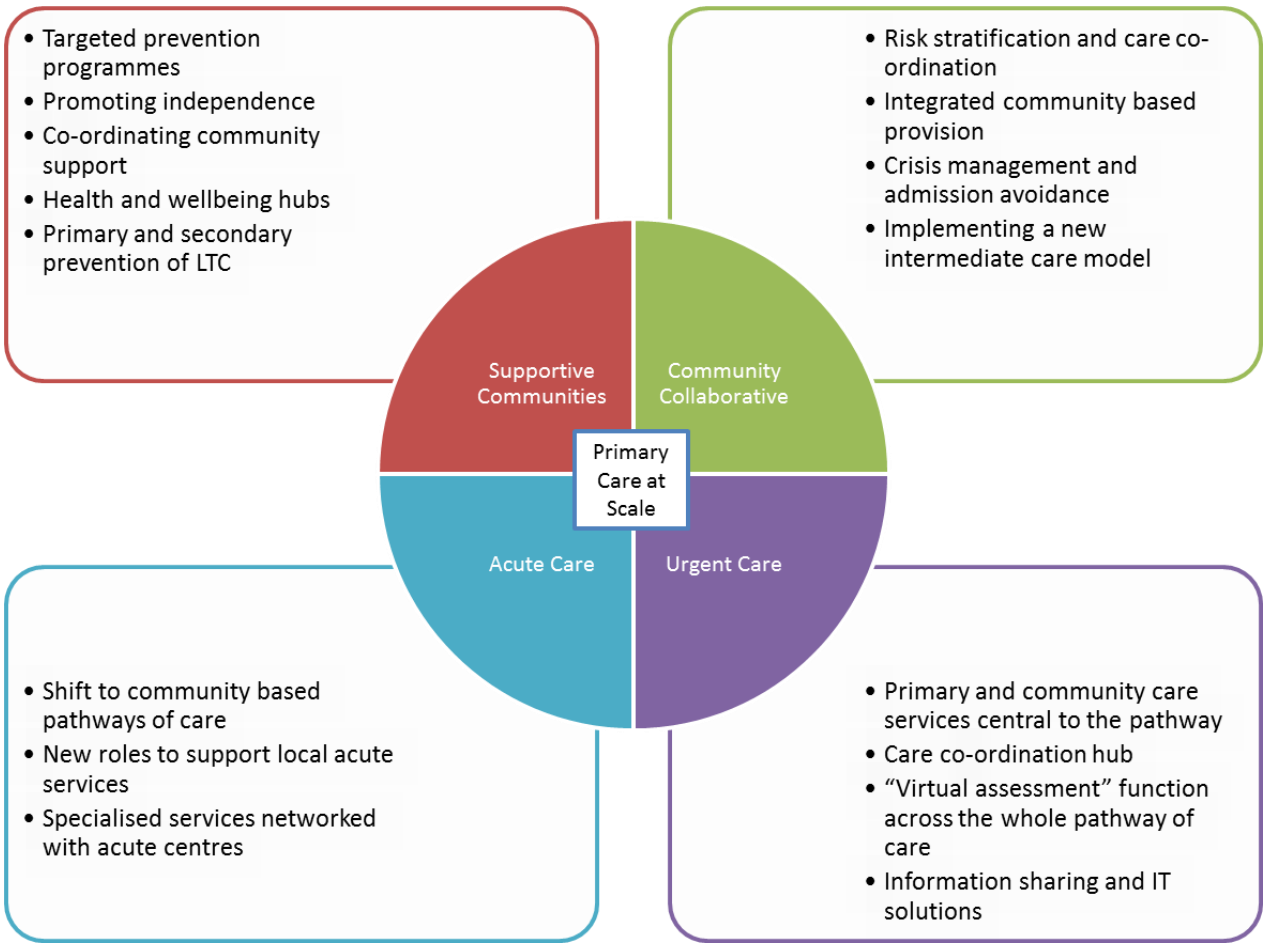
This plan is based on securing a change in the relationship between the citizen and public services, such that individuals and their communities take on the prime responsibility for maintaining their own wellbeing and independence. The intention is to enable the public to avoid the crises that would otherwise push them into reliance on statutory care services. Under this new approach, the statutory sector will play a vital role as a catalyst for the development and maintenance of the necessary community capacity, supporting a lead taken by our vibrant local voluntary sector partners. Our services will be designed through a philosophy of supporting self-care, cohesive delivery in the community wherever practical, and reduced reliance on specialist care, whether provided in hospital or in residential and nursing homes.

Recent analysis of current spending shows that 48% of budgeted spending is on acute services, with a further 13% on residential, nursing and continuing care. Herefordshire's new model of care will deliver a significant shift in this position, as:

- Investment in preventative services and self-care will have a medium to long-term benefit in avoiding the need for acute and institutional care services – albeit we are prudent on the scale of financial benefits that can be realised within the five-year timeframe of the STP
- Investment in primary care at scale and community services will have a short- and medium-term impact in redirecting work from acute settings and providing financial benefits.

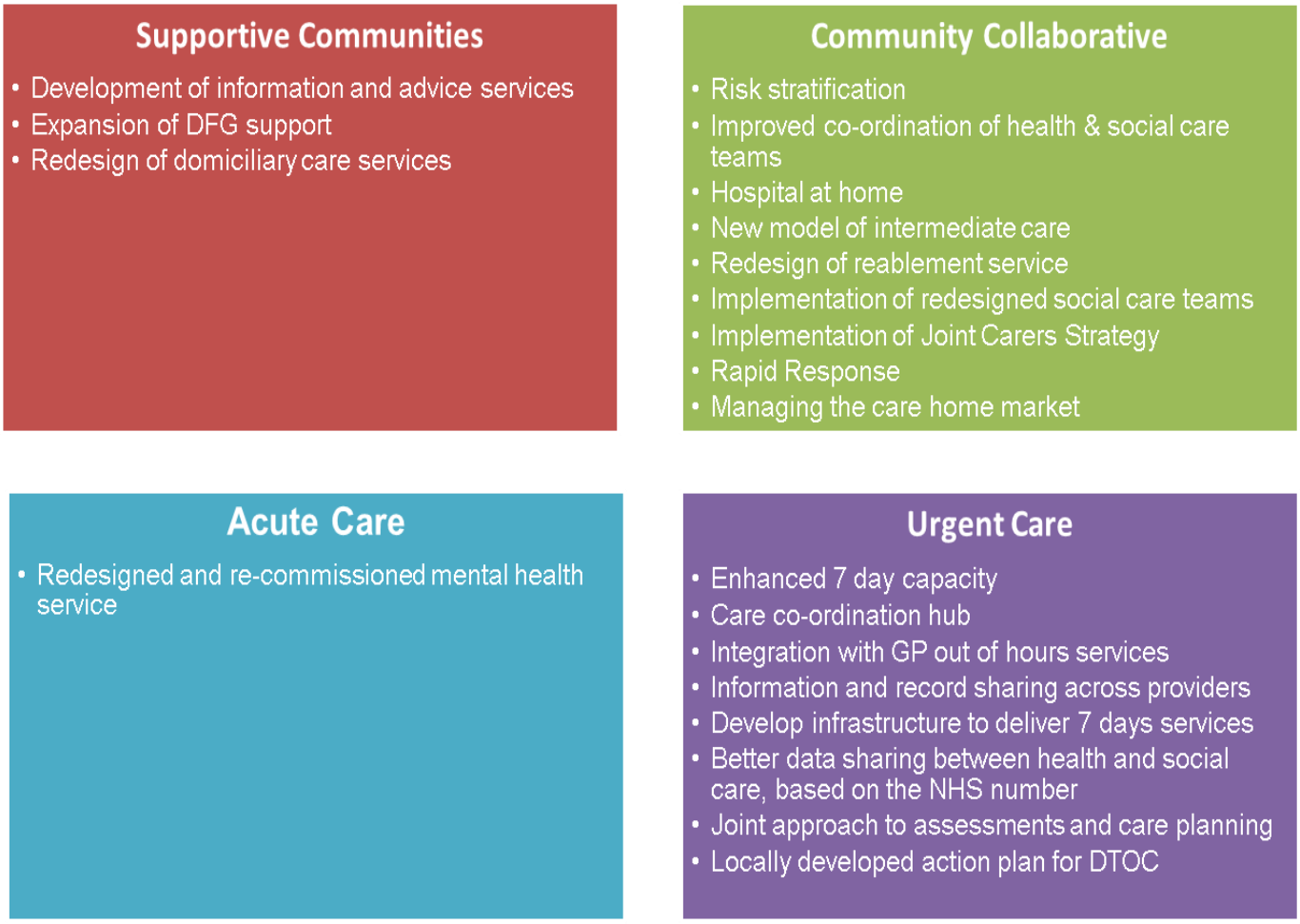
The diagram below sets out the key deliverable workstreams of the One Herefordshire transformation programme and lists some of the key features of the projects that they are delivering. The BCF plan is a key enabler supporting many areas of that programme.

Section 75 agreement – appendix 5



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

In line with both with the NHS England 'Five Year Forward View' and the existing One Herefordshire programme, we expect to test new models of care delivery, drawing on concepts such as community development and empowerment, integrated primary, community, mental health and acute provision, clinically networked services, and technology-driven delivery solutions. The BCF plan underpins this wider One Herefordshire plan in a number of ways and clearly links into the work-streams of the transformation programme as shown below ***(B.1.ii)***:



The vision for future service delivery in Herefordshire embraces national thinking on new models of care, and embodies a number of themes, including a commitment to:

- Empower communities to behave differently and reduce demand for services
- Support enhanced provision of primary, community care and mental health care at scale
- Utilise technological innovations to deliver improved care
- Deliver preventative and tailored care to support people keeping well, at home
- Develop proposals for primary care at scale that underpin the delivery of the above
- Support local delivery of acute hospital services
- Consolidate clinical networks across care settings to ensure optimum sharing of expertise to deliver high quality, safe and cost effective services

The Future Vision

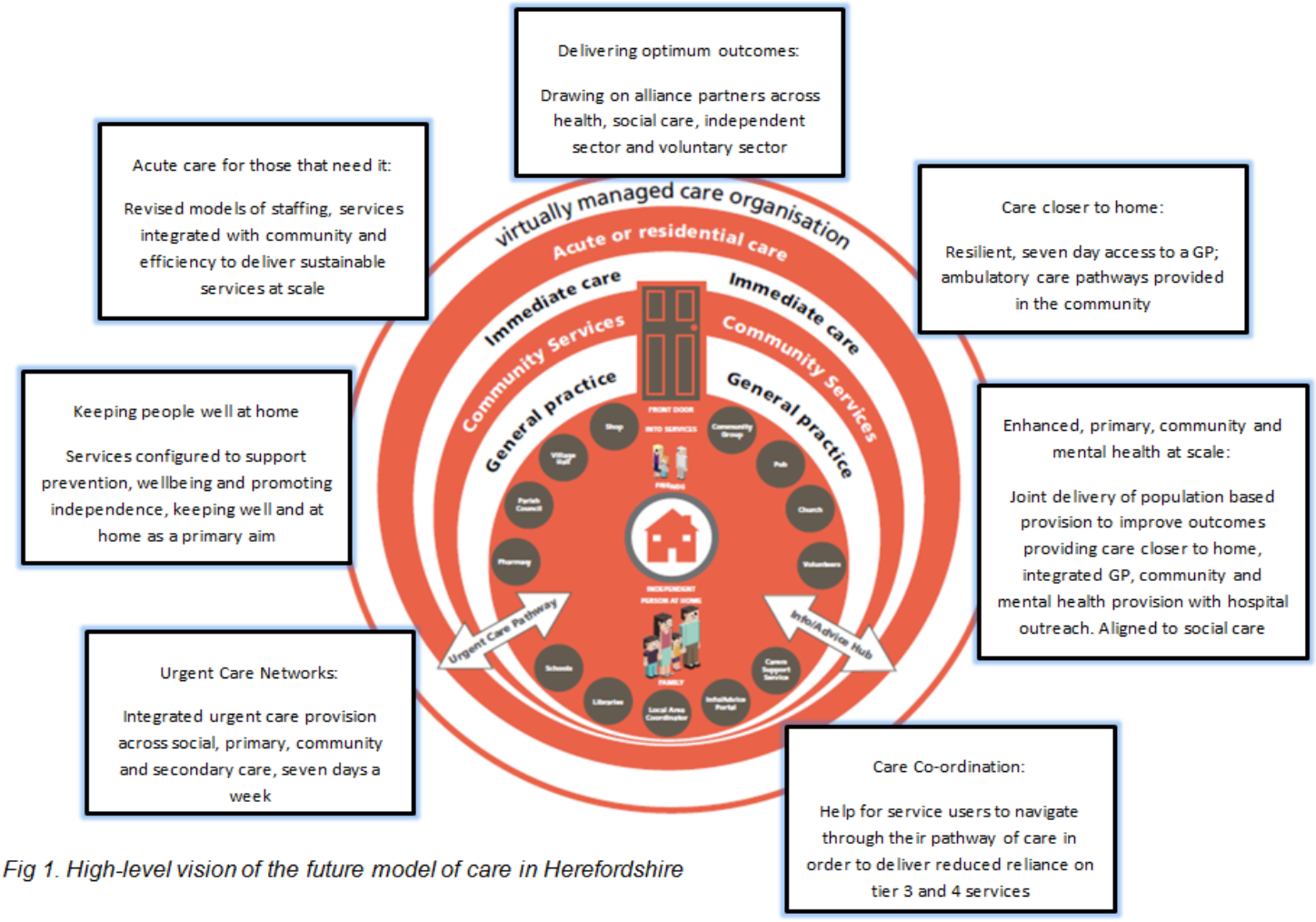


Fig 1. High-level vision of the future model of care in Herefordshire

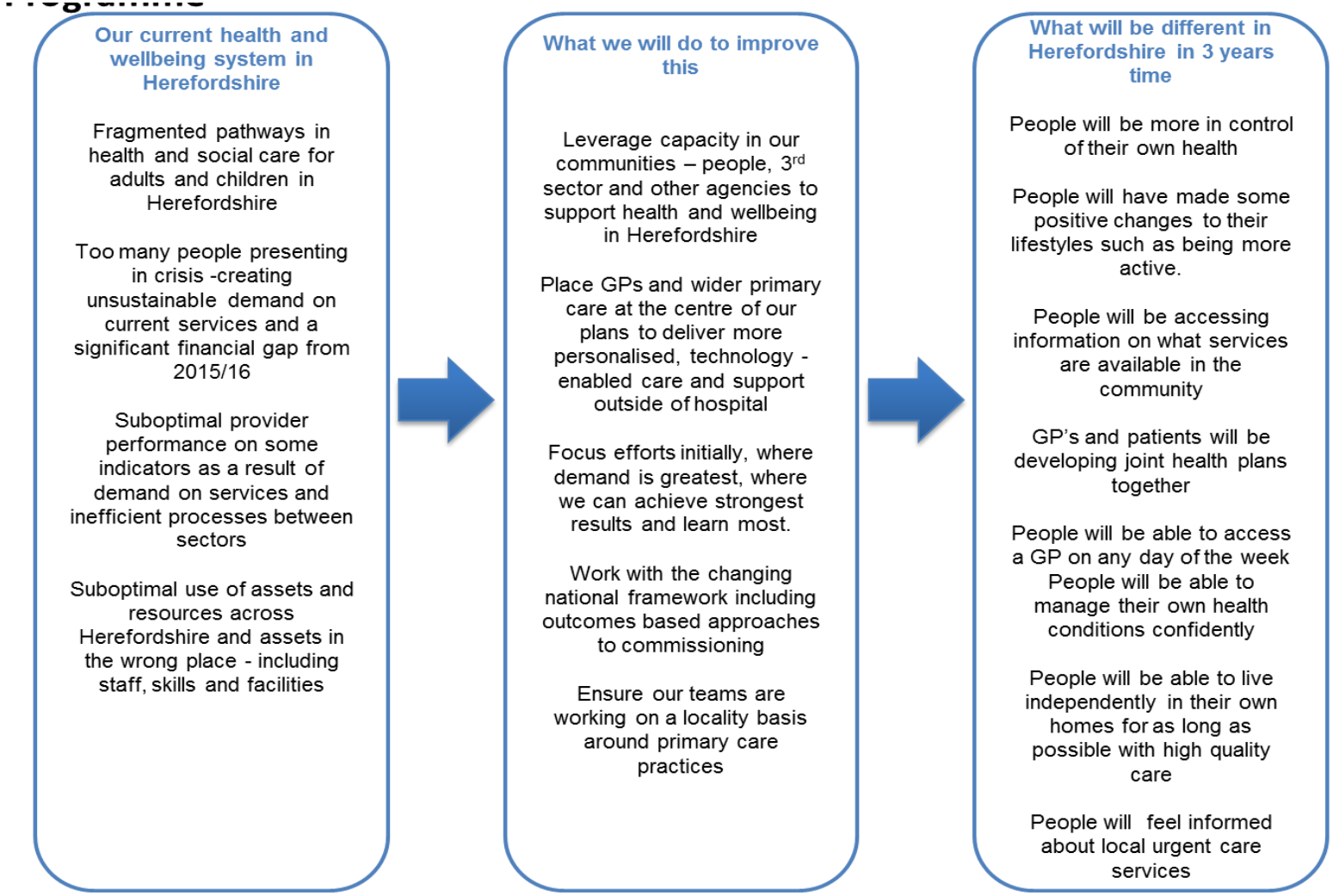
At a strategic level the BCF intends to support the One Herefordshire alliance in achieving the following **aims *(B.2.iii)***:

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

- to ensure that we have sufficient workforce is that is appropriately trained to provide the services our population require in the future.

3. EVIDENCE BASE FOR CHANGE

The vision for Herefordshire is illustrated below. This provides a **clear comparison between current state and planned state post-plan delivery and is described in terms of changes to patient and service user experience and outcomes *(B.1.iii)***:



Section 75 agreement – appendix 5

Further details in relation to the changes and developments to be delivered through the BCF plan 2016/17 are contained within the Integrated Action Plan (section 4) and within section 3.2 – The Challenges in Herefordshire.

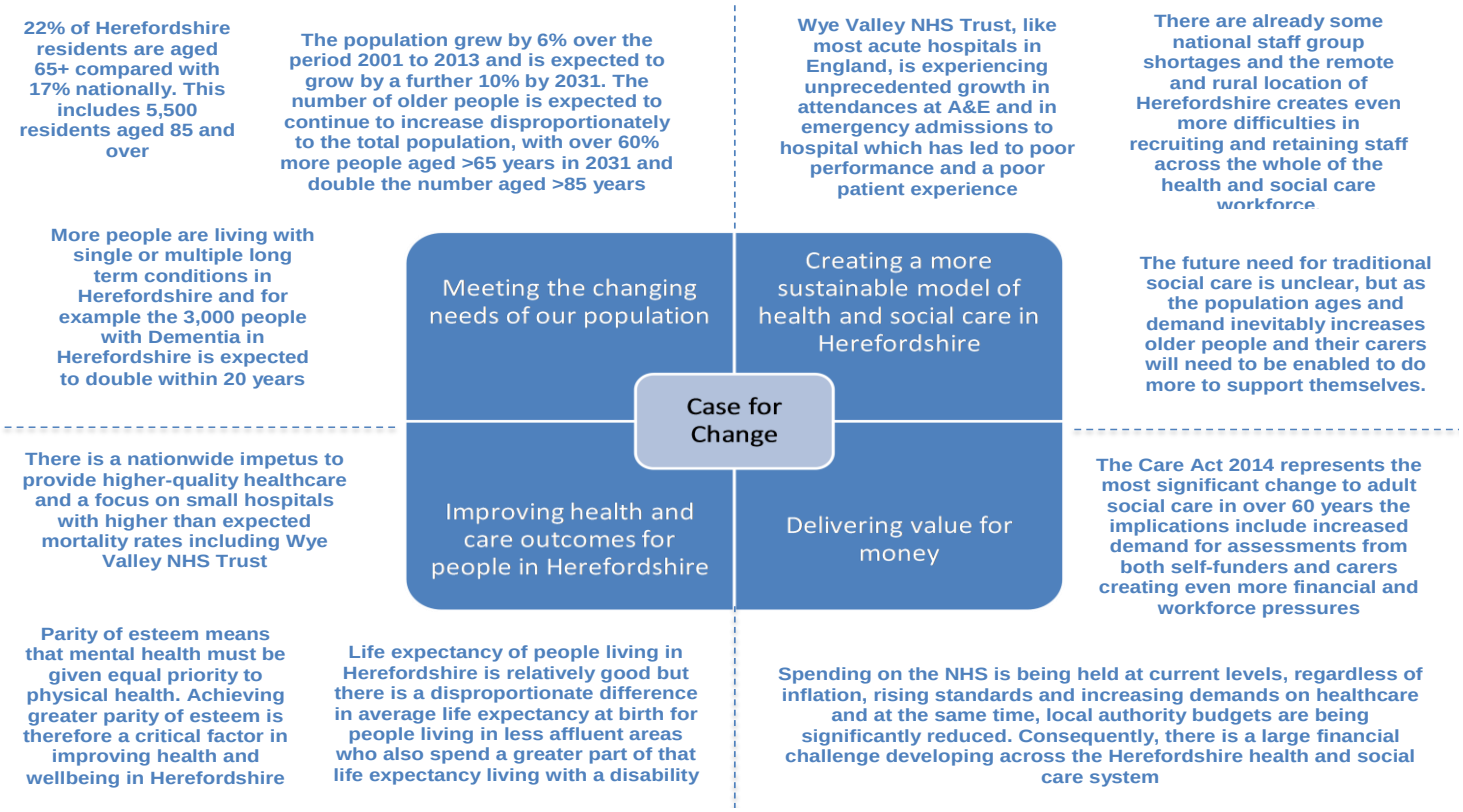
3.1 SUPPORTING THE CASE FOR CHANGE

There are a number of local challenges in Herefordshire that we must address if we are to ensure sustainable services:

- **Our population is small and its rural nature means that it is widely dispersed** – the population in 2013 was 186,100 and has grown by six percent since 2001 through migration only. Almost all of Herefordshire's land area falls in the 25% most deprived in England in relation to geographical barriers to services. Transport is severely limited, with limited railway and road networks. There are few public transport routes that are commercially viable, which further restricts mobility. Access to health services in rural areas is limited with 21% of rural households having to travel 2.5 miles or more to visit their GP or other health services.
- **Herefordshire has a much older population than nationally and this will grow** - 23% of Herefordshire residents are aged 65+ compared with 17% nationally. This includes 5,500 residents aged 85 and over. The number of older people is expected to continue to increase disproportionately to the total population, with over 60% more people aged 65+ in 2031 and double the number aged 85 and over.
- **People living longer will experience more health and wellbeing issues** - more people are living with single or multiple long term conditions in Herefordshire, for example, the number of people with Dementia in the county is expected to double within 20 years, from 3,000 to 6,000. Linked to this, Wye Valley NHS Trust, like most acute hospitals in England, has experienced significant growth in attendances at A&E and in emergency admissions to hospital and this has had an impact on performance and patient experience.
- **All of our provider and commissioner organisations are facing challenges to their finances, service delivery and sustainability** - this was dramatically highlighted in the recent report produced by Ernst and Young (partly funded by NHS England). This showed that even with significant changes in behaviour, and unprecedented efficiency savings, our local economy would still be facing a gap of £30m-£38m by the end of the decade.

- **Our services lack the scale and efficiency to meet the needs of the future** - As one of the smallest Trusts in England; WVT faces significant diseconomies of scale when providing a range of general hospital services for such a small population. The diseconomies of scale cannot solely be resolved by reducing the range of services through providing them at another hospital, as the distances are such that a range of services have to be available within the county, not least to serve the population of Powys. In contrast, some services that are provided at scale, such as mental health, are more resilient as a result.
- **National issues with recruitment and retention are felt more acutely in Herefordshire** - there are already some national staff group shortages and the remote and rural location of Herefordshire creates even more difficulties in recruiting and retaining staff across the whole of the health and social care workforce.
- **We have significant infrastructure challenges** - many of our buildings are outdated and our services have outgrown them. At the same time, changes in the model of delivery mean we have a number of sites that could be rationalised without impacting the quality of care. However improvements in the physical infrastructure would need to be made. There is a need to review the health and social care estate to assess the possibility of greater efficiencies. Our IT infrastructure is also limited but there are many opportunities; the secondary care services have extremely low digital maturity and are largely paper-based but our primary care services are extremely well integrated across one system.

The illustration below details Herefordshire's case for change:



Data driven explanation of issues that the BCF plan is addressing (B.2.i)

In developing this BCF plan, insights from the Herefordshire Joint Strategic Needs Assessment (JSNA) have been used to understand the current and future population trends as well as the real and predicted changes in use of unplanned care and those being supported through primary care and social care services. The following **data supports the case for change and illustrates a clear and quantified understanding of the precise issues that the BCF will be used to address in Herefordshire (B.2.i),** ***(B.2.iv)***.

Herefordshire's population grew by 6% over the period 2001 to 2013, largely as a result of inward migration and is expected to grow to approximately 205,300 by 2031. However the number of older people is expected to continue to increase disproportionately to the total population, with over 60% more people aged >65 years in 2031 and double the number aged >85 years. Although the life expectancy of people living in Herefordshire is relatively good, there is a disproportionate difference in health outcomes for people in less affluent areas who generally have a shorter average life expectancy at birth, (6.2 years for males and 5.9 years for females) and spend a greater part of that life expectancy with a disability compared with residents in less deprived areas.

Primary care

Whilst overall primary care is of a high quality there is some variation in performance and in Herefordshire in 2011-13, across the GP-registered population, there were 567 premature deaths amounting to 12,695 potential 'years of life lost' from conditions that are usually treatable.

Similarly, over the past 5 years, the number of unplanned hospital admissions in Herefordshire from chronic conditions that should normally be managed in a primary or community care setting (often referred to as 'ambulatory care sensitive conditions') has been increasing.

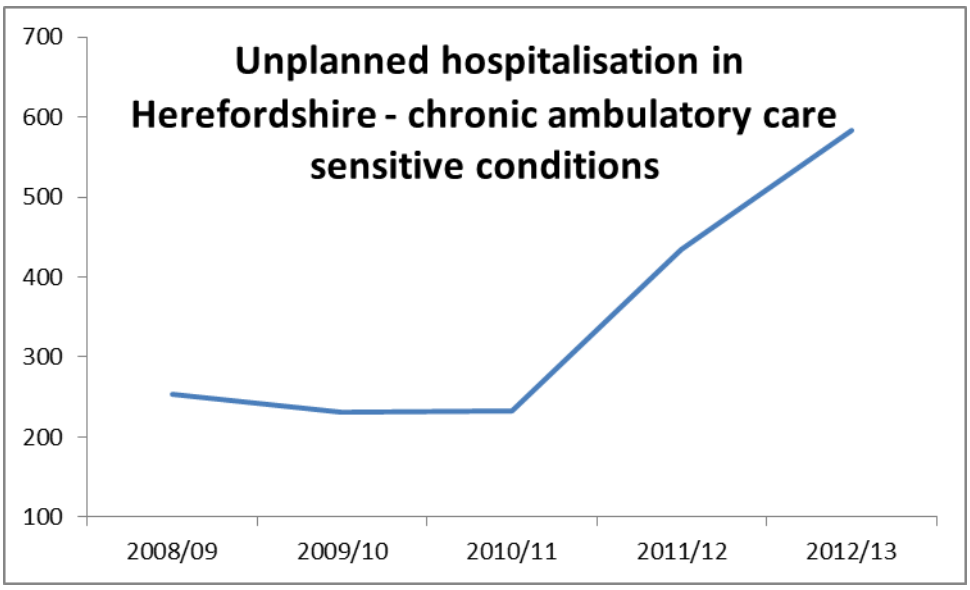


Figure: Unplanned hospitalisation for chronic ambulatory care –sensitive conditions (Indirectly age/sex standardised rate per 100,000 population) Source: The Health and Social Care Information Centre (http://www.hscic.gov.uk/)

Community-based services

Community-based services involve a range of service types and providers, including social care, district nursing, health visiting and community mental health care. Providers have reported that services have struggled in recent years to cope with an increase in workload and referrals**,** and the trend is set to continue due to the increase in our elderly population.

This extra burden has adversely affected their ability to respond as swiftly and effectively as we would like, and to be more effective, they need to be better integrated with primary care and with hospital –based specialised care in Herefordshire. In the 2011/12 National GP Survey, 55% of respondents in Herefordshire said that they had a long standing health condition and although 70% of people said that they felt they had sufficient support from relevant services and organisations to manage their

condition, more often than not this care and support is not well joined-up and may result in duplication of effort without improvement in the outcomes of care.

Adult Social Care

Adult social care and support in Herefordshire is provided by Herefordshire Council working with private care homes, home care agencies and other organisations to deliver services on its behalf. In 2013-14 the local authority funded adult social care for 4,200 people aged 18 and over. Seventy two per cent received this care mainly because of a physical disability, frailty or sensory impairment. Nearly three quarters of adult social care clients are aged 65 and over. Social care providers have struggled in recent years because of severe downward pressure on fee rates due to cuts in social care budgets and because they are finding it increasingly difficult to compete with other employers in attracting workers into a career in social care.

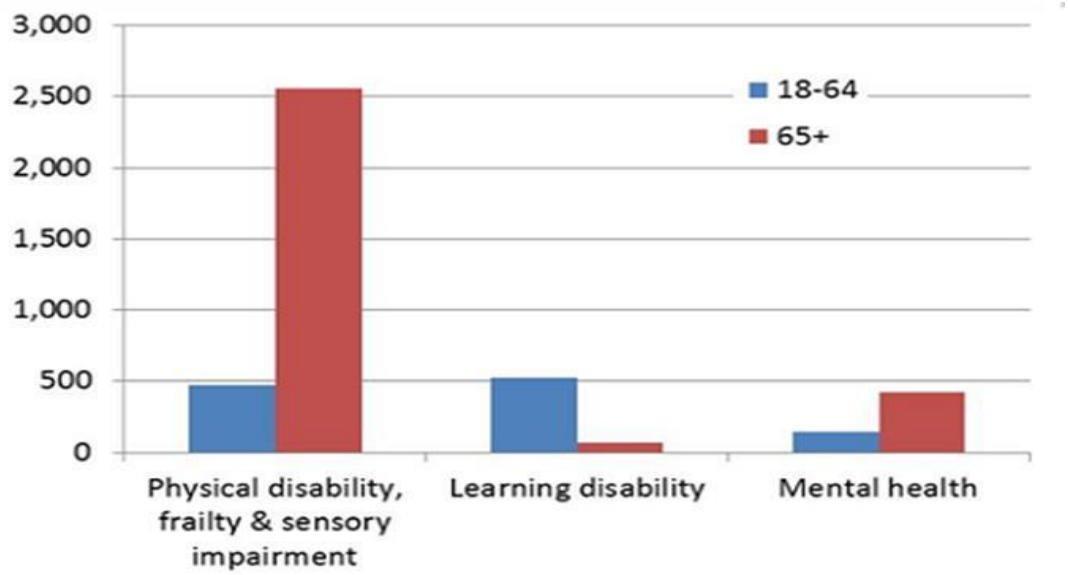


Figure: Adult social care clients (persons) in Herefordshire 2013/14

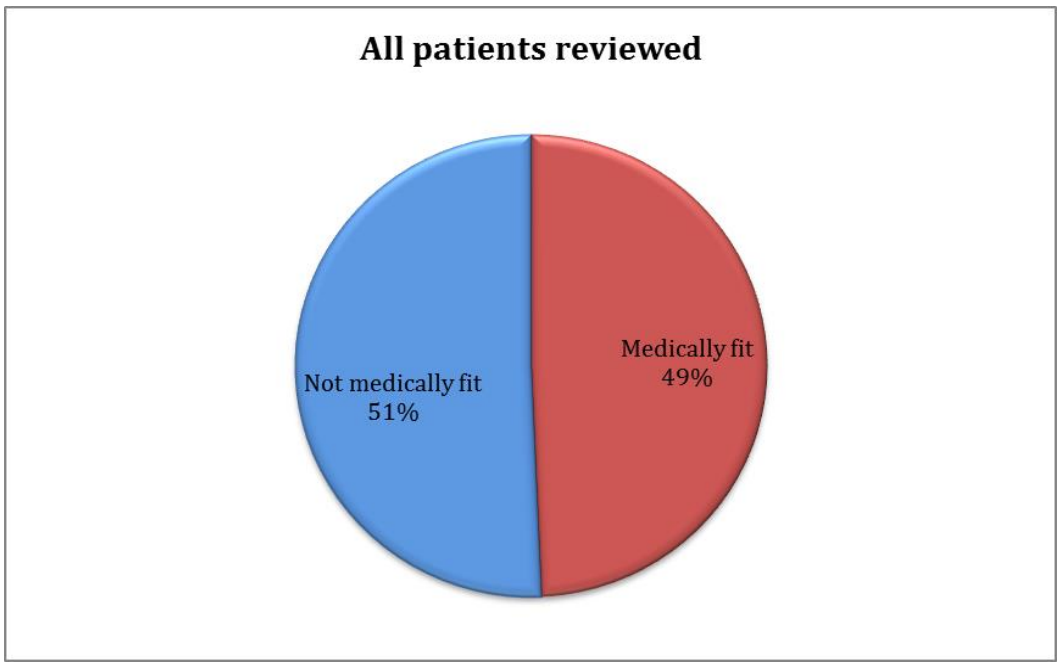
Source Understanding Herefordshire 2014, Herefordshire County Council

Herefordshire supports a smaller proportion of older people in social care than the national average, due in part to residents being on average healthier and more able to self-fund than elsewhere. The future need for social care is unclear, but as the population ages and demand inevitably increases (for example, an estimated 3.000 people with dementia could almost double in 20 years) older people and their carers will need to be enabled to do more to support themselves.

Section 75 agreement – appendix 5

In addition to the data taken from the JSNA, a recent Length of Stay review, conducted during January 2016, has provided a clear evidence base for the development of Herefordshire's DTOC plan. This review was carried out using a tried and tested methodology developed by the Emergency Care Intensive Support Team ECIST which has been used in many acute and community hospitals across England. Four multi-disciplinary teams were formed and visited a number of community hospitals and wards, where a total of 144 patients were reviewed.

Of the 144 patients reviewed 49% (71) were found to be medically fit for discharge from their current bed but waiting for some form of onward care, intervention or equipment. The average LOS of those found to be medically fit is 23 days and on the day of the review the 71 patients had occupied 1669 bed days.



Data analysis of the review concludes the following:

- There are a high proportion of patients across the hospital wards reviewed who are medically fit for discharge but waiting for intervention.
- The majority of patients are waiting for some form of external assessment/input to allow them to move on.
- Patients are deteriorating whilst waiting for discharge and alternating between being fit and unfit.
- Length of stay for patients who are medically fit is high at 23 days.

Section 75 agreement – appendix 5

3.2 THE CHALLENGES IN HEREFORDSHIRE

The table below summarises the key challenges facing Herefordshire (source One Herefordshire Plan) and identifies the activities of the BCF plan which will support their resolution. This clearly identifies **the precise aspects of the change that the local area is intending to deliver using the BCF *(B.1.iv).*** This table details the changes which will be delivered through the BCF plan, within consideration to impact and provides clear links to its contribution to the delivery of the One Herefordshire Plan ***(B.1.iii)(B2.i)***

The Problem	What we will do to address this	BCF Contribution / Alignment to One Herefordshire Plan
Lack of capacity across statutory services against a backdrop of increasing demand	Leverage capacity in the community, including the public, third sector and other agencies to promote independence	Development of community links model (April 16) to develop local solutions and support.
Abundance of voluntary assets, poorly co-ordinated and poorly understood	Co-ordinated voluntary support, linked to health and wellbeing hubs and care co-ordination service	Development of information and advice services, community and web based (Feb 16), Further enhancements / developments of web system in 2016/17
Disparate community services, little co-ordination	Community and mental health locality teams, integrated with primary care and social care Development and implementation of joint service specification for community health, mental health and social care services	Social care teams redesigned, locality and complex teams to promote closer working with community health and mental health Single model agreed through One Herefordshire programme.

Section 75 agreement – appendix 5

The Problem	What we will do to address this	BCF Contribution / Alignment to One Herefordshire Plan
Fragmented urgent care pathways in health and social care	Development and implementation of joint service models and specifications. Care co-ordination centre acts as a hub, allowing healthcare professionals to navigate care pathways Review of RAAC (Rapid Access to Assessment and Care) provision to align with community services redesign. Increased focus on Delayed Transfers of Care from community settings to support improved pathways for individuals to the most effective setting to meet their needs.	Joint Service Specification for community health, mental health and social care services agreed as part of One Herefordshire Community Collaborative project. Implemented in health contracts from 1st April 2016.
Too many people presenting in crisis creating unsustainable demand	Focus on prevention, case finding and proactive case management of high risk clients – optimal management of long term conditions, frailty and the implementation of an agreed urgent care strategy	Expansion of DFG Redesign housing support Intermediate care redesign to support step up provision Role out of Risk Stratification and “Virtual Ward” model across the county.
Bed occupancy of acute and some community hospital beds routinely 98%	Reduce to best practice occupancy levels of 92% through reducing demand and increasing capacity	Redesign domiciliary care model (2016-2017), rapid response service. Step up / step down beds

The Problem	What we will do to address this	BCF Contribution / Alignment to One Herefordshire Plan
	ECIP review commissioned in early 2016 and demonstrates that around 50% of current occupancy of acute and community beds assessed as “medically fit”. Alternative models of provision, assessment and transfer required to support improved flow.	Intermediate care redesign Providing an option for self-funders Joint Service Specification for community health, mental health and social care services
Lack of information sharing between providers means that service users receive inefficient sub-optimal care	Protocols for sharing information agreed and IT systems linked	Social care system upgrade, potential for web based data sharing? IM&T Programme Board in place and working collectively on Digital Roadmap, linking in with STP, to support long term improvement across all systems.
Services commissioned in silos and not aligned	Community commissioning would be aligned between HCCG and HC, and through the STP, wider opportunities are being explored for commissioning to be aligned at a strategic level, where this is appropriate and able to deliver demonstrable benefits, with Worcestershire and other neighbouring areas.	BCF key enabler to support the development of integrated commissioning. Joint Service Specification for community health, mental health and social care services.

Workforce Challenges

In Herefordshire we have specific challenges around recruitment and retention of staff and the system change we are planning to implement will need to take account of these. Any system change requires the full engagement and support from the workforce and effective service delivery across a system will only be possible when the clinicians and practitioners are fully engaged in the process.

Herefordshire's model proposes system change that moves from the acute to the community, to a team working approach across disciplines based around the GP practice to one that promotes self-help and enables people to manager their own conditions through peer support groups.

To achieve this will require significant cultural, relational and behavioural change; not just changes in organisational structures or processes but in the ways in which staff work alongside patients and residents. We have already started to identify some merging good practice and a genuine willingness to change. We propose to progress this by identifying our current workforce capacity, **assessing future capacity and workforce requirements across the system** and creating some early implementer change projects ***(C.1.iv)***.

Risk Stratification

Identifying those most at risk within our communities and supporting them to self-care and reduce their reliance on care services is key. As detailed within the BCF plan 2015/16, within Herefordshire 5.5% of adult population is deemed to be at risk of sudden deterioration and hospital admission. This figure was derived from work by the former PCT in collaboration with the BUPA risk stratification tool. Herefordshire CCG is currently working through IG compliance issues and is implementing the Aristotle risk stratification tool across the county. Currently each GP practice determines a patient's risk of hospital admission via clinical search of the primary care patient data base. Currently each GP practice in Herefordshire has identified 2% of their patients who are most vulnerable to sudden deterioration and hospital admission and are ensuring personalised care plans are developed with a named accountable GP for each patient. Within the adult patient population of Hereford City the risk stratification (virtual ward) pilot supported the most vulnerable 3% of the practice population with development of a jointly produced personalised care plan. The intention with implementation of the HiHub risk stratification tool is to increase identification over the coming months. The roll out of risk stratification across Herefordshire, supported by the extension of the Virtual Ward and Hospital at Home programme is well advanced and the project aims to achieve significant reductions in

emergency admissions and improvements in the safety and quality of care for some of the most vulnerable individuals being managed in community settings. ***(B.2.ii)***

The risk stratification tool is in place within Herefordshire and is used to inform monthly multi-disciplinary meetings, where a range of organisations are present including GPs, mental health, adult social care, occupational therapy, physio therapy, ambulance service and integrated care practioners. However, due to the often limited implementation of the tool and its sparse data set, it is often supplemented by patient information provided by professionals at a locality level. In order to encourage GP participation in risk stratification case management, Herefordshire CCG are currently implementing a local incentive scheme with each GP practice in the county. Practices are to be incentivised for identifying, through the use of an approved computerised risk stratification tool nominated by the CCG, patients who will benefit from proactive case management. Once the consistency and quality of the information collated by the risk stratification tool is improved Herefordshire will then by in a stronger position to use this data more effectively to improve quality and reduce costs based upon a segmented risk stratification approach **(B.2.ii).**The following high level timescales apply to the implementation of risk stratification in Herefordshire:

Action	Deadline
GP Local Incentive Scheme agreed with Practices	April 2016
Display of patient facing advice and posters including individual patient opt out opportunities	April-July 2016
Data sharing agreements with Practices	April – May 2016
Full testing of the GP extract in first GP Practice	May 2016
Risk Strat tool with Secondary Care data accessible in all GP Practices	June 2016
Monthly GP MDT meetings inc use of risk stratification to case find patients – incremental approach	May –October 2016
Additional 5 GP Practices agreement to GP data extraction	June-July 2016
Remaining GP Practices agreement to GP data extraction	July – September 2016
Monitoring report of risk stratification usage to inform case finding	end Q3 2016

4. INTEGRATED ACTION PLAN

The following section details the strategic objectives of the principal schemes in the BCF plan, provides an update on the changes delivered during 2015/16, and gives a high level perspective on the additional developments planned for 2016/17 and longer term aims for delivery by 2020. ***(B.1.iii)***

SCHEME: MINIMUM PROTECTION OF ADULT SOCIAL CARE	
Strategic objective of the scheme	To maintain the existing levels of NHS (section 256) investment in social care in order to enable the local authority to support services which meet the wider strategic objectives of the BCF.
Planned Change 2015/16	Investment in a community based model of care across a range of services which addresses one or more of the following key criteria: • Prevention • Managing demand • Early intervention / Rapid Response • Intermediate care • Managing long term conditions
Change Delivered 2015/16	The Protection of social care funding was invested in the following areas: • Urgent care and rapid response • Community equipment • Reablement • Intermediate care • Carers, including reprocured carer's services • Mental/LD health • Demand management Key outcomes achieved: ✓ The reprocurement of carer's services ✓ The implementation of an information advice and guidance service (to divert demand). ✓ Improvements in community equipment service delivering savings for both council and CCG ✓ Implementation of rapid access to discharge bed provider framework ✓ Realignment of the care management teams with additional focus on hospital discharge and the advice and referral team
Planned Developments 2016/17	This funding will enable the ongoing delivery of services. The investment will support the delivery of the strategic aims and objectives outlined within this plan.

SCHEME: MINIMUM PROTECTION OF ADULT SOCIAL CARE	
	Specific developments within these service areas for 2016/17 include: • Implementation of redesigned social care teams into locality / complex care teams • Review and redesign of reablement services to align with the wider development of community health, mental health and social care services. • Redesign of the RAAC provision to enable a community based support service offering both "step up" and "step down" provision • Implementation of the Joint Carers Strategy • Reduced delays in transfer of care from community settings to the most appropriate setting to support individual needs
Further Developments to 2020	• Further development of aligned working arrangements • Implementation of an outcomes focused home care provision • Further development of preventative services

SCHEME: CARE ACT IMPLEMENTATION	
Strategic objective of the scheme	To ensure that all duties under The Care Act 2014 are met.
Planned Change 2015/16	For the BCF to be utilised to meet the requirements of the new duties, including: • Setting national eligibility criteria • Implementing statutory safeguarding adults boards • New duties for self-funders • Duties for self-funders • Provision of advocacy • Provision of information and advice
Change Delivered 2015/16	• New information and advice website launched • City centre IAS service open • Pop up hubs will be implemented across the county
Planned Developments 2016/17	• Enhance content of IAS • Re-procure advocacy service • Initial local area development of community links model
Further Developments to 2020	• Rollout community links model countywide • Develop / expand preventative / self help services • Preparation for delivery of phase 2 of Care Act – details TBC

SCHEME: COMMUNITY HEALTH AND SOCIAL CARE SERVICES REDESIGN	
Strategic objective of the scheme	To deliver the right Community Health and Social Care services in the most appropriate way by reviewing the current menu and method or models of provision and implementing the changes required to achieve the transformation aims and objectives.
Planned Change 2015/16	• Improved patient care, safety and experience • Improved Urgent Care • System benefit • Improved systems efficiency, cost effectiveness • Improved outcomes A short description of the existing initiatives and service areas within this scheme is set out in the appendices.
Change Delivered 2015/16	• Roll out of Virtual Ward and Hospital at Home provision across the county • Implementation of a highly effective falls rapid response service • Review of the short break provision for children and families • Re-procured the carers information and advice centre • Rapid response service was enhanced to provide additional support for community and hospital discharge
Planned Developments 2016/17	• Full implementation of the joint service model for community health, mental health and social care services • County wide roll out of the Virtual Ward and risk stratification model, identifying and supporting more individuals in community settings. • Reduction in delayed transfer of care from community settings through an increased focus and development of risk sharing arrangements across health and social care to support and incentivise improvement • Continuation of the short break provision for children and families • Rapid response service will continue at an enhanced level • Intermediate care strategy to be implemented with a focus on step up/step down provisions • Commencement of engagement on redesign of the community hospital

SCHEME: CARE ACT IMPLEMENTATION	
	and intermediate bedded provision
Further Developments to 2020	• Review of all carer services • Full implementation of intermediate care provision • Step change from community hospital and intermediate care bedded provision and focus on community provision • Improved pathways and alignment across acute, community, mental health and social care provision reducing complexity and improving efficiency and effectiveness of care

SCHEME: DISABLED FACILITIES GRANT	
Strategic objective of the scheme	The purpose of the disabled facilities grant is the delivery of essential structural changes to enable people to remain in their own homes and avoid the need for admission to residential care
Planned Change 2015/16	• Using the CSR assumptions approximately 10% of adaptations result in avoiding the need for admission to a care home. • The average cost of an adaptation in Herefordshire is £4.8k. The grant for 2015/16 is £0.866m which enables circa 180 adaptations per annum, resulting in a possible 18 avoided care home admissions
Change Delivered 2015/16	✓ Currently forecasting to spend full grant allocation in line with plans
Planned Developments 2016/17	Grant increases to £1.558m enabling an additional 144 adaptations to be undertaken, circa 325 in total, subject to OT capacity. This gives the potential to avoid circa 32 admissions based on CSR assumptions. • Establish a working group to review the DFG scheme • Continue to work with Housing colleagues to ensure a joined up approach to improving outcomes across health, social care and housing.
Further Developments to 2020	Extrapolating DFG funding forward to 2020 would result in circa 400 adaptions per annum, 40 care home admissions avoided.

SCHEME: SOCIAL CARE CAPITAL	
Strategic objective of the scheme	To enhance community capacity, support system changes required to meet the information technology changes required arising from the Care Act and BCF national condition relating to the NHS identifier
Planned Change 2015/16	• Complete systems updates for use of NHS identifier • Complete system upgrades for Care Act compliance • Upgrade social care system for enhanced capabilities / better integrated working
Change Delivered 2015/16	✓ NHS identifier embedded in social care systems – used for additional pool reporting ✓ Upgrades complete ✓ Mosaic upgrade phase 1 go live April 16
Planned Developments 2016/17	No funding for social care capital after 1 April 2016. Scheme ceases to exist
Further Developments to 2020	Not Applicable

SCHEME: CARE HOME MARKET MANAGEMENT	
Strategic objective of the scheme	To deliver more effective market management across Herefordshire to enable the more cost effective purchasing of Residential and Nursing placements through both the council and Continuing Health Care (CHC).
Planned Change 2015/16	Savings released through this scheme to be utilised to provide additional funding for the protection of social care above the minimum funding level. Scheme expected to deliver: • Better care outcomes for people • Better functioning system • Better value for money • Financial savings
Change Delivered 2015/16	✓ Unified contract currently in negotiation and under development. Liaising closely with providers with regards to contractual proposals and implementation milestones. ✓ Care home market strategy developed encompassing both council and CCG information

Section 75 agreement – appendix 5

SCHEME: CARE HOME MARKET MANAGEMENT	
Planned Developments 2016/17	• Agree and implement unified contract in relation to residential, nursing and CHC placements.
Further Developments to 2020	Alignment of internal processes including payment processes. Development of market capacity aligned to health and social care needs. Outcomes based commissioning to be developed and to consider incentivized support for addressing DTOC issues in the county.

5. NATIONAL AND LOCAL METRICS 2016/17

The following section provides an overview of 2015/16 performance and an update in relation to the following national and local metrics:

- Non-elective admissions
- Permanent Admissions to Residential and Nursing Homes (Age 65+)
- Older people at home 91 days after Reablement
- Delayed Transfers of Care
- Reduction in Fall Related Admissions
- Patient experience

Metric: Non-elective admissions *(E.1.i, E.1.ii. E.1.iii)*

2015/16 target

14,786

2015/16 performance and update

Description: Total non-elective admissions to hospital (general & acute), all ages, per 100,000

A number of schemes have been set up during 2015/16, including via the SRG programme, to address the increased demand. These include rapid assessments, fallers first response, virtual wards and hospital at home.

Plan					**Actual**			
Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	**Q4 14/15**	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**
4,311	4,182	4,178	4,462	4,527	**4,108**	**4,072**	**4,204**	**4,473**

Achieved: 16,857

2016/17 target

Partners have developed a range of schemes that will impact on NEA in 2016/17. This work has built on success of schemes in 2015/16 and subsequent evaluation. This modelling has also been undertaken to assess the impact of the

	CCGs QIPP schemes and is linked to the Contract Negotiations. For example this includes: • The plan is based on the QIPP planning submission which includes all expected NEA reductions therefore no additional quarterly reductions are expected within the BCF plan; please note this is a change from the first submission. • This assumption will be tested before the next submission. • Impact of Virtual wards schemes during 15/16, subsequent analysis and modelled as lead to projected impact of county-wide roll-out for 16/17 • Continued impact of Falls scheme during 16/17 on NEA, building on successful roll-out in 15/16, • Continued use of RAAC beds, as an alternative to hospital admissions • Development of Care co-ordination Hub, and proactive signposting and management in community settings • Projected impact of Hospice at home and anticipatory care planning developments in 16/17 based on pilots and experiences elsewhere • CHC – management of market to ensure improved care planning and avoidable admissions; and development of personal budgets, to improve self-care and self-management, and to enable choice to minimise avoidable admissions • Enhanced Re-ablement schemes to reduce readmissions

Metric: Permanent Admissions to Residential and Nursing Homes (Age 65+) *(E.2.i, E.2.ii, E.2.iii)*	
2015/16 target	680.4
2015/16 performance and update	**Description:** Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population. Permanent admissions to residential and nursing care experienced a 16% surge in admissions during 2014/15 which provided a higher baseline figure for 2015/16. During the past year there has been a steady state of admissions and this is expected to continue in 2016/17. The implementation of a culture change through the care management team

is in development to review the cases being referred into residential and nursing homes with a view to source alternative provisions of care.

Permanent Admissions to Residential and Nursing Care													
65+ Rate (YTD)		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	2013/14	53.9	120.0	171.5	232.7	296.4	338.1	436.1	477.7	512.0	558.5	595.3	607.5
	2014/15	71.6	149.9	219.3	290.9	313.3	349.1	398.4	434.2	478.9	530.4	584.1	655.3
	2015/16	**50.9**	**101.9**	**132.0**	**180.6**	**196.8**	**238.5**	**266.3**	**296.4**	**324.1**	**345.0**		

2016/17 target

	Actual 14/15	Planned 15/16	Forecast 15/16	**Planned 16/17**
Annual rate	653.2	680.4	484.4	**487.0**
Numerator	283	302	215	**221**
Denominator	43,326	44,387	44,387	**45,382**

Metric: Older people at home 91 days after Reablement *(E.3.i, E.3.ii, E.3.iii)*	
2015/16 target	85.0
2015/16 performance	**Description**: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

and update

The community reablement provision has experienced a consistent performance for the last two reporting quarters. The target of 85% has been revisited with a view to reduce this to 80% which is consistent across the country. The reablement provision in Herefordshire is a small, targeted provision therefore a slight change in the reporting would show a large outturn in the performance of the service.

Location of clients at 91 days following completion of Reablement Intervention												
Percentage at home 91 days (YTD)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	50.0%	86.0%	86.5%	82.5%	78.5%	78.6%	78.9%	79.1%	79.0%	77.9%		

2016/17 target

	Actual 14/15	Planned 15/16	Forecast 15/16	**Planned 16/17**
Annual %	73.3%	85.0%	79.0%	**80.0%**
Numerator	55	544	79	**80**
Denominator	75	640	100	**100**

Metric: Delayed Transfers of Care (E.4.i, E.4.ii, E.4,iii)	
2015/16 target	516.3
2015/16 performance	**Description**: Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+) A number of schemes have been delivered during 2015/16 which are being worked through to help address the

and update

pressures of delayed transfers of care, including earlier identification of potential discharges, additional RAAC capacity and brokerage and additional support to self-funders and care homes. To date, the number of delayed cases continues to rise with forecast to continue. Quarterly figures are therefore likely to be further above the target. Data is taken as a snapshot at month end and therefore can appear volatile.

Delayed Transfers of Care (delayed days) from hospital per 100,000 population								
	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4
Target Rate	539	527	477	527	448	461	474	516
Actual Rate	539	712	559	602	614	611	750	693

2016/17 target

	2016/17			
	Q1	**Q2**	**Q3**	**Q4**
Quarterly rate	609	606	744	513
Numerator	932	928	1139	790
Denominator	153,009	153,009	153,009	153,968

Metric: Reduction in Fall Related Admissions

<table>
<tr><td>2015/16 target</td><td></td></tr>
<tr><td>2015/16 performance and update</td><td>The Falls Responder Service provides a 24/7 mobile response to adults who have fallen in their home environment and are uninjured. The team are trained to safely move an individual who articulates that they are uninjured, provide a welfare check, provide signposting to sources of support, notify the GP and refer (with consent) to the Falls Prevention Team for follow up clinical assessment and intervention. A follow up telephone call is made to each individual 24 hrs after the responder visit to clarify impact post fall.

Since the introduction of the Falls responder service monthly analysis of WMAS conveyances to Hereford County Hospital which are coded as 'Fall' (as a percentage of all WMAS conveyances) are measured as a 12 month rolling average, this indicates a reducing trend for falls conveyances. The falls responder data also indicates that the number of WVT admissions per month with a falls diagnosis measured as a 12 month rolling average indicates an overall decline in the number of admissions. Monthly data analysis indicates that the responder service is delivering the projected system benefits alongside positive patient feedback.</td></tr>
<tr><td>2016/17 target</td><td><table>
<tr><th></th><th>Planned 15/16</th><th>Planned 16/17</th></tr>
<tr><td>Metric Value</td><td>16.0</td><td>0.0</td></tr>
<tr><td>Numerator</td><td>732.0</td><td>0.0</td></tr>
<tr><td>Denominator</td><td>4561.0</td><td>0.0</td></tr>
</table>
The metric for 15/16 was to reduce admissions which is forecast to achieve. The identified metric for 16/17 for the falls responders service will be expected to reduce the ambulance conveyance and A&E attendances.</td></tr>
</table>

<table>
<tr><th colspan="2">Metric: Patient experience</th></tr>
<tr><td>2015/16 target</td><td>User experience (ASCOF) 83.0</td></tr>
</table>

<table>
<tr><td>2015/16 performance and update</td><td>The performance of this metric is based upon survey outputs, taken from an annual data collection. Surveys were distributed during January 2016 to approximately 880 service users. To date (17 March 2016) around half of these have been returned. Strata response rates will be calculated at the end of the survey period in order to establish confidence level.

Returns are currently being manually uploaded in order to collate results.</td></tr>
<tr><td>2016/17 target</td><td>The target has been set on the basis of continuous improvement, and in line with our previous years performance of 67% and trends of comparators.

Improvements in this measure will not be specific to BCF initiatives as the survey is based on a random sample of service users. Evidencing the cause-effect of any one initiative in an overall population satisfaction measure will be difficult. However any improvements made in the result will indicate general improvements made within the system.

Please be aware that we are proposing a change to the measure for this year and as such comparison with last year’s performance is not possible.

<table>
<tr><th></th><th>Planned 15/16</th><th>Planned 16/17</th></tr>
<tr><td>Metric Value</td><td>83.0</td><td>70.0</td></tr>
<tr><td>Numerator</td><td>265.0</td><td>182.0</td></tr>
<tr><td>Denominator</td><td>320.0</td><td>260.0</td></tr>
</table>

Used ASCOF 4b measure in 15/16 which references feeling safe. Changed to ASCOF 3a for 16/17 customer satisfaction as this is a more meaningful measure.</td></tr>
</table>

6. MEETING THE NATIONAL CONDITIONS 2016/17

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

- Jointly Agreed BCF Plan
- Maintain provision of social care services in 2016/17
- Supporting progress on meeting the 2020 standards for seven day services
- Better data sharing between health and social care, based on the NHS number
- A joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact on the providers that are predicted to be substantially affected by the plans
- Agreement that a proportion of the allocation is invested in NHS commissioned out-of-hospital services
- Agreement on a local action plan to reduce delayed transfers of care

6.1 JOINTLY AGREED BCF PLAN

Herefordshire's BCF Plan for 2016/17 was signed off by The Health and Wellbeing Board (HWB) on 21st April 2016. This final submission (27th June 2016) has been approved on behalf of the council by the Director for Adults and Wellbeing, the Director of Operations for the CCG and the chair of the HWB prior to submission. ***(C.1.i)***

In agreeing the plan, the CCG and council commissioners have engaged with health and social care providers in both the acute and private sectors. This has been done to ensure that they understand the implications of the proposals contained within this BCF plan insofar as they relate specifically to services they provide to the BCF partners and **to achieve the best outcomes for local people *(C.1.ii)*. There is joint agreement across commissioners and providers as to how the BCF in Herefordshire will contribute to a longer strategic plan**. The CCG and council, as commissioners, and Wye Valley NHS Trust and 2gether NHS Foundation Trust, as providers, are all fully engaged in the alliance to deliver the One Herefordshire Plan and all are sighted on the role of the BCF within the wider transformation programme.

The Disabled Facilities Grant (DFG) has again been allocated through the BCF fund and therefore ***local housing authority representatives have been involved in developing and agreeing the***

plan (C.1.vi). Herefordshire is a unitary authority which does not devolve DFG to a second tier authority. The management of the DFG sits within the local authority housing team in the adults and wellbeing directorate of the council, and is overseen by the head of prevention. ***This assists in ensuring that a joint up approach to improving outcomes across health, social care and housing are achieved.*** Many DFG referrals are received via social care staff and assessment of eligibility for DFG is consistent with delivering wider health and social care benefits, and keeping people safe in their own homes.

6.2 MAINTAIN PROVISION OF SOCIAL CARE SERVICES IN 2016/17

Adult social care services in Herefordshire will continue to be supported within the BCF plan 2016/17 in a manner consistent with 2015/16 ***(C.2.v)***. Broadly, funding is assigned to the same service areas although some areas have seen increases (due to in year pressures such as DOLS) or decreases following successful recommissioning of external services (e.g. carers) which have delivered the same level of service, or improved service outcomes for less. Funding is reallocated to make best use of the available funds to services which are aligned to supporting health outcomes.

Protection of adult social care (PASC) has not been protected in real terms as the overall increase in the BCF minimum fund allocation for Herefordshire has been capped at £55k or £0.5%. A real terms uplift of 1.9% would equate to £86k on the 2015/16 figure of £4,520k, more than the total uplift for the fund. We have therefore determined that the most pragmatic solution is to pro rate the uplift in line with the 2015/16 allocations across social care and community health schemes. This means that funding for PASC has increased by £21k only, £65k less than a real terms uplift. ***(C.2.vi)***

As stated above, due to the adjustments to the NHS funding formula Herefordshire CCG has not received the full inflationary uplift as it is deemed under the new formula to be funded above the target. To have awarded a full inflationary increase to the PASC funds would have created an additional pressure on the already financially challenged CCG. The partners have therefore agreed that applying the minimal uplift awarded for the CCG minimum BCF allocation prorata to the 2015/16 allocations was the most appropriate action.

The LGA Care Act indicative funding allocation model would assign funding of £506k for Care Act implementation in Herefordshire, an increase of £48k, whereas the current assumption is an uplift of only £2k.

Overall social care is therefore underfunded by £111k for 2016/17. **In setting the level of protection for social care the local area has ensured that any change does not destabilise the local social and health care system as a whole *(C.2.vii)*.** As the funding for PASC shows a marginal uplift compared to 2015/16 this has reduced the risk of destabilisation of social care services, but will slow down the pace of change.

The Joint Spending Plan section of this document (section 7) provides **a comparison to the approach and figures set out in the 2015/16 plan *(C.2.viii)***. Herefordshire is not planning any significant changes from the schemes included in 2015/16. It should be noted that the approved BCF plan for 2015/16 included indicative figures for the additional pooled resource. When partners finalised the figures these were adjusted down to the level shown in the table in section 7 below and have been used for in year reporting. A high level comparison to the original BCF will show an overall reduction year on year of circa 12% but in reality funding is above the amended 2015/16 budget.

Funding is reallocated to make best use of the available protection of adult social care (PASC) funds to services which are aligned to supporting health outcomes. In agreeing the PASC funding for 2015/16 significant discussions between council and CCG over a considerable period were necessary to agree the allocation of the PASC funds to ensure that the CCG was satisfied that the services invested in were providing health benefits. The overall approach for allocating PASC is consistent with 2015/16 and therefore meets the requirements of the 2012 DH guidance ***(C.2.viiii)***.

6.3 SUPPORTING PROGRESS ON MEETING THE 2020 STANDARDS FOR SEVEN-DAY SERVICES

This approach will prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week **(C.3.ii)** and improve discharge planning.

Plans are in place to provide 7 days services (throughout the week, including weekends) across community, primary, mental health are social care **(C.3.i)** and the approach will support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care **(C.3.iii).**

The One Herefordshire Programme, via its Urgent Care and Community Collaborative workstreams, and the schemes within the BCF, have a central focus on ensuring coherence across primary, community and secondary care, seven days a week. This will be achieved through:

- Professional Facing Care Co-ordination Hub which delivers multi-disciplinary clinical input to support decision making and co-ordinating and simplifying:
- Access to most appropriate care that can prevent emergency admissions e.g. diagnostics, community services, social care
- emergency admissions and discharges
- access to specialist opinion and advice (through regional procurement)
- Integration with GP out of hours services to achieve better of continuity care for users, patients carers.
- Improved access to records, including information and record sharing across providers, enabling front line staff to access records to improve the continuity of care and work toward an integrated approach to access of records to effective care across Herefordshire
- Developing IT interoperability enabling direct booking of appointments across service providers first phase NHS 111 direct booking of extended hours primary care appointments
- Building on learning from the Prime Ministers Access Fund (2015) pilot, which makes available primary care extended hours 6-8pm Monday to Friday in three locations across the county and 10am to 2pm on Saturday and Sundays in Ross on Wye and Leominster and 8am to 8pm in Hereford. Core to the success of this work has been full access to patient's primary care record with consent sought at time of clinical consultation.
- To work with primary care at scale to further develop locality based 7 day access to primary care, the PMAG extended hours approach will be marinated in 16/17, primary care at scale evolving model April 2017.
- Wye Valley NHS Trust and 2gether Foundation Trust are working to develop integrated multidisciplinary place based care formulated around GP practice population; a newly appointed joint director of community services is taking this forward in 16/17, with the evolving model being in place by April 2017. This work will improve continuity of information, care co-ordination, transition planning, discharge planning and hospital avoidance, and community based care as an alternative to hospital based care
- As part of the Community Collaborative work focus on virtual community team model drawing together community functions delivered through a multi-disciplinary team identifying the vulnerable

through a risk stratification approach and taking a case management approach to establish individual care plans and person centred –outcomes – with focus on education, self-management and reducing hospital admissions, attendances and outpatient appointments. Aligned to this is a quality initiative across both 2g, WVT and West Midlands designed to reduce frequent attendees across several pathways.

- The principle of seven day working is embedded within One Herefordshire and our service redesign plans. **(C3.iv)**
- Our Delayed Transfer of Care action plan (see attachment) describes in more detail several areas of focus that is aimed to support the timely discharge of patients
- Primary care and community services central to the urgent care pathway – with increased capacity and capability over 7 days at locality level
- Potential realignment of resources within Minor Injuries Units and the Walk-In Centre, to simplify access routes for the public, reduce service duplication, and realign workforce and skill sets to primary care and A and E. The Walk-In Centre and Minor Injury Units are to remain open with no immediate changes while proposals for urgent care and for seven-day GP services are being developed, but we are reviewing these services to determine whether care is being provided in the best place at the best time for patients. The outcome of the review is not yet known and no decisions have been made. We will be undertaking a comprehensive and robust consultation with the residents of Herefordshire as part of our work.
- An Integrated NHS111/GP Out of Hours service is currently being commissioned across the West Midlands, on behalf of 16 CCGs which includes Herefordshire. Each CCG in the West Midlands has an opportunity to influence how the NHS 111 service works in their area and we will be ensuring that NHS 111 will be integrated with Herefordshire's urgent care services. Local schedules attached the NHS 111 and Out of hours to ensure appropriate local delivery.
- A public facing "virtual assessment" function across the whole pathway of care, to move towards "talk before you walk", across primary care, NHS 111, WMAS and the "front door" of A and E. Consistently assessing and directing people to the most appropriate service, with redirection to primary care whenever appropriate.
- The brokerage function within the Adults Wellbeing directorate for the local authority provides 7 days a week support to enable hospital discharges

- Enhanced capacity has been provided to hospital social care management function 7 days a week
- The approach to delivering seven day services will be underpinned by the integrated urgent care pathway and health hubs.
- Plans for 2016/17 are in place for the developments outlined above as part of the One Herefordshire plan but are subject to further development and refinement.
- Hospice at home to support quality and effective EoLc 24/7 hospice at home service was commissioned and started in February 2016 to enable people to die in their preferred place of care outside of hospital.

6.4 BETTER DATA SHARING BETWEEN HEALTH AND SOCIAL CARE, BASED ON THE NHS NUMBER

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

By April 2016, every local area is now required to deliver, co-ordinated by the CCG,

- A Footprint detailing the partners and the governance arrangements to drive the local health and care system to become paper-free at the point of care.
- A baselined and benchmarked process towards becoming paper-free at the point of care using a new Digital Maturity Self-Assessment Tool.
- A digital roadmap outlining the steps (operational and strategic) to be taken towards being paper-free at the point of care.

The major recommendation from the workstream to date is that Herefordshire should implement a shared care record, with data being supplied from providers once appropriate systems are in place. This would provide a platform that improves the quality of care, the information available to professionals and clinicians and should, with appropriate business change, reduce time in hospital, support living at home longer, improve outcomes for patients and reduce costs.

As yet, the financial evidence about the level of saving that might be achieved is not extensive. There is more evidence of improved outcomes for service users and patients. Additionally, there are a set of

smaller activities that would support working within the county. These “quick wins” leverage existing investments and would improve efficiency. This set of activities should be progressed to be in place by Mid-2016.

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

Within Herefordshire, **the right cultures, behaviours and leadership are demonstrated locally by all partners, fostering a culture of secure, lawful and appropriate sharing of data to support better care. *(C.4.i)*.** The **NHS number is being used as the consistent identifier for health and care services *(C.4.ii)***. For example, the NHS identifier is being used for reconciliation and reporting purposes within the Care Home Market Management BCF pool and is available for reporting within social care systems. All systems being developed or investigated have an API interface ***(C.4.iii)*.**

The cultures, behaviours and local leadership are demonstrated through the collaborative approach taken within the four key workstreams of the One Herefordshire transformation programme in which all partners actively participate to develop local solutions.

It is recognised that there is a requirement for **appropriate Information Governance controls to be in place for information sharing in line with the revised Caldicott principles and guidance** (available by the IGA). To date, the council has achieved 74% of the current IG toolkit submission and is at least level 2 in all areas ***(C.4.iv)***. A Herefordshire memorandum of understanding on information sharing is in place and local data sharing agreements amongst partners are in the process of being developed. All staff receive mandatory training in information governance and specific multi-agency face-to-face training is in the planning stages for roll-out in the coming months.

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

implementing privacy notices. Consent forms were also reviewed as part of the work for the changes brought about by the recent Care Act ***(C.4.v)***.

These changes highlighted will be an enabler for integration of services in the future and will provide the foundation of successful partnerships. All stakeholders are committed to the delivery of better data sharing to improve and enhance the journey through health and social care. ***(C.4.vi)***

6.5 A JOINT APPROACH TO ASSESSMENTS AND CARE PLANNING

The proportion of our local population which has been identified (using our virtual wards scheme) and through the risk stratification tool is 2% **(C.5.i).** The electronic risk stratification tool draws together primary and secondary care data to identify those individuals likely to experience significant deterioration and hospital admission. These vulnerable individuals are offered targeted support, an individual care plan and proactive case management from a member of the multi-disciplinary community team.

Herefordshire Council and CCG have developed and implemented an aligned assessment for continuing healthcare (CHC) and have also fully implemented the joint support planning process, with an accountable professional assigned to each case.

There is a joint approach to dementia care and living well with dementia in Herefordshire – with a clear shared vision across our system to increase the availability of early diagnosis of dementia, and to support people with dementia, their carers and families to live well with dementia. The model of dementia care is based on a primary facing pre and post diagnosis support. This includes efficient access to assessment (within 4 weeks); a partnership between mental health services and voluntary sector to offer tailored person-centred care that recognizes the different stages of the illness, e.g. carers support, information and advice, maximizing independence, advance care planning; and care coordination. Health and social care are working together to ensure that multi-agency and multi-disciplinary input is coordinated and provided for people with dementia within the community. The coordination extends to ensuring support is provided during times of ill health, e.g. hospital stays, and in different settings, e.g. Care Homes **(C.5.ii)**

We currently have an Integrated Urgent Care Pathway project in place, which is a joint project between the Local Authority and Wye Valley NHS Trust to further develop an integrated Urgent Care Pathway, utilising the existing community health and locality social care teams to maximise

opportunities to avoid admissions into the acute hospital, support earlier discharge and facilitate discharge to assess where there is further recovery or rehabilitation required to enable longer term planning to take place. This project develops the footprint for multidisciplinary working building on, lead professional (Key Worker), Trusted Referrer and Trusted Assessor roles across multiple Health and Social Care teams.

The strategic objective is to enable individuals to remain as independent and healthy as possible in their usual place of residence, to minimise admissions and subsequent spend within the acute hospital environment thereby facilitating investment in community health and social care services to meet our shared objectives of safely and effective care which maintains independence within the community for vulnerable adults.

The pathway prompts rapid responses to urgent care requirements, establishing the principles of right care, in the right place and at the right time, maintaining the person's independence within their usual community setting by deploying the optimal skill mix to ensure the response provided is appropriate and proportionate to the assessed needs. As a health and care system we are working towards the default position where individuals are supported to remain at, or return to their home.

The delivery plan detailed below provides key milestones for Herefordshire's joint approach to assessments and care planning **(C.5.iii-iv).**

Delivery	**By when?**	**By who?**
Commitment and scoping of a plan to develop joint or aligned assessments, with the aim to shift to prevention and reduce the number of high cost service users/patients.	Q1 2016/17	CCG and LA
Agree proposal for a functional delivery model for health and social care.	Q1 2016/17	CCG and LA
Full governance agreement to the functional model to include the JCB, System Redesign group, One Herefordshire working groups – • Urgent Care • Community Collaborative • Supportive Communities	Q1 2016/17	CCG and LA

Section 75 agreement – appendix 5

Delivery	By when?	By who?
Share the proposal and develop further with key providers. To include: • WVT • 2gether Foundation Trust • Shaw Healthcare • Blanchworth • Key LA providers.	Q1 2016/17	CCG and LA
Develop further joint working across agencies and community (provider input required). To include the following: ➢ Risk stratification ➢ Virtual wards/hospital at home ➢ Rapid response ➢ Voluntary sector ➢ Mental Health	Q1 and ongoing	CCG and LA
Risk stratification tool to be developed through the community teams to identify people 'at risk' of entering the system.	Q1 2016/17	Community collaborative
Establish joint approach to care planning in line with the delivery model (self-assessment and appropriate professional assessments) and agree milestone plan.	Q1 2016/17	CCG and LA
Identify and establish key processes in relation to key priority populations (e.g. frail/elderly)	Q2 2016/17	CCG and LA
Providers and commissioners to agree pathway and process implementation	Q2 2016/17	CCG and LA
Identification of potential Trusted Assessors, to achieve focus on functions not roles and to enable workforce efficiencies across providers.	Q2-3 2016/17	CCG and LA
Plan for rollout of training programme for Trusted Assessors	Q4 2016/17	CCG and LA

Section 75 agreement – appendix 5

Delivery	By when?	By who?
Care Home Inreach Team to review care home residents to identify those without a diagnosis of dementia but who might have dementia, assess them and request that their usual GP adds them to the dementia QOF register if dementia is diagnosed.	Q4 2016/17	CCG
Community dementia team to make effective links with community hospitals to develop process for identification of patients requiring dementia assessment	Q1 2016/17	CCG
Targeted case finding for key groups with GP surgeries and Mental Health Liaison Service, e.g. frail elderly people, older carers, people with LTCs, patients in care homes, and people with learning disabilities.	Q4 2016/17	CCG
Multi-agency dementia training to aid joint working	Q1 2016/17	CCG

Through implementing the above delivery plan health and social care teams will use a joint process to achieve effective joint working which benefits patients/service users through promoting independence, preventing hospital admission reducing people entering into the care system and ensuring people are in the right part of the system as quickly as possible.

6.6 AGREEMENT ON THE CONSEQUENTIAL IMPACT OF THE CHANGES ON THE PROVIDERS

Herefordshire have reviewed this section following the submission two assurance process and believe the narrative below meets the KLOE requirements. Please note the assurance process was rag rated fully met by one reviewer and not met by the other.

Providers are fully briefed on the projects included within the BCF that impact on them. We are working with our providers to support delivery of the key elements of the One Herefordshire projects and where appropriate, changes are reflected in our contractual relationship with providers.

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

appropriate conflicts of interest safeguards are in place). **Implications for local providers are set out clearly within this process and allow recognition of service change consequences *(C.1.v)***.

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

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

The impact of local plans has been agreed with relevant health and social care providers *(C.6.i)*. The CCG's contract with its main acute provider (WVT) includes QIPPs and contractual changes that reflect the implementation and extension of schemes that are supported through the BCF – e.g. extension of the Virtual Wards across the whole county. Activity and performance trajectories are modelled, alongside financial impact and these are taken into account through contract negotiations. A clear provider engagement plan will be developed within the BCF 2016/17.

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

There is ongoing public, patient and service user engagement in the planning process by partners, through our usual activities. A significant engagement programme was undertaken in summer 2015 to support the development of the Health and Wellbeing Strategy which underpins the transformation programme and informed the setting of our local objectives. CCG and council provide regular updates to governing body, Cabinet and members as part of the routine governance and assurance processes. ***(C.6.ii)***

These align to provider plans and the longer term vision for sustainable services *(C.6.iii)* through the One Herefordshire Plan

The **importance of mental health as well as physical health** was demonstrated as it was the number one priority arising from the consultation on the health and wellbeing strategy. A joint work programme on the redesign of mental health services is currently underway. ***(C.6.iv)***

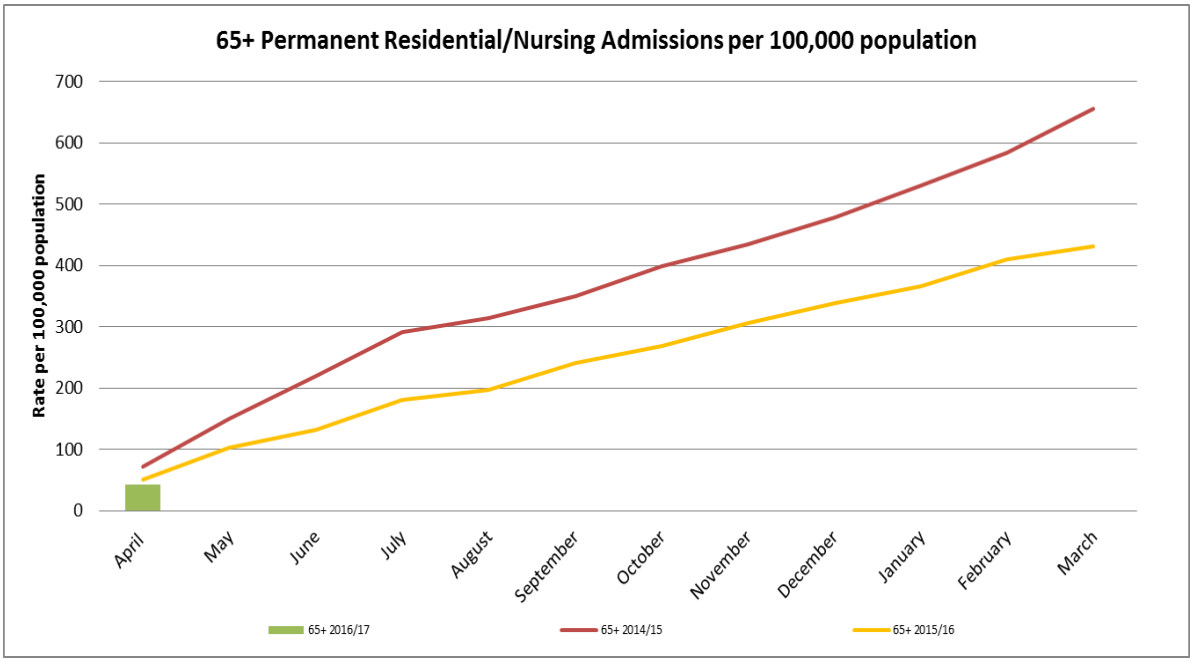
A demonstration of clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans is shown in the One Herefordshire Plan. ***(C.6.v)***

6.7 AGREEMENT THAT A PROPORTION OF THE ALLOCATION IS INVESTED IN NHS COMMISSIONED OUT-OF-HOSPITAL SERVICES

Within Herefordshire there is agreement that NHS commissioned out-of-hospital services and services that were previously paid for from funding made available as a result of achieving their non-elective admission, continue in a manner consistent with those agreed in 2015/16 ***(C.7.vi).*** The community health scheme meets the requirement for allocation of at least £3,339k to be invested in NHS commissioned out of hospital services. The funding has been allocated in full and not retained as part of a local risk sharing agreement. This funding is allocated to district nursing and other community based nursing ***(C.7.i)***. The specific detail is clearly set out within the summary and expenditure plan tabs on the BCF planning return template ***(C.7.ii).***

In developing and forming an agreement in relation to the allocation invested in NHS commissioning out-of-hospital services a range of data analysis has been completed which considered the long term trend in admissions and the success of the schemes implemented to date. The information provided below is a sample of the data monitoring and analysis which is completed on a regular basis by Herefordshire's Joint Commissioning Board **(C.7.iv)**.

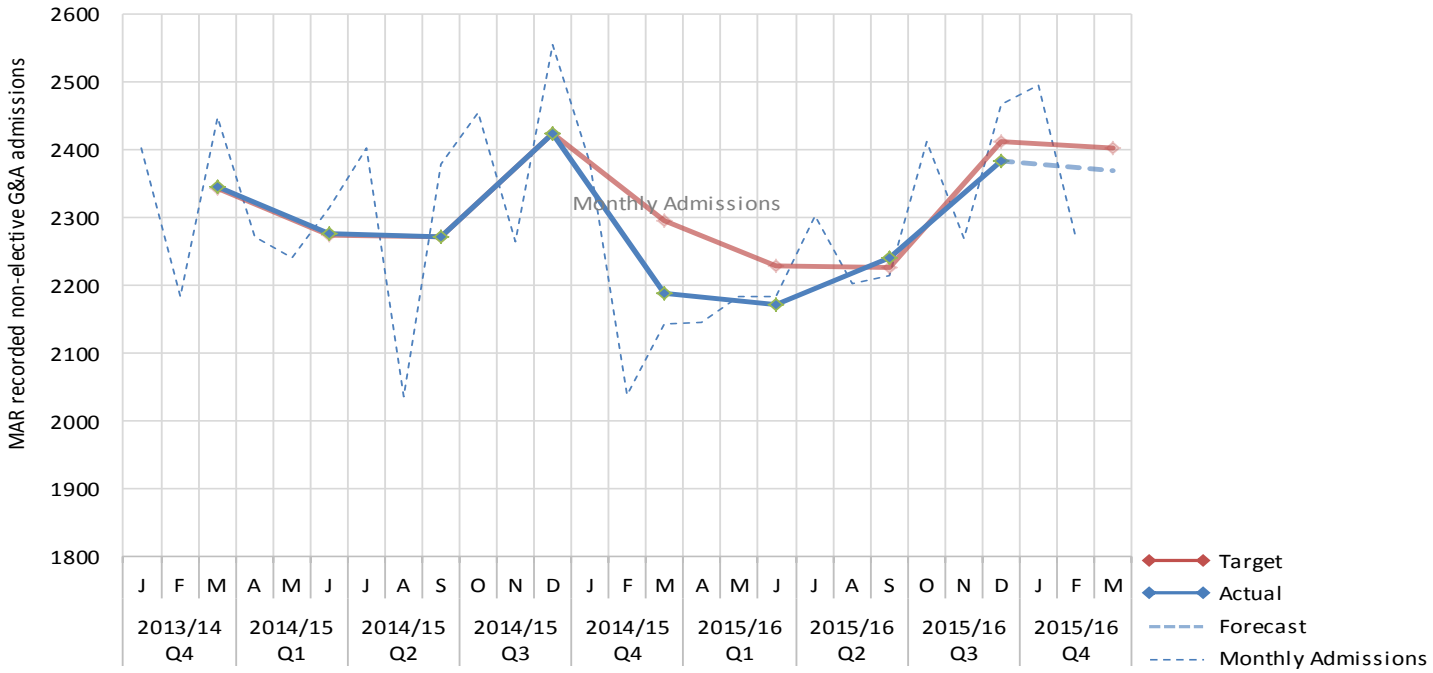
Admissions to Residential & Nursing Homes (Age 65+)



2015/16 data, whilst still in draft, presents a significant improvement in the previous year's results. This is in part due to the more rigorous process of the quality assurance panel, challenging the appropriateness of all residential placements. The target for 2016/17 admissions is to maintain at those levels recorded in 2015/16, therefore the target this year is 2015/16 actual line.

Non-elective Admissions

A number of schemes have been set up via the BCF programme, to address the demand in non-elective admissions with a view to reduce these further. These include rapid assessments, falls first response, virtual wards, and hospital at home.

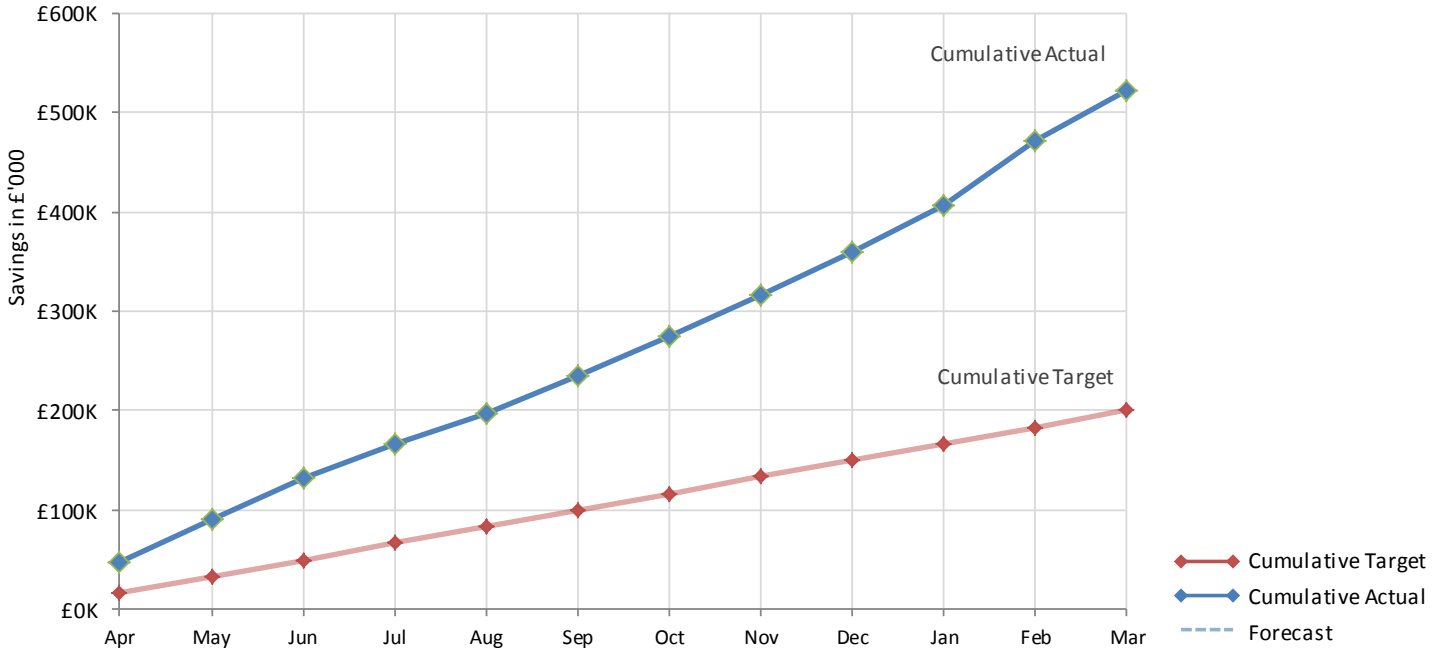


Intermediate Care Scheme Redesign

A number of schemes are being worked through to help address the pressures of non-elective admissions, including earlier identification of potential discharges, increased capacity in brokerage and additional support to self-funders and care homes. During 2015/16 a Rapid Access to Assessment and Care scheme was delivered, however the effectiveness of the scheme is currently being discussed and partners are working together to carry out a complete review and redesign of the intermediate care pathway and offer in Herefordshire **(B.2.iv)(C.7.iv).**

The review will be supported by analysis undertaken of the non-elective admissions and modelling this for the future demand of unplanned activity. The schemes such as the falls response service has been an effective provision in supporting unplanned activity and is identified as a scheme that will continue **(C.7.iii).**

Falls Response Service



Falls represent a large proportion of ambulance conveyances to wye Valley Trust and the falls related admissions are high. The graph above illustrates the falls response measure, which is in line with the HCCG QUIPP scheme. This is in relation to the impact of service changes in reducing falls related costs. The falls first responder's scheme continues to help address the gaps in the falls pathways in Herefordshire, caring for those fallers who have not received serious injury. Due to the continuing success of this service it has been agreed to continue to invest in this service, in order to assist in reducing the number of non-elective admissions reported. **(C.7.iv)**.

6.8 AGREEMENT ON A LOCAL ACTION PLAN TO REDUCE DELAYED TRANSFERS OF CARE (DTOC)

A local area action plan for DTOC has been developed and is attached to this document, which demonstrates clear lines of responsibility, accountabilities and measures of assurance and monitoring ***(C.8.i), (C.8.vii)***. The aim of this plan *is to reduce delayed transfers of care ensuring that people are discharged in a timely manner to the most appropriate setting to meet their needs.*

A number of objectives are identified in our DTOC plan which include:

- to ensure that our local DTOC improvement plan is based on national guidance and best practice ***(C.8.viii)***
- to ensure that the DTOC improvement plan is implemented within the framework of the overall System Resilience Group plan for improving patient flow and performance, with all partners engaged in and accountable for implementation **(C.8.iii)**
- to ensure a whole pathway approach, with an emphasis on prevention and admission avoidance as well as on discharge planning.
- to monitor and assure progress against key milestones and performance through the JCB and Systems Resilience Group
- to provide a framework for shared outcomes through risk pooling.

Our DTOC plan will be a key component of monitoring and reporting in both the System Resilience Group and the Joint Commissioning Board. As such it sits within the overall context of the System Resilience Group plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge). The plan was discussed within the February SRG and will be presented formally at a future meeting. ***(C.8.iii***) The adoption of a risk share agreement for DTOC has been considered and is further discussed within section 8 of this plan – financial risk sharing and contingency ***(C.8.v).***

In delivering and further developing the DTOC plan, we will continue to engage with the relevant acute and community trusts ***(C.8.vi).*** We have a process of continuous engagement with our local independent and voluntary sector providers on a range of topics. A key element of the DTOC plan is the use of intermediate care and step up / step down beds as the redesign of these services is a key focus of the 2016/17 BCF the engagement with providers through our current processes will form an integral part of this. ***(C.8.ix)***

The local area, including the local acute and community Trust, has developed a detailed action plan for reducing delayed transfers of care. Unify data indicates that Herefordshire, and the local acute provider is not a significant outlier in terms of acute delayed transfers, and the action plan focusses upon non-acute delayed discharges. A significant amount of work is being undertaken, following on from schemes begun in 2015/16, the plans are laid out in detail in the DTOC Action Plan. The local area target is based on the action plan delivering reductions in DTOC by the end of 2016/17, such

that there is a 7.5% reduction in DTOC per 100,000 population in Herefordshire compared to the out-turn performance for 2015/16 **(C.8.ii.)**

Reducing delayed transfers of care is an important enabler in HCCG's operational plan. Reduction in DTOCs is important to the Acute and Urgent care work streams of the CCG's operational plan, and reducing DTOCs per 100,000 population is a key target in the Urgent Care work stream. The plan reflects the importance of BCF as an enabler in the wider transformation of health and social care in Herefordshire. The importance of reducing DTOC through working with the local acute and community provider Trust is reflected in the detailed DTOC action plan. Work with the local provider reflects ECIP analysis and recommendations and also the provider is working with peer organisations to improve discharge performance. This work will promote adoption of best practice and effective interventions, as well as improving data quality **(C.8.iv).**

The local DTOC stretch targets have been established and developed and are detailed within section 5 of this document. **(C.8.ii.)**

7. JOINT SPENDING PLAN

Funding contributions for 2016-17 *(A.3.iii)*

Herefordshire's minimum fund contributions and indicative additional contributions from each partner are summarised below. This table also **sets out any changes from funding levels in 2015/16 *(A.3.iv).*** The final budget contributions for the additional pool are based on the cost of care for current clients as at end March 2016.

Overview of Contributions 2016/17 versus 2015/16

£'000	Ref No.	Source	Funding by LA	Funding by CCG	Total 2016/17	Total 2015/16*[1]	Incr *[2] (Decr)
Protection ASC	1	Minimum		4,541	4,541	4,520	21
Care Act	2	Minimum		460	460	458	2
Community Health & Social Care	3	Minimum		6,748	6,748	6,716	32
Sub Total Minimum Fund		Minimum		**11,749**	**11,749**	**11,694**	**55**
DFG (15/16 figs incl. SC capital)	4/5	Min Fund	1,558		1,558	1,356*[2]	202
Care Home Market Mgmt	6	Additional	19,468	9,272	28,740	27,048	1,692
Total Indicative BCF			**21,026**	**21,021-**	**42,047**	**40,098**	**1,949**

*[1] The figure reported for BCF budget for 2015/16 is lower than the budget included in the approved plan. This is because at the time of submission the exact criteria for the additional pool contributions had not been finalised, and final contributions were confirmed at a lower level as out of county placements were excluded from the final pool. Overall funding for 2016/17 is now confirmed and agreed by the partners.

*[2] in 2015/16 social care capital contribution £490k, DFG £866k

*[3] increase in minimum BCF provisionally allocated pro rata

The minimum fund includes the former carer's breaks and reablement funding at the same level as 2015/16 in line with the original BCF allocations and assumptions. (***A1.i, A1.ii, A1.iii, A1.iv, A1.v***)

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

The Herefordshire BCF plan maintains the schemes identified in the 2015/16 BCF submission and therefore an assessment of the impact of these changes on these services is minimal, however the impact of the key schemes is summarized below **(A.3.v).**

The funding for the protection of social care includes increased support to deliver DOLS in response to the increased demand seen as a result of legal rulings.

The funding currently identified for RAAC within the protection of social care will be reallocated. Partners are currently discussing the form that this new service will take. One option under consideration is an alternative service in the community to support hospital discharges, potentially through an expanded / enhanced rapid response service. This has the potential to support discharge for approximately double the number of patients as the existing scheme on a full year equivalent basis.

The increased funding for DFG in 2016/17 provides the potential to deliver additional adaptions, potentially up to 100 more in year (subject to local capacity). Based on central government estimates this may lead to the delay of residential admissions of up to 30 people (10% per CSR projections).

The investment in the falls response service has proved very successful delivering more than double the target savings in 2015/16. This scheme is jointly funded by the CCG, council and the provider.

Section 75 agreement – appendix 5

In relation to pool 2 the partners are looking to reduce the risks by engaging providers to actively risk share and improve provision across the entire pathway. This is work in progress and may result in a reduction in the pool 2 budget in year as these arrangements and confirmed.

The risk stratification and hospital at home services has proved to be highly successful and is being rolled out county wide and will impact further in 2016/17.

The scheme summary is included within tab 4 HWB expenditure plan of the reporting template but is shown below for completeness.

Section 75 agreement – appendix 5

Scheme Summary (Ref Tab 4)

Scheme Name	Ref No	Scheme Type	Area of Spend	Comm.	Provider	Source of Funding	Expenditure		
							2016/17 (£'000)	Budget 15/16 (£'000)	Outturn 15/16 (£'000)
Intermediate Care - reablement (Kington court)	3	Reablement services	Comm Health	CCG	NHS Community	CCG Min.	534	484	484
Integrated Community Care (community health svcs)	3	Integrated care teams	Comm Health	CCG	NHS Community	CCG Min.	3,806	3879	3879
Early Interv'n & rapid response / intermed. care -Hospital at Home	3	Pers. support/care @ home	Comm Health	CCG	NHS Community	CCG Min.	768	800	800
Early Interv'n & rapid response - Risk Stratification	3	Pers. support/care @ home	Comm Health	CCG	NHS Community	CCG Min.	768	800	800
Early interv'n & rapid response -Falls Response service	3	Pers. support/care @ home	Comm Health	CCG	NHS Community	CCG Min.	123	123	123
Intermediate Care - Step up / Step down community bed	3	Intermediate care services	Comm Health	CCG	Charity/Vol. Sec.	CCG Min.	240	153	153
Prevention - Short breaks / respite care for children and families	1	Ledbury Road (carers)	Comm Health	LA	NHS Acute	CCG Min.	427	427	427
Carers Support	1	Carers	Comm Health	LA	Charity/Vol. Sec.	CCG Min.	50	50	50
Support to ECIP/DTOC	1	Joint Commissioner	Comm Health	CCG		CCG Min.	32	0	0
Reablement	1	Reablement services	Social Care	LA	Charity/Vol. Sec.	CCG Min.	420	420	420
Carers Support	1	Support for carers	Social Care	LA	Private Sector	CCG Min.	460	843	718
Community Equipment / HIA	1	Pers. support/care @ home	Social Care	LA	Private Sector	CCG Min.	272	266	266
Rapid Response / OT	1	Pers. support/care @ home	Social Care	LA	Local Authority	CCG Min.	670	595	648
Kington Court	1	Intermediate care services	Social Care	LA	Private Sector	CCG Min.	366	366	366
RAAC	1	Intermediate care services	Social Care	LA	Private Sector	CCG Min.	494	494	352
Integrated Crisis and urgent care	1	Integrated care teams	Social Care	LA	Local Authority	CCG Min.	712	641	713
LD Health	1	Other	Social Care	LA	NHS MH Provider	CCG Min.	331	331	331
Other Social Care Demand	1	Other	Social Care	LA	Local Authority	CCG Min.	793	564	706
Support to ECIP/DTOC	1	Other	Other	LA	Local Authority	CCG Min.	23		
Care Act	2	Support for carers	Social Care	LA	Charity/Vol. Sec.	CCG Min.	460	458	458
Disabled Facilities Grant	4	Pers. support/care @ home	Other	LA	Private Sector	LA Min	1,558	866	866
Care Home Market Management CCG contribution	6	Other	Contin. Care	CCG	Private Sector	CCG Add'l	9,272	8685	9888
Care Home Market Management LA contribution	6	Other	Social Care	LA	Private Sector	LA Add'l	19,468	18363	18418
Social Care Capital	5	Other	Other	LA	Private Sector	LA Min	-	490	490
Total BCF							**42,047**	**40,098**	**41,356**

*Reference numbers to cross reference scheme details to high level summary table above

The total allocated to carers support across the CCG and council is £937k, including £477k former carers grant (***C.2.iv, A.1.iv***).

8. FINANCIAL RISK SHARING AND CONTINGENCY

A **fully populated and comprehensive risk log** is located within the appendices of this plan ***(B.3.V)***. This has been developed in partnership with all key stakeholders and provides a description of how risks will be managed operationally.

The following KLOEs have been addressed within this submission of the narrative plan:

(B.5.i), (B.5.ii), (B.5.iii), (B.5.iv), (C.7.iii), (C.7.v)

The BCF plan for 2015/16 contained a risk share arrangement for pool 2 for the first year of operation. The risk share arrangement recognised that a revised arrangement would need to be negotiated for future years. The Joint Commissioning Board were to use the first year of the BCF to monitor and evaluate both performance and risks arising in year to inform the development of more sophisticated risk share arrangements for future years.

The BCF fund is fully allocated to existing schemes within Herefordshire, and no funds have been retained for contingency or payment for performance purposes.

Herefordshire took up the offer of regional support to develop a local approach to risk share arrangements for 2016/17. The support was used to consider the options for risk share arrangements in relation to non-elective admissions, DTOC and the additional aligned fund contained within the BCF plan for 2016/17. The support facilitated a workshop between both partners and to inform the discussions with best practice of risk sharing arrangements and the development and implementation of these in other areas.

Partners have worked together to consider the use of a local risk sharing agreement with respect to a number of key areas, including DTOC. Following clear consideration partners have concluded that a risk share, in relation to DTOC, NEA and schemes contained within pool 1 of this plan would not be of benefit to either party at this time. In regards to pool 1, as previously mentioned, partners are currently working together to review and redesign the Intermediate Care Scheme (previously delivered through the RAAC framework). This redesigned service offer will provide a therapeutic reablement provision within clients homes following discharge from hospital, as well as utilising existing block contracts to deliver bed-based intermediate care options in the county and will focused on unplanned activity and supporting DTOC ***(C.8.v)***.

Section 75 agreement – appendix 5

The principles of a risk and benefit sharing arrangement has been agreed for Herefordshire which is based on behavioural change and service innovation within the system aligned to the funding contained within pool 2.

The risk share arrangement for pool 2 is currently being finalised with the detailed funding split to be agreed. It will be based on a cap for risk and benefits to both partners and will be consistence with guidance.

The delivery of service innovation with the implementation of the unified contract for the residential and nursing commissioning of placements and assertive reviews for continuing healthcare provision are key deliverables for this risk and benefit share arrangement.

The following scoping of the risk sharing arrangement for pool 2 has been undertaken.

The partners are finalising that the risk share agreement will be restricted to a defined and agreed cohort of clients. This client cohort will be defined as follows:

1. Includes those clients who are not funded at the usual price*2 and who have not been reviewed in the twelve month period since 1st April 2015

2. The list of clients identified in 1 above will be jointly assessed by the council and CCG to agree which clients are likely to result in a behaviour change*3 due to the length of time since the last review or for other reasons relating to a change in the approach being taken by the commissioner.

3. The defined client list excludes any clients identified by the CCG as being part of separate arrangements with 2g for risk share.

4. The defined list will exclude non-reviewed clients who, the partners jointly agree, are unlikely to have incurred a substantive change in health and care needs in the intervening period. These clients will be classified as business as usual and excluded from the specific risk share arrangement.

5. The eligible clients list, as defined above, will include the totality of eligible clients, this is a total of 27 clients and is within appendix one of this document.

6. The expectation will be that the clients will be reviewed within the next six months and the monitoring of the reviews will be through the Better Care Fund Partnership Group, with further reporting to the Joint Commissioning Board.

*2 in this context the usual price is defined as any local authority client funded at either the old, or new usual price for older peoples residential and nursing care (£570, £523, (old / new nursing

rates),£468, £457 (old/new residential & dementia rates) per week), and clients who receive FNC/FCO only support from the CCG

*3 in this context the term behaviour change means that the partners agree that due to the length of time since the last review a stepped change in level of needs is likely to be identified upon review which may result in a change of statutory partner responsibility for the individual client.

The cohort of clients that has been scoped for the risk share agreement is quantified in the table below:

Clients not reviewed since 1/4/15	**Number**	**CCG £k**	**LA £k**	**Total £k**
CHC	4	314		314
Joint Funded	1	34	-	34
LA non usual price clients	22	6	1,031	1,037
TOTAL	**27**	**354**	**1,031**	**1,385**
Proportion		26%	74%	

The non-financial risks associated with not meeting the BCF targets are:

- The BCF targets contribute to both partner organisation strategic objectives and this will have a negative impact on delivery of these.
- Further pressures and destabilisation will be placed on a fragile health and social care system
- The people of Herefordshire outcomes will not be improved
- Limiting our ability to meet the changing needs in the population

The principles and risk share arrangement and will be subject to the section 75 agreement. The delivery of the risk share will be monitored on a monthly basis within the BCFPG and will routinely reported to the JCB. The financial risk will be applied to the overall net cost or gain from those clients who change statutory responsibility with the balance being agreed on an annual basis.

9. DELIVERING THE PLAN

The delivery plan below details **key milestones associated with the delivery of the plan of action in 2016/17** ***(B.3.iv)*** Please see the attached risk log for further information regarding managing risk in relation to the following delivery plan.

Section 75 agreement – appendix 5

Delivery	By when?	Accountable partner*
HWB sign off BCF plan 2016/17 (12th April 2016)	Q1 2016/17	Both
BCF plans 2016/17, including pooled fund arrangements commence	Q1 2016/17	Both
Agree approach to Risk share arrangements	Q1 2016/17	Both
Single S75 to be developed and agreed	Q2 2016/17	Both
Approval of unified contract	Q1 2016/17	Both
Implementation of unified contract	Q2 2016/17	Both
Implementation of redesigned social care teams into locality / complex care teams	Q4 2015/16	LA
Monitor effectiveness of redesigned social care teams via BCPG	Q2 2016/17	Both
WISH (Wellbeing Information & Signposting for Herefordshire) service launched	Q1 2016/17	LA
Enhance content of IAS	Q2 2016/17	LA
Review and reconfigure RAAC framework arrangement	Q1 2016/17	Both
Implementation of Herefordshire Carers Strategy	Q2 2016/17	Both
Develop a provider engagement plan	Q1 2016/17	Both
Care Co-ordination Centre mobilised	Q1 2016/17	Both
Submit System Transformation Plan	Q1 2016/17	Both
Agreed county-wide Estates Strategy that supports consolidation & transformation	Q3 2016/17	Both
Devolution of acute specialities to community settings	Q3 2016/17	CCG
Increased primary care capacity through development of primary care at scale	Q3 2016/17	CCG
New community Health and Wellbeing Hubs opened in x localities	TBC	CCG
Single physical and mental health community teams in place	Q1 2016/17	CCG
Re-procure advocacy service	Q1 2016/17	LA
Initial local area development of community links model	Q1 2016/17	Both
Establish working group to review DFG scheme	Q1 2016/17	Both
Procurement exercise following redesign of domiciliary care	Q2 2016/17	LA
Intermediate care redesign	Q2 2016/17	Both

Section 75 agreement – appendix 5

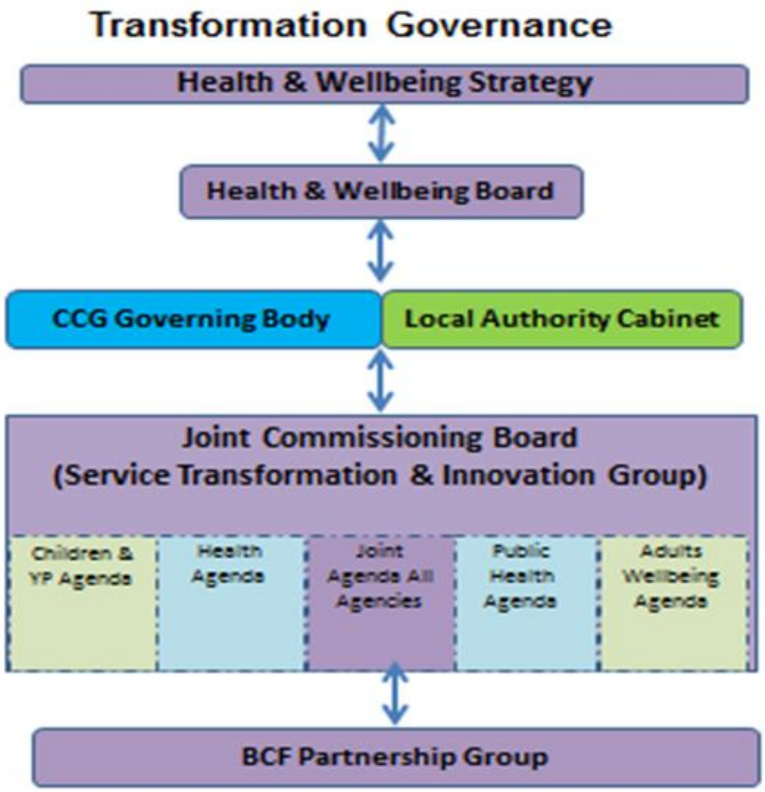
Delivery	By when?	Accountable partner*
Primary care and community services - Increase capacity and capability over 7 days at locality level	National announcement awaited	CCG
Integrate NHS 111 with Herefordshire's urgent care services	Mobilisation of new contract Q4 2016/17	CCG
Complete consultation exercise regarding Minor Injuries Units and Walk-In Centre	Q1 2016/17	CCG
New model of care for community hospitals	Q1 2017/18	CCG
Integrated single gateway for urgent care	Q1 2017/18	CCG
Single health and social care record	Q1 2018/19	Both

* Accountable partners are identified as Herefordshire Council (LA), Herefordshire CCG (CCG) or both.

10. GOVERNANCE AND ACCOUNTABILITIES

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

Section 75 agreement – appendix 5



The BCF Partnership Group includes representation from provider organisations and is responsible for overseeing implementation of the action plan and for the continuing review and development of the fund.

Oversight and responsibility for the BCF is embedded within the Senior Leadership Team of both Adults and Wellbeing within the council and the Clinical Commissioning Group ***(B.3.i)***. In both cases this is in the form of a senior leader who is able to maintain the profile of this agenda and ensure linkages to wider health and social care matters as well as connection to the corporate council agendas in the case of Adults and Wellbeing

A dedicated multi-agency group (the Better Care Fund Partnership Group) is supporting focus and progression of the Better Care Fund and acts as the key problem solving vehicle and is accountable to the Joint Commissioning Board. The JCB will receive a monthly highlight report from this group with key decisions and issues being escalated to the board for resolution as appropriate

An integrated performance report has been developed and is shared with the Joint Commissioning Board on a monthly basis. Such **arrangements are in place to support joint working** ***(B.3.iii)*** and to enable a move to increasing alignment of our commissioning arrangements, including development of joint strategies and commissioning arrangements, in particular in relation to adult community health

and social care services including personal budgets, support to carers, care home market management, mental health and learning disabilities. The next stages of completion of our BCF section 75 agreement will include confirmation of the future ways of working to support delivery of our shared objectives ***(B.3.ii)***.

The proposed governance structure for the wider transformation programme can be located within the One Herefordshire report, in the appendices of this document.

11. INTEGRATION PLAN

Herefordshire has developed the One Herefordshire plan which is an alliance of all the health and social care organisations working together to address the fundamental issues facing our community.

The BCF plan is a key component and integral part of this overarching plan for Herefordshire.

Herefordshire has also agreed its STP footprint and governance arrangements as part of its relationship with Worcestershire, details of which can be found in the appendices. The One Herefordshire plan, which the BCF plan supports, is the central contribution on behalf of the county to the wider STP plan.

12. APPENDICES – SUPPORTING INFORMATION

One Herefordshire Plan As per submission two	**STP - Governance** As per submission two
2016/17 DTOC plan As per submission three	**JSNA – Evidence Base** As per submission two
Risk Register As per submission two	**Original BCF Plan** As per submission two