# Herefordshire Better Care Fund Plan 2022/23

## Herefordshire Health and Wellbeing Board

**September 2022**

**Contents**

## 1. Executive summary

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

**Our priorities for 2022-23**

Herefordshire's Better Care Fund (BCF) Plan for 2022/23 will continue to support our long-term vision, and build on previous system priorities and strengthen what has been achieved so far. Our plan sets out the work we need to do to further develop the way we work together on our shared priorities to deliver key outcomes for local people. Priorities for the BCF 2022-23 include:

- Community Resilience and Prevention.
- Hospital Discharge Support.
- Partnerships and Integration Support.
- Social Care Services.
- Carers Support.
- Care Market Development.
- Social Care Demand.
- Community Health Services.

Herefordshire's BCF funding continues to be used for several key core social care and NHS community services - operational social work, brokerage, integrated discharge, community health and care services, Deprivation of Liberty Safeguards **(**DoLS), short-term and long-term placements in home care and care homes, and discharge to assess; it is central to the delivery of health and social care in the community.

Herefordshire continues to invest in services which improve the health and wellbeing of people in Herefordshire, by enabling people to take greater control over their own health and the health of their families, and helping them to remain independent within their own homes and communities.

System partners are working together to ensure that robust metrics are in place.

| Metric | Detail |
|---|---|
| Avoidable admissions | Unplanned Admissions for chronic ambulatory care sensitive conditions (NHS OF 2.3i) |
| Residential care admissions | Annual rate of older people whose long term support needs are best met by admission to residential and nursing care homes. (ASCOF 2A part 2) |
| Effectiveness of reablement | People over 65 still at home 91 days after discharge from hospital with reablement (ASCOF 2B part 1) |
| Discharge destination | Percentage of discharges to a person's usual place of residence (SUS data) |

Detailed information regarding spend allocation for the BCF 2022-23 is available in the planning template. The table below provides a high level summary which highlights key focus areas of spend including community based schemes, integrated care planning and navigation and reablement in a person's own home.

**NHS Commissioned Out of Hospital spend from the minimum ICB allocation**

| | |
|---|---|
| Minimum required spend | £4,300,073 |
| Planned spend | £8,625,984 |

**Adult Social Care services spend from the minimum ICB allocations**

| | |
|---|---|
| Minimum required spend | £6,505,975 |
| Planned spend | £6,505,974 |

**Scheme Types**

| | | |
|---|---|---|
| Assistive Technologies and Equipment | £0 | (0.0%) |
| Care Act Implementation Related Duties | £1,292,021 | (5.3%) |
| Carers Services | £483,220 | (2.0%) |
| Community Based Schemes | £8,315,321 | (34.4%) |
| DFG Related Schemes | £2,268,653 | (9.4%) |
| Enablers for Integration | £658,557 | (2.7%) |
| High Impact Change Model for Managing Transfe | £1,321,985 | (5.5%) |
| Home Care or Domiciliary Care | £298,523 | (1.2%) |
| Housing Related Schemes | £0 | (0.0%) |
| Integrated Care Planning and Navigation | £4,066,891 | (16.8%) |
| Bed based intermediate Care Services | £796,657 | (3.3%) |
| Reablement in a persons own home | £3,081,270 | (12.7%) |
| Personalised Budgeting and Commissioning | £0 | (0.0%) |
| Personalised Care at Home | £0 | (0.0%) |
| Prevention / Early Intervention | £445,511 | (1.8%) |
| Residential Placements | £1,154,843 | (4.8%) |
| Other | £0 | (0.0%) |
| **Total** | **£24,183,452** | |

## Key changes since our previous plan

Since our previous BCF plan, our focus has increasingly been on the way we can further integrate our services to support people, and focus on broader engagement and links with primary care and the voluntary sector.

Several key 'place' level challenges are understood and partners are working together to address, for example, recruitment and retention of staff across care sector and cost of living care in a rural community. There are many opportunities for further joined up working and the BCF continues to support the delivery of Herefordshire's HWBB and Integrated Place Strategy and Priorities.

New ways of thinking and models of delivery that require a collaborative and flexible approach to deploying our resources, including our workforce, to meet system wide pressures, not only in hospitals, but also in social care, primary care, mental health and community-based services are continually being explored.

We are applying health inequalities considerations to our work in the BCF, in terms of how the activities are supporting people that are more likely to experience adverse outcomes and ensuring a culturally sensitive approach.

## 2. Background and context

Herefordshire is a predominantly rural county, with the fourth lowest population density in England. The city of Hereford, in the middle of the county, is the centre for most facilities; other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington. 95 per cent of the land is classified as rural, with 53 per cent of the county's population living in rural areas.

The Joint Strategic Needs Assessment, published by Herefordshire Council, is the main source that has informed the population assumptions; in addition, the Older People Needs Assessment (2018) has qualified levels of frailty and dementia across our population. Further local data can be found at: Home - Understanding Herefordshire. The main challenges for Herefordshire are rurality, sparsity of population, and ageing population. The BCF metrics bear this out, as older adults are more likely to have longer lengths of stay in hospital and are less likely to be discharged home. The BCF plan aims to address these challenges through improved integrated discharge, integrated and expanded community services, increased reablement through discharge to assess, upstream interventions to reduce hospital admissions and by strengthening community resilience through Talk Community.

All partners continue to be committed to equality and diversity using the scope of the Equality Act 2010 and demonstrate that we are paying 'due regard' in our decision making in the design and delivery of services. It is fundamental that individuals are at the heart of all activities and services. All partners continue to work to enable all people to access services, and ensuring those people requiring additional support due to, for example, a learning disability and/or autism, have equal access to services and are supported to be as independent as possible in the community wherever possible.

The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the act. This is through improving the health and wellbeing of people in Herefordshire by enabling them to take greater control over their own homes and communities. Where appropriate, an Equality Impact Assessment (EIA) is undertaken for separate schemes and services that are within the BCF. Where large changes are planned via the BCF an EIA will be completed. It is not envisaged that the content of this plan will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender reassignment, marriage and civil partnerships (in employment only), pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The council has worked across all directorates to support businesses, residents and communities throughout the pandemic to remain as safe as possible and to prevent and reduce spread of infection and protect those most vulnerable in our society. The focus now moves towards recovery. To support the recovery a Recovery Plan is currently being delivered, which focusses upon the local economy, community wellbeing and organisation. The recovery plan also focuses on the immediate actions needed in the short term and priorities include:

Through the partnerships with Public Health, Voluntary Community Social Enterprise (VCSE) and trusted local voices, we can connect with our communities to improve relationships with those who experience the greatest health inequalities. Organisational development is required to build awareness, knowledge, skills and clearly set out the relevance to everyone's role on how they can reduce health inequalities.

## 3. Planning Requirement (PR1)
## A jointly developed and agreed plan /involving stakeholders

Ongoing, system wide discussions and meetings have enabled a range of key stakeholders to be involved in the preparation and review of proposals that sit within the Better Care Fund (BCF) plan 2022/23.

Engagement and involvement has been through a variety of system and internal meetings, including the One Herefordshire Partnership, which brings partners together at Place level as part of the Integrated Care System in Herefordshire and Worcestershire, and through the sharing of data and wider documentation.

Ongoing engagement and collaboration via Talk Community has enabled the VCSE sector to contribute to priorities and ongoing developments highlighted in the plan. At a strategic level housing colleagues continue to input into priorities and developments associated with the BCF plan including representation at appropriate board meetings.

**Key stakeholders** involved include:

Herefordshire Council internal stakeholders (including Cabinet Member), One Herefordshire Partnership, Wye Valley NHS Trust (WVT), Herefordshire and Worcestershire Health Integrated Care Board (HWICB), Primary Care Networks, Taurus Healthcare, Clinical Practitioners Forum, Joint Strategic Commissioning Executive Group, Herefordshire Health Watch and voluntary and community organisations.

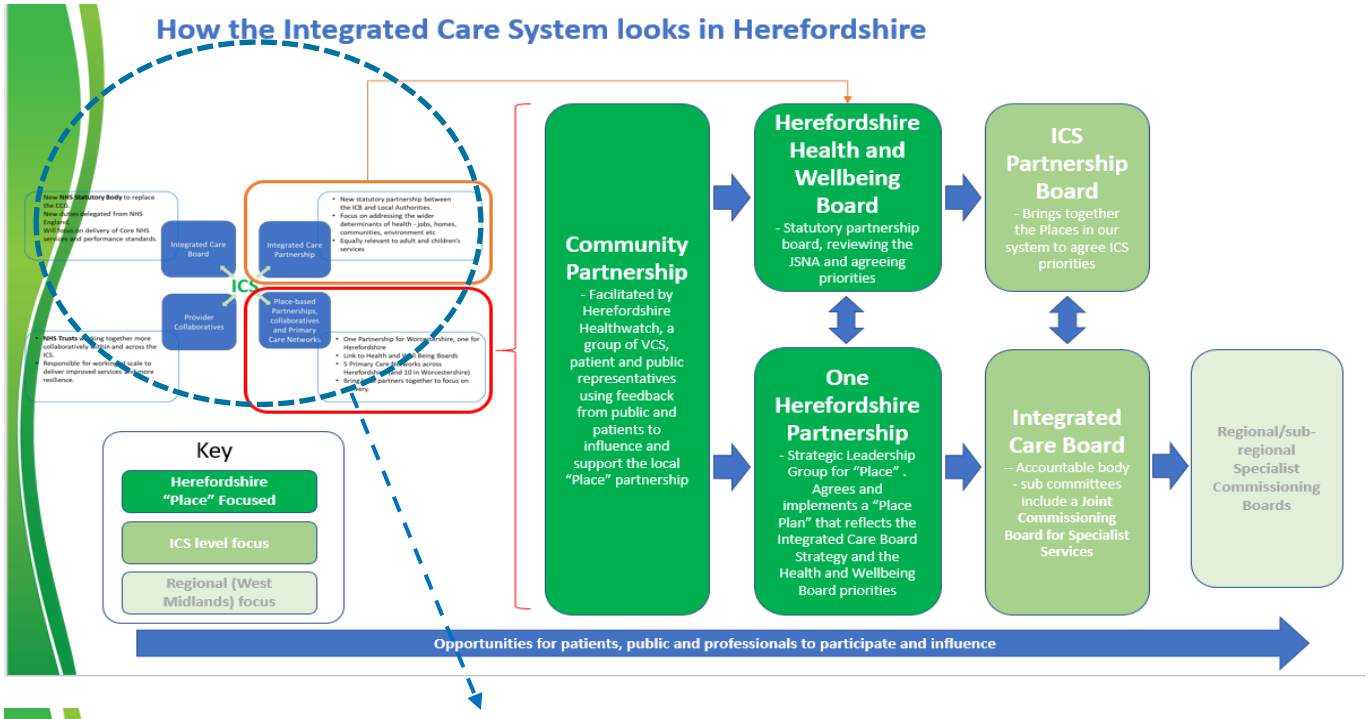
### Governance

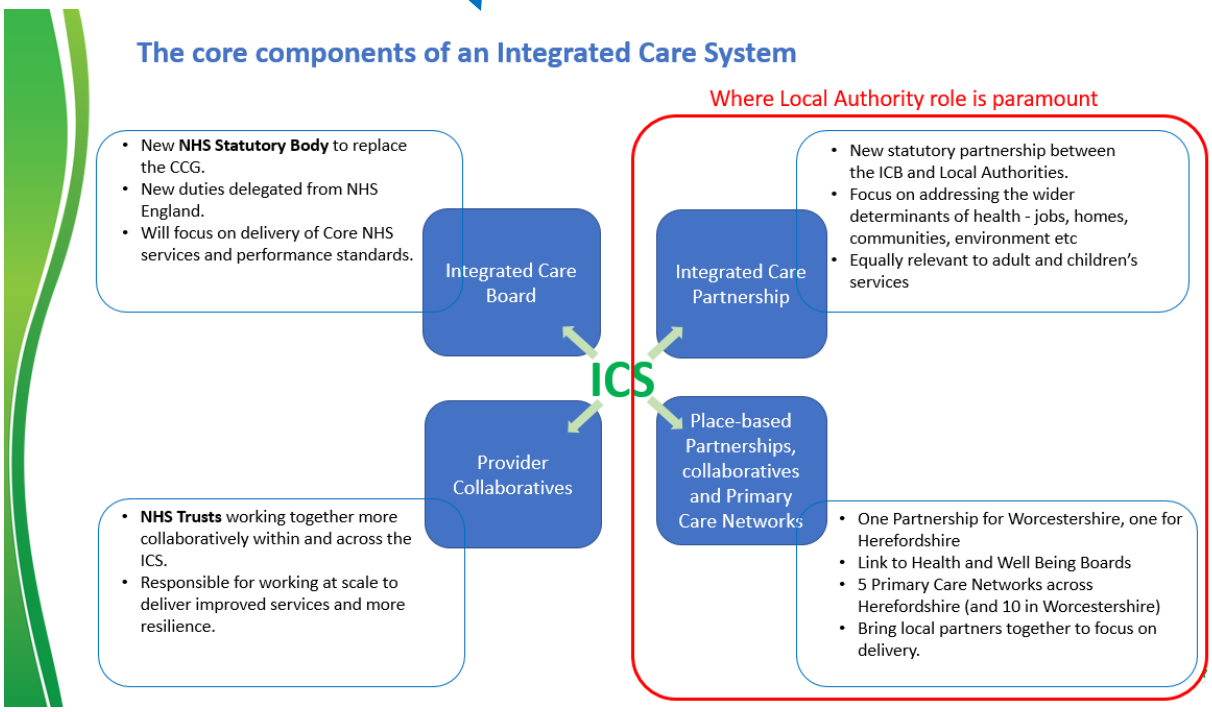
The Herefordshire Health and Wellbeing Board is responsible for agreeing the BCF plans and for overseeing delivery through quarterly reporting.

The responsibility for the BCF is embedded within the Senior Leadership Teams of both the Community Wellbeing Directorate of the council and the Herefordshire and Worcestershire Integrated Care Board (ICB). In each organisation, chief officers and their senior leadership teams, are able to maintain the profile of the shared agendas and ensure linkages to wider health and social care commissioning and delivery, as well as alignment with the council's wider purpose, articulated through the council's County Plan. Ongoing provider forums and engagement also feed into future intentions.

With the new ICB, further governance arrangements (as illustrated below) are in place including reporting to various strategic commissioning groups with updates on delivery and reviewing next steps and intentions.

These groups link into the One Herefordshire Partnership to ensure that we continue to build an ambitious approach to integration.




Programme governance arrangements are in place to support joint working and to enable a move to increasing alignment of commissioning arrangements, including the development of joint strategies and commissioning, in particular in relation to adult community health and social care services. These incorporate implementation of personal budgets, support to carers, care home market management and service development relating to mental health and learning disabilities.

The **One Herefordshire Partnership (1HP)** board is the vehicle by which Herefordshire Place partners work together at a strategic level and is a key enabler of the BCF plan delivery.

The Herefordshire Place partners are:

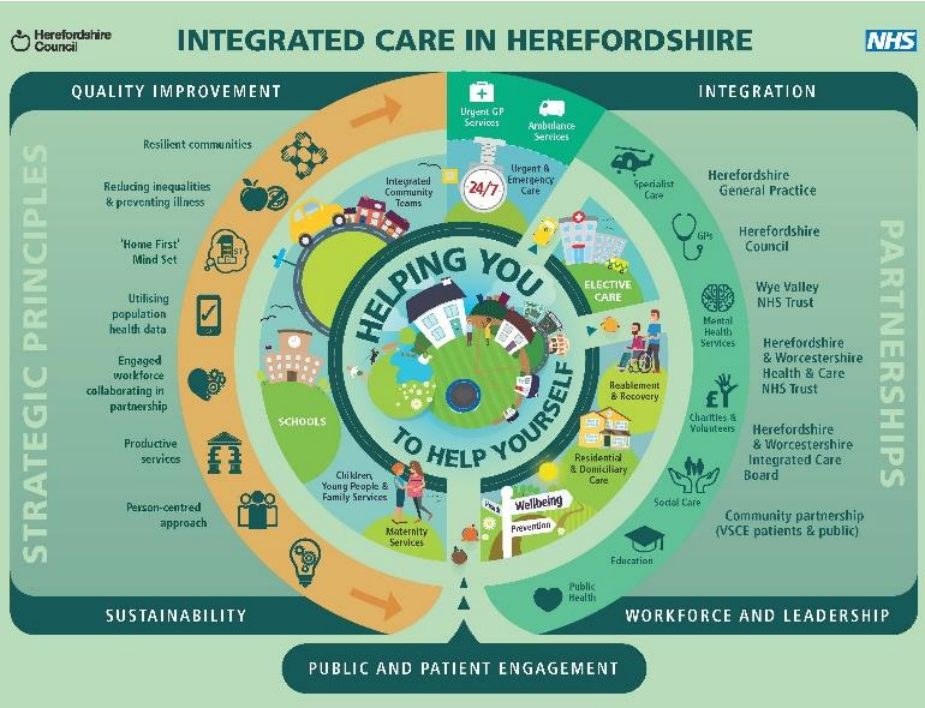
| | | |
|---|---|---|
| Herefordshire Council | Herefordshire General Practice | Herefordshire and Worcestershire Health and Care NHS Trust |
| Wye Valley NHS Trust | Herefordshire and Worcestershire ICB | |

The primary purposes of the 1HP are to:

- set the strategy for Herefordshire's health and care services;
- approve priorities, programmes, plans and objectives;
- receive updates on progress against the objectives and performance of integrated services; and
- ensure that appropriate engagement with the public, service users and staff has taken place.

## 4. Planning Requirement (PR2)
## A clear narrative for the integration of health and social care

Integrated working across health and care provides the opportunity to deliver the best possible outcomes for local people and achieve the best use of our collective resources. By working collaboratively and having a clear focus (as illustrated in the diagram below), we can ensure that the priorities are representative of the needs of our local population. The BCF is a critical element of delivering 'place' plans as it provides the joint funding to support schemes that deliver on our local priorities.



For people who need both health and social care services, the aim is that they receive the right care, in the right place, at the right time. There is particular focus on addressing health inequalities and in achieving improved health outcomes for all by targeted use of the funds available.

**Joint priorities**

- Tackling health inequalities.
- Digital innovation.
- Improving urgent care services.
- Supporting our workforce.
- Ensuring the delivery of high quality services.
- Developing our approach to population health management.

A **Joint Health and Wellbeing Strategy** is currently in development and with the establishment of a new Integrated Care System for Herefordshire and Worcestershire it brings a timely opportunity for the new strategy to inform and deliver action at both the system and place level.

The coronavirus pandemic had a profound impact on our health and wellbeing, affecting outcomes across the life course. It has shone a light on some of the health and wider inequalities that persist in our society. A new strategy therefore presents an opportunity to include our aspirations and priorities for tackling inequalities as part of our recovery recognising that many of the causes of ill-health are deep rooted in society.

Indicative timescales for the development of the strategy are summarised below with the aim to publish the final strategy in March 2023 for implementation in April 2023, under the following guiding principles:

- The priorities in the strategy will be based on need, supported by actions based on evidence of effectiveness.
- Prevention (in all its forms) will be at the heart of all we do
- A 'proportionate universalist' approach – something for everyone and more for those who need it the most
- The strategy will focus on areas where partnership action adds value and there is commitment across the system
- Narrowing health inequalities as a core aim

The strategy is developed in close collaboration and consultation with residents and local partners from health, social care, local authorities and voluntary sector.

**How is our plan contributing to reducing health inequalities in Herefordshire?**

The BCF Plan is a platform for articulating how we will use system, county and place level collaborations to strengthen health inequality in strategic and operational planning.

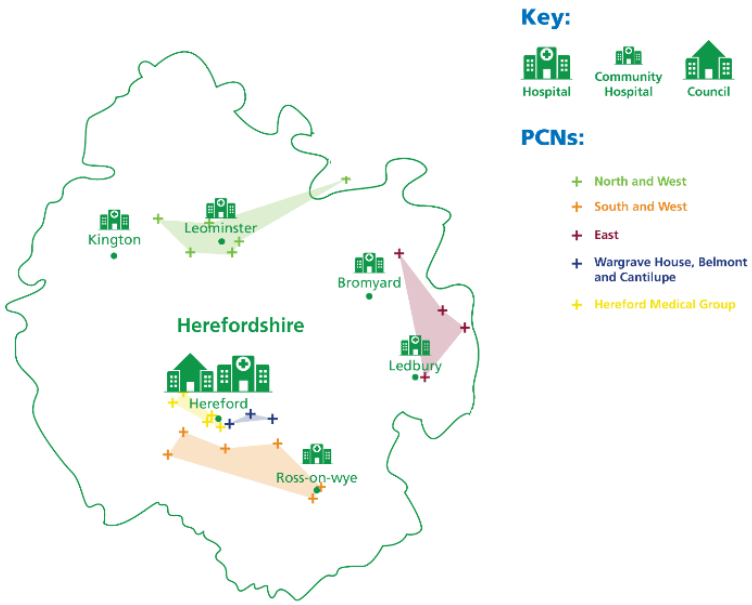
All of the PCNs have oversight through the Herefordshire Health Inequalities Group and feed into the ICS Health Inequalities and Prevention Collaboration along with discussions at Community Partnership meetings.

Herefordshire's PCN Approach includes:

- Partnership working – people, statutory bodies, VCSE and business.
- Views of people with lived experience.

- PCNs working collaboratively with Public Health and the Herefordshire Health Inequality Group for advice, guidance and expertise on how to approach developing plans.
- Innovation & transformation.
- Cohesive approach – data sharing, monitoring and evaluating impact.

By the end of September 2022, PCNs and commissioners will jointly work with stakeholders and council commissioners, VCSE partners and local clinical leaders, to design, agree and put in place a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs.




Herefordshire and Worcestershire ICB serves a population of over 800,000 people across two diverse counties where there is variation in health outcomes across communities, and differences can be seen when considered by ethnicity, deprivation and rurality. The factors which drive this variation can be complex and Herefordshire & Worcestershire ICB and system partners are committed to understanding these reasons and working in partnership with people and communities to break down barriers and enable everyone to feel they can access health services when they need to, allowing timely support and treatment.

Partners across the system are coming together at the Herefordshire and Worcestershire Integrated Care Partnership Assembly to develop and agree an Integrated Care Plan which will share the vision for integrated care, improved health and care outcomes and a reduction in unwarranted variation in outcomes. Underpinning this strategy are the joint strategic needs assessment (JSNA) which provides an assessment of the health needs of the population and focused work to reduce unwarranted variation in outcomes. In Herefordshire & Worcestershire, health provision is working to **CORE20PLUS5**, an approach to reducing health inequalities and unwarranted variation developed and used across the NHS in England. This focuses efforts to increase tailored support to those living in the most deprived 20% of the national population (CORE 20) and locally define groups including unregistered populations and those experiencing barriers due to health literacy. The key clinical areas of variation are Maternity, Severe Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis and Hypertension.

In order to address variation in outcomes in these 5 clinical areas, Herefordshire & Worcestershire ICB has invested over £4.3m within Primary Care Networks (PCNs) to deliver improved outcomes. All PCNs have worked with councils, voluntary sector and communities, implementing initiatives which support people to access services, go through relevant health checks and ultimately, where clinically appropriate, enter treatment. For every person who enters treatment earlier than they would have done, their opportunity for an improved outcome increases and we will help to reduce the health inequalities we see in our counties. Interventions include both medical and non-medical, covering accessing support groups, tackling loneliness and supporting people to understand the implications of a diagnosis and importantly how they can take simple steps in their day to day lives to improve their health and wellbeing. The system will measure on and report on the ambition to improve outcomes over the next 5 years.

The **Tackling Health Inequalities Board** (Herefordshire and Worcestershire) continues to work collaboratively.

- A review of a specialist dental pathway is underway.
- Lifestyle advisor teams are supporting improvements in management of weight for those with Learning Disabilities following outcomes of LeDeR reviews.
- We are increasing awareness of use of Respect (Recommended summary plan for emergency care and treatment) for people with LD.
- We are raising awareness of MCA and its place in identification and recognition of health needs and to improve outcomes
- HW LeDeR Strategy 2022 to 2025 has been produced (herefordshireandworcestershireccg.nhs.uk).

A review of the joint Herefordshire and Worcestershire Autism Strategy should be published in April 2023 and will be a 3 year strategy. This focuses on 7 priority areas which mirror the priority areas within the National Strategy for Autistic Children, Young People and Adults 2021 to 2026. It focuses on the following:

- Improving understanding and acceptance of Autism within Society.
- Supporting more autistic children into employment.
- Tackling health and care inequalities for Autistic people.
- Building the right support in the community.
- Improving support within the criminal and youth justice systems.
- Keeping safe – This is a Herefordshire place based priority.

## 5. Planning Requirement (PR3)<br>A strategic, joined up plan for Disabled Facilities Grant Spending

Our approach to bringing together housing, health and care is to work collaboratively across partner organisations, including the voluntary and community sector, to support people and continue to work to deliver the goal of maximising independence and people living well at home.

### Disabled Facilities Grant

The DFG is a capital grant pooled into the BCF to promote joined-up approaches to meeting people's needs to help support more people of all ages to live in suitable housing so they can stay

independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care and strategic use of the DFG can support this.

Under the Care Act there is a requirement for closer cooperation of services that support the health and wellbeing of those who may be in need of care and support. An emphasis is placed on greater integration between health and social services to deliver more person-centred outcomes. The strategic direction for DFG is to continue to work to deliver the goal of maximising independence and people living well at home. Working with the councils' Housing services we look to use DFG to help increase the amount of suitable available housing in Herefordshire to enable more people to remain at home, living well for longer.

The DFG aims to support vulnerable, disabled and older people to be independent, enabling carers to continue their role safely, preventing accidents and helping people to return from hospital. It therefore crosses the boundaries between housing, health and social care and reflects the increasing national focus on the integration of housing with health and social care services.

This year, Herefordshire Council's allocation is £2,268m. Our target is to complete 200 mandatory DFG grants and 20 discretionary DFG or assistance grants in the financial year.

Adaptations costing £1,000 or less are referred to as minor adaptations and as such are procured outside of this budget under the council's duties within the Care Act or via social landlords. However within the flexibilities offered under the council's Home Adaptations and Assistance policy, a free rapid response minor adaptations service to prevent delayed discharge from hospital is provided plus a small Handyperson's service to assist people living in their own homes with small repairs, maintenance and improvements, at subsidised cost. These two schemes are funded via the DFG capital budget.

Under the new government flexibilities on the use of DFG funding particular emphasis will be placed on supporting housing strategy to prevent and relieve homelessness, including a contribution of £250k towards 6 properties specifically acquired to prevent homelessness, and a contribution of £500k to enable continued partnership working between Strategic Housing, Prevention Services, private and social registered landlords and external agencies ensuring funds are available for accessible housing schemes and adaptations within such properties. This is in line with government guidance on use of DFG to support capital projects that benefit social care.

As in previous years, the DFG will be used to support the delivery of community equipment services, including technology enabled living. Community equipment covers a wide range of equipment for home nursing usually provided by the NHS, such as pressure relief mattresses and commodes, and equipment for daily living such as shower chairs and raised toilet seats,. It also includes, but is not limited to:

- Minor adaptations such as grab rails
- Ancillary equipment for people with sensory impairments
- Telecare equipment such as fall alarms

Community equipment plays a vital role in enabling disabled people of all ages, including children, to maintain their health and independence, and to prevent inappropriate hospital admissions. Modernisation of community equipment services therefore supports policy initiatives such as:

promoting independence for disabled people; intermediate care services; the reduction of falls by older people, and support for carers.

The use of DFG funding is designed to meet the challenges presented in the to offer practical help to the residents of Herefordshire to live independently at home including the provision of adaptations, technology enabled living and community equipment, preventing, delaying or reducing the need for care and support. In practical terms this includes, but is not limited to:

- Adaptations to aid independent living for older persons in their own homes rather than moving to care homes.
- Reducing the need for, and scale of care packages.
- Assisting with hospital discharge to return home.
- Efficient delivery of nursing at home services.
- Reducing hospital admissions.
- Improving housing safety and security.
- Reducing the risk of falls at home.
- Preventing and relieving Homelessness.
- Linking with other agencies to help reduce fuel poverty.

Our current Regulatory Reform Order (RRO) offers include:

- An emergency repayable grant which offers a means tested grant to help to remedy serious risks to health and safety caused by structural or environmental defects in a person's own home. The service has received an increasing number of referrals for this support from social care colleagues and is working jointly with those colleagues to help find solutions and rectify these hazards to ensure the vulnerable person's greater safety and enable them to remain living in their home.
- The service also liaises quarterly with housing association colleagues to discuss and agree actions plans to resolve any relevant issues that have come to light with regards to adaptations, repairs or other housing support required for their vulnerable residents.
- The minor adaptations service run by the Home Improvement Agency (HIA) includes a rapid response option to facilitate hospital discharge, and a small handyperson's service.
- A fast-track option for some major adaptations is also available for specific circumstances such as hospital discharge or other urgent situations.
- The Independent Living Services work jointly with Strategic Housing colleagues to look at design requirements or adaptations required when accessible new build properties are being built for disabled adults/children whose needs cannot be met via the accessible homes register.

Options for emergency and transitional accommodation for older, and disabled people are being scoped. The scoping exercise also seeks to identify the supply of adapted and accessible properties with reference to demand, particularly with respect to any regional imbalances between demand and supply. There is also the matter of accessible and adapted housing required for people whose history of rough sleeping has led to physical disabilities and mental ill health.

The council has a new supported living scheme for people with mental health needs, utilising affordable housing quotas as part of the planning process for a new development. Similarly, we are seeing a new 80 unit extra care scheme as part of another affordable housing development for older people, where there will be collaboration with local DN team/s.

## 6. Planning Requirement (PR6)
**An agreed approach to implementing the BCF Policy objectives, including a capacity and demand plan for intermediate care services (National Condition 4 - Implementing the BCF Policy Objectives)**

Partners in Herefordshire are committed to meeting the BCF policy objectives, to:

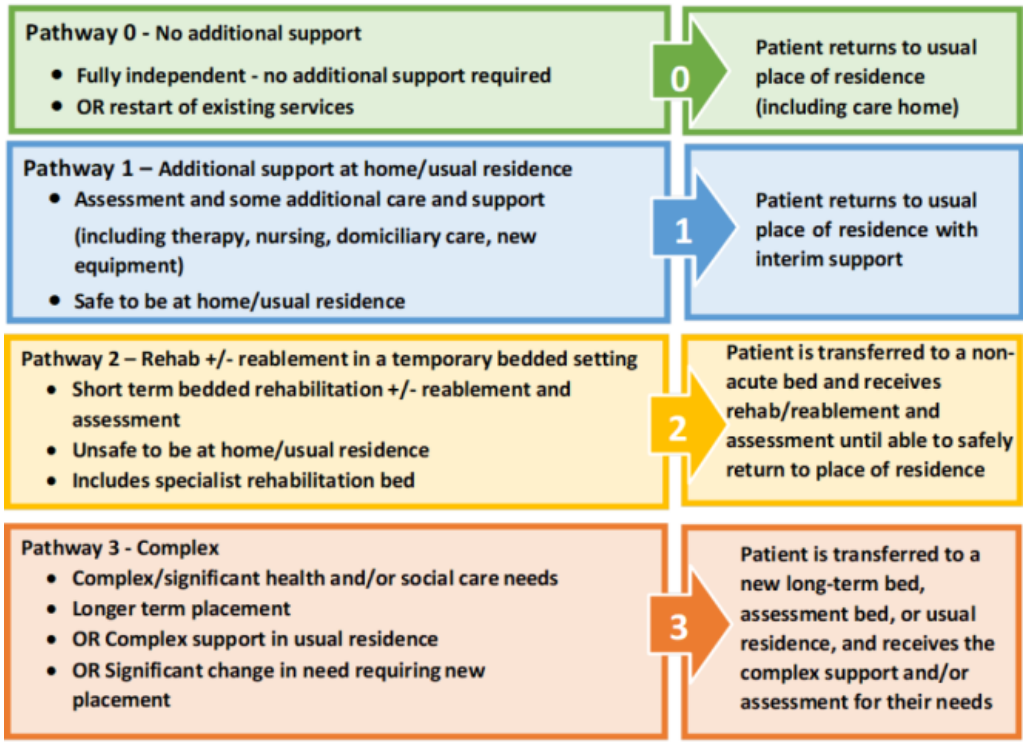
- Enable people to stay well, safe and independent at home for longer; and
- Provide the right care in the right place at the right time.

As part of our improvements to ensure as a system we are 'providing the right care in the right place at the right time' a review of demand and capacity modelling has been undertaken in line with planning requirements, which is located at Appendix 2.

## 6.1 Discharge to Assess, Integrated Discharge Team, Community Integrated Response Hub and Home First

### Discharge to Assess (D2A) model

Discharge to Assess (D2A) is based on four pathways for discharges from acute hospital beds, Pathway 1 (Home) being the optimum pathway for patients who need additional support:




For the Herefordshire system, a number of services make up D2A provision for pathways one, two and three, including reablement services, block home care provision and bed based provision. National funding via DHSC ended on 31st March 2022 and from 1st April 2022 discharge pathways have been funded locally. Current discharge pathways have not changed and are funded via the BCF. This funding source is sufficient to sustain the current model for most of this financial year, but after that point an agreed, affordable, recurrently funded solution must be in place.

Increased use of BCF funding has been invested in Wye Valley Therapy Support and a new Care

Act Assessment Team & new posts in Social Care Complex Care. The ICS Point of Prevalence audit is being undertaken on 21 September 2022, which, along with the demand and capacity template (located at appendix 2) will inform future modelling.

Teams across Herefordshire, including WVT, Herefordshire Council and General practice information leads are combining data sets to provide a greater understanding of the current Discharge to Access pathway. This looks to demonstrate patients being accessed by the integrated discharge team and then the onward journey of the patient, split by discharged home (pathway 0) and referrals onto pathways 1, 2 or 3.

**Integrated Discharge Team**

The Integrated Discharge Team are responsible for supporting Complex Discharges across Wye Valley Trust Acute and Community Hospitals. The ethos of the integrated team, which is made up of NHS and adult social care staff, is to identify patients at ward level, working with patients, families and ward staff whilst patients are not medically stable by planning discharge arrangements and discharging patients as soon as possible once medically stable.

Integrated Discharge Coordinators have been employed to support wards ensuring that effective discharge processes are undertaken thus improving patient flow. The innovative team consists of Health and Social care colleagues, working together, to ensure the safe and timely discharge of patients following the Discharge to Assess model of working. The coordinators work closely with ward staff, attend twice daily ward MDT meetings using the ethos of 'Why not Home, Why not Today' and communicating with patients, relatives and other community services to provide a proactive and continuous process of discharge planning, avoiding delays and thereby improving patient experience.

The discharge dashboard will graphically present numbers of patients sitting with the Integrated Discharge Team (IDT), numbers referred to specific pathways and a high-level drill down to understand caseloads better. This overlaid with capacity of services will provide an operational insight into patient activity currently in the system. Starting with daily refreshes with the view to move to more real-time.

**Community Integrated Response Hub**

***System partners work in collaboration to the 'Home is Best' principle.***

The Community Integrated Response Hub (CIRH) provides the function of an urgent community response and consists of five responding assets:

- Hospital at Home Therapy – (Wye Valley NHS Trust) Joint/interdisciplinary working with nurses, support workers and therapists is commonplace for patients requiring both routine monitoring and 2-hour response interventions.
- Hospital at Home Nursing - (Wye Valley NHS Trust).
- Home First.
- Virtual GP (vGP) - (Taurus Healthcare).
- Community Advanced Clinical Practitioners (ACPs) - (Wye Valley NHS Trust).

Work is being undertaken to expand the CIRH to become a single point of access for a variety of health pathways. The current offer will continue but will include additional pathways such as Patient Initiated Follow up (PIFU), care homes and long-term conditions.

The Single Point of Access (SPA) will be developed to respond to the increasing need for new models and service developments coming on-line. Central hubs for transfer, Virtual Ward, early

supportive discharge support receive escalation calls from primary, secondary care, the council and NHS111 and there will be a response from the SPA.

**Home First**

The Home First Service provides a short term, reablement offer to support people to retain or regain their independence and work to get someone back as close to their previous level of independence as possible, which is our enabling approach. The service promotes the health, wellbeing, independence, dignity and social inclusion of the people who use the service. The enablement ethos is fundamental to the delivery of this service.

Home First responds and works quickly, flexibly and efficiently as possible to stop someone from losing their independence, to facilitate the most positive outcome for individuals. This involves ensuring that care planning is focussed on people's strengths and abilities, how these can be built upon and how people can be assisted on their journey to independence. As well as managing risk and safety with the right level of intervention.

Throughout 2022/23, system partners will continue to invest in the growth of the Home First service (via the BCF) in order to support multi pathways, including hospital discharge. The Home First service transferred from Herefordshire Council in July 2022 and is now delivered by Hoople Care.

## 6.2 Talk Community

**Talk Community (**Talk Community Directory) continues to be one of the council's strategic and primary approaches to demand management and admission prevention. Talk Community is bringing Herefordshire together to encourage residents, businesses, community leaders and our Council to play their part in making Herefordshire a better place to live and work.

The Customer Service Team acts as a single point of contact, maximising the use of the Talk Community web-site as a primary tool for the provision of information and signposting with the aim of assisting customers to get the right support, when they need it within their communities. The Talk Community web-site provides a platform to connect the people of Herefordshire to community groups, events, hubs and information to help them stay happy and healthy. It is a one stop shop for online national and local information, advice and guidance for the whole of Herefordshire across all ages, which supports our early help and prevention agenda. Evidence from key performance data indicates that the web-site is reaching those people that require help and support. The number of users has increased from 6.6k to 9.1k since April 22 to July 22, with page views increasing from 18.6k to 26.8k and number of hits increasing form 8.7k to 13.9k for the same period.

Growth of the Talk Community hubs continues, with a network of 67 hubs across Herefordshire, creating local, accessible, safe places for people to connect to their community and find out about support, services, groups and activities that can help them stay independent, happy and healthy at home. Wye Valley NHS Trust (WVT) has launched a pilot, volunteer-led Talk Community Hub, at the County Hospital (acute) site. The main emphasis of the model is information and signposting and is available to anyone visiting the County hospital including patients, carers, visitors and staff. This will link into existing support services at the County Hospital including the Eye Care Liaison Officer (ECLO), Defence Medical Welfare Service (DMWS) and Macmillan Information & Support service. The model will also work alongside discharge coordinator roles to support patients, carers and families during admission and prior to discharge. Talk Community brings together community, third sector and statutory services to connect with peers and share ideas and experiences within the

local PCN areas - working with communities to identify and address issues that affect them, increase sustainability of communities by facilitating the development of partnerships and collaborative approaches and helping identify any gaps in provision.

Other support being offered/undertaken by Talk Community include, but are not limited to:

| | |
|---|---|
| **Mental Health Support** | Mental health awareness training provided to 150 people and mental health first aid training to 50 people enhancing mental health support within communities. Offer QWELL online support tool enabling residents to access online support 24/7. |
| **Financial Support** | Money on your Mind toolkit to support residents to access local and up to date financial support information. 7 voluntary organisations funded to be debt & financial management centres with 34 volunteers trained. |
| **Community Broker Team** | A person-centred approach to care planning. Recognising individuals are more likely to live happier and healthier lives when supported to retain their independence and access their local communities for as long as possible; the team has mapped in detail the community services across Herefordshire. |
| **Healthy Lifestyle Service** | Healthy Lifestyles team offer a wide range of healthy lifestyle information, advice and support to help residents make changes in their lives to improve health & wellbeing. Structured one to one and group support to stop smoking, get more active, eat better, drink less, lose weight, lower blood pressure and cholesterol |

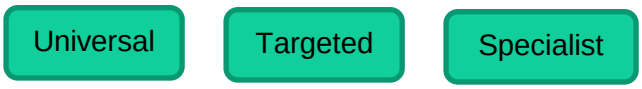
## 6.3 Integrated approach to commissioning - Falls

Herefordshire Council are working collaboratively with commissioning partners across the system in order to further develop integrated approaches to commissioning. A current example of this is the system wide review and development of an integrated falls pathway, as detailed below.

Business as usual services funded and delivered through the BCF/iBCF which '***enable people to stay well, safe and independent at home for longer***' include several Falls Prevention services. In Herefordshire there are 3 key services currently commissioned to deliver support for people identified as moderate and high risk of falls. These are:

- Falls Prevention Service.
- Falls Responder Service.
- Falls Care Navigator Service.

A falls review is being scoped collaboratively for the future blueprint of Falls Prevention support and services in Herefordshire is divided into 3 key areas of service delivery:




The **Universal** offer is designed to be accessible to all residents, carers, and professionals across Herefordshire. It is proposed that this single, streamlined, multiagency developed offer will be

accessible through the Talk Community online directory and will contain information, advice and guidance which is tailored to be suitable for all patient profiles (from LOW through to SEVERE). A vast communication/engagement plan will be developed in order to ensure all stakeholders are made aware of the Universal provision available and a small working group will be established to work together to develop the content. A 'no wrong door' concept will be adopted, where professionals from across the health and social care sector will be encouraged to refer customers / patients to the Universal offer as soon as possible. This provides an opportunity to ensure the messaging is consistent across statutory and community services.

The **targeted** provision will be further developed and available to those in the MEDIUM / HIGH cohorts. The training proposed for the health and social care workforce will aim to support professionals to increase their knowledge regarding Falls Prevention and ensure awareness of the Universal offer and ability to work with individuals to complete the self-assessments and checklists available. Herefordshire's Public Health is supporting a review of the falls prevention model, in order to strengthen the upstream, preventative part of the proposed new falls pathway.

It is proposed that the **specialist** commissioned services will introduce an eligibility criteria which enables them to focus services upon those who are at HIGH and SEVERE risk of falls. These specialist services will provide specialist physiotherapy and OT assessment and support, specialist service to provide outreach to repeat fallers, respond to falls and provide training and assist with developing the Universal offer.

- Talk Community Customer Services also support the falls prevention agenda by sending out falls leaflets, postcards and A4 posters to a number of stakeholders.
- Through the Talk Community Directory - Falls prevention - Talk Community Directory

Further work is planned to ensure that this pathway is an alternative to ambulance attendances, through introducing support to care homes on falls and to ensure that the NHS111 is able to refer to the falls service.

Herefordshire council will be taking forward the recommissioning of services within the pathway during 2023. This will lead to a new partnership between NHS providers, local communities and the council's Talk Community and public health programmes, to reduce avoidable falls and the consequential impact on health services and social care.

## 6.4 High Impact Change Model (HICM)

The **HICM** is designed to support local system partners to improve health and wellbeing, minimise unnecessary hospital stays and encourage the consideration of new interventions. The table below provides an overview of Herefordshire's local, joint self-assessment.

**High Impact change Model - Herefordshire self assessment and improvement plan**
August 2022

https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high/about

| High Impact Change Area | Self Assessment Where are we now? | Summary of current position |
|---|---|---|
| **Change 1: Early Discharge Planning** | **Plans in place** | Herefordshire's Integrated Discharge Team continues to facilitate discharge planning.<br>Plans in place to look at the elective pathway from pre-op through to discharge.<br>The Red Bag Scheme is currently not active. |
| **Change 2: Monitoring and responding to system demand and capacity** | **Established** | System partners continue to work together to monitor and respond to system demands.<br>A Point of Prevalence audit is planned to take place in September and a demand and capacity dashboard is currently being developed. |
| **Change 3: Multi-disciplinary working** | **Mature** | The Integrated Discharge Team is developed and embedded.<br>Partners work closely together throughout the Urgent Care Pathway including daily huddle meetings, where patient trackers and progress are discussed. |
| **Change 4: Home First D2A** | **Mature** | Wherever possible, people are supported to be assessed in their usual place of residence.<br>The council has introduced the CAAST team, who complete Care Act assessments once people have been discharged. |
| **Change 5: Flexible working patterns** | **Mature** | Demand and capacity is currently being mapped across the system, which will inform if seven-day working patterns are required/suitable. Seven-day services in place where required. |
| **Change 6: Trusted Assessment** | **Mature** | Trusted Assessors are in place and available for Care Home assessments.<br>People are safe and having assessments in a timely way. |
| **Change 7: Engagement and Choice** | **Established** | Admission advice and information leaflets are readily available, including web based information.<br>Alternative languages and accessibility options are currently being explored.<br>The local authority has a range of information available to support individuals and families to make decisions regarding care. The Talk Community Directory is available to all and provides a rich source of advice and information. In addition to this there are currently 67 Talk Commuhity Hubs in Herefordshire which offer up to date health and wellbeing information and help bring residents together by connecting people to services, groups and activities within their local community or across the county. |
| **Change 8: Improved discharge to care homes** | **Established** | System partners meet with Care Home providers on a 4 weekly basis, to discuss a range of topics and issues. In addition, information, best practice, policy and guidance documents are distributed to Care Homes on a regular basis.<br>Care Homes are encouraged to access clinical support via the Community Integrated Response Hub.<br>Care Home Clinical Practitioners continue to work to identify individual provider needs to inform day to day activity; enhance individual care through collaborative working, to broaden knowledge and skills to ensure the successful delivery of clinical support and advice to Residential and Nursing Homes across Herefordshire. |
| **Change 9: Housing and related services** | **Mature** | Referral pathways to Home adaptations, equipment and telecare services are well established and services are delivered promptly.<br>The impact of homelessness and housing issues are fully understood and the local authorities' housing solutions team is available 24/7. A dedicated Housing Solutions Officer is in place to specifically support discharge. |

## 7. Key areas of progress and developments (PR7)
(Planning Requirement – BCF Pool matched funding)

**Hoople Care** has been established in order to assume the management of adult social care services that have been in-sourced by the council. The council has recognised that some services cannot be provided in social care markets with the appropriate consistency of quality and value for money. It has therefore taken decisions to in-source or create new services over recent years.

The transfer of registration will help to implement objectives within Herefordshire's market position statement 2020/2025. This underlines the council's willingness to consider its role in markets where the market cannot meet demand challenges and needs of individuals. Transferring the services to Hoople Care will ensure consistency in regulated service delivery.

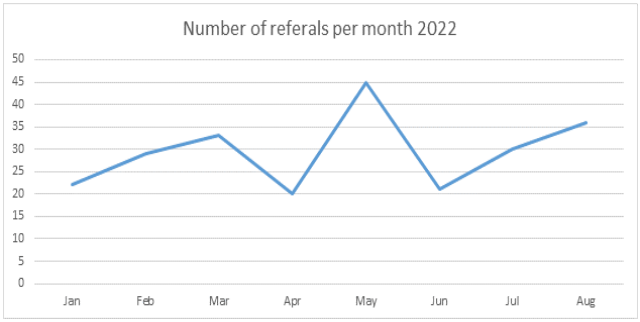
- The vision is for Hoople Care to become a leading care provider and have a strong presence in the market.
- The establishment of Hoople Care over time is expected to support resilience and stability in the care and support market in Herefordshire.
- It is proposed to enhance the Hoople Care model building on the successful insourcing of the residential services for learning disabled people.
- There will be further opportunity to combine the council's recruitment and training provider (Hoople) with its care provision to improve and sustain the quality of in-house services.
- There is an opportunity to aligning to the council's Talk Community's approach and Hoople connecting people into communities on a strengths based model.
- Hoople Care will contribute to, support and develop the health, family support and social care workforce.
- There is potential for collaborative working between the Hoople Care provision and the wider NHS services and the Integrated Care System (ICS).

The **Clinical Care Home Practitioners** continue to be funded via iBCF with the team employed by WVT (Integrated Care Division). The team have continued to work to identify individual provider needs to inform day to day activity; enhance individual care through collaborative working using gold standard evidence based education as a resource to broaden knowledge and skills to ensure the successful delivery of clinical support and advice to Residential and Nursing Homes across Herefordshire.

**Outcomes**

1. To increase education and confidence in recognising deterioration and enable the resident to stay within their own home environment.
2. To provide a more consistent access to education and support and to ensure that all care home staff are able to deliver safe, high quality, compassionate care.
3. To ensure that all nurses undertake the necessary clinical education or training with competency assessment in practice to support development of their knowledge, skills and expertise.
4. To reduce hospital admissions within our community and acute hospital sites.

The **Trusted Assessor** model was implemented in Herefordshire during 2018-19, and continues to be a valued resource in helping to reduce the number of delayed discharges, supporting individuals to be discharged to the appropriate care home or Discharge to Assess location, along with increasing time efficiency for care home managers. So far in 2022 the TA's have had 236 patients referred which shows an increase on previous years (2021 was 227 and 2020 was 131 by August).




**Home First wage increase** - Agreement with partners to increase hourly rate of Reablement Workers and Assessment and Review Officers to boost recruitment and retention. Home First provides an essential reablement service that facilitates early discharge from hospital and a return home for patients. It is known that the longer a person remains in hospital the more likely it is that they will experience reduced confidence and mobility and worse outcomes overall. Having a full complement of staff available within Home First would reduce delays for people ready to leave hospital.

Delays in providing this service not only impact on the individual patient but bed space issues for the hospital which in turns creates capacity issues across the whole health and care system The increase proposed to make employment in reablement work and the wider social care sector more attractive for people in the local employment market, providing pay above the living wage having a positive impact for the local economy and support an important function in reducing pressure on hospitals and enabling patients to return home without any unnecessary delays.

**Workforce, Recruitment and Retention -** An element of iBCF funding has been allocated to the redesign and marketing of the Herefordshire Cares website (www.herefordshirecares.co.uk) and social media campaign.


Herefordshire Cares engages both potential and existing care workers as the Herefordshire 'go to place' for news, information, opportunities, support and developments at national, regional and local level. The new approach is aiming to improve local recruitment and entrants to the local care sector.

Care Home providers and home care providers can advertise vacancies for free on the Herefordshire Cares website. In October and November, with provider engagement we are undertaking some filming for the website with care workers in their work place to highlight the sector. The team are also linking with Skills for Care, local colleges and ICS on system workforce training and requirements.

**Supporting unpaid carers**

Unpaid family carers are central to the delivery of high quality and integrated health and care services in Herefordshire. Both the council and NHS partners have given significant focus to their strategic work relating to carers and are now bringing forward a joint co-ordinated approach to strategy and engagement. Herefordshire council conducted comprehensive consultation and engagement with unpaid carers in 2021 in reviewing its existing carer's strategy and developing the new strategy. The content and focus of that strategy is entirely the product of that carer and stakeholder engagement. Across the ICB footprint, multiple agencies have collaborated to develop

a carer's charter approach with a focus on access to and participation in services. The Herefordshire strategy and ICB approach are now fully aligned and will shortly be adopted formally by the place based board for Herefordshire. The joint approach is focused on the rights of carers, their access to health and care services for themselves and their participation in the delivery of services to those they care for, promoting independence and prioritising take up of upstream, preventative services. Partners are now reviewing overall resourcing of services to unpaid carers in the light of adult social care reforms.

BCF funds the provision of carers respite placements with Acorns Childrens Hospice and St. Michael's Hospice Carers Support (£293,499K). The ICB continue to support carer's breaks through the Better Care Fund including the NHS provision for people with life-limiting conditions, providing respite care in appropriate clinical environments. Furthermore, the NHS minimum contribution will continue to support implementation of the Care Act through the provision of assessment, advice and support to carers. Within the strengths-based approach in reablement, the engagement and support to carers is an integral part, ensuring that carers are well-informed and supported. This includes access to equipment and aids. We also recognise that social isolation, fuel poverty and the wellbeing of carers is paramount. This is promoted through Talk Community throughout Herefordshire.

**Implementing Care Act Responsibilities**

Similar to previous years our Care Act responsibilities are met by the Carers Support Contracts (£225K). The council has also invested in a new Care Act Assessment Team (CAAST) part-funded by BCF (£229K).

The Care Act Assessment team (CAAST) is a bespoke team established within Adult social care delivery. Team members have the requisite qualifications and skill base to undertake a holistic assessment under the Care Act 2014 of individuals at their most optimum point of their recovery and reablement after a discharge from hospital. Assessment practitioners complete the assessment with individuals and carers using the Strength based model and currently undertake the assessments within the D2A model time frame of up to six weeks. This team has been specifically trained to assess and identify that individuals and their carers have maximised their independence and ensure that all opportunities are explored to promote further independence and wellbeing. For example by facilitating therapy assessments and interventions, grants for improved housing conditions and equipment, have been sign posted to ensure connections to their community and universal services. The plan is for all of the team to be trained to prescribe a range of aids (technology and equipment) or identify where more complex assessments are needed by OT's.

CAAST has responsibility for running the urgent care discharge spreadsheet (shortly to become the hospital to home digital pathway) which maps the individuals journey from hospital bed to final destination. Performance indicators show that individuals are now assessed well within the expected time frames. The feedback from partners, locality teams and clients and stakeholders has been very positive. For most discharges there is now one team to liaise with regarding someone who has been discharged rather than the five teams previously. CAAST is solely focused on the hospital discharges and does not have to navigate the other priorities of locality teams and so responsiveness to timeframes has vastly improved.