Herefordshire Better Care Fund and Integration Plan 2023-2025

Herefordshire Health and Wellbeing Board

June 2023

Executive Summary

The Better Care Fund (BCF) is pooled budget held between the council and the NHS that funds a range of essential community based health and adult social care services. 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 BCF Plan is a two year plan, to enable the national conditions and objectives to be met. The plan covers 2 financial years, income and expenditure for the second year being provisional pending confirmation of allocations and review of all BCF schemes by the Integrated Care System for Herefordshire. The plans for metrics and capacity demand are one year plans and will be refreshed accordingly for the second year plan.

Our priorities for 2023-25

Herefordshire's Better Care Fund (BCF) Plan for 2023-25 will continue to support our long-term vision, and build on previous system priorities to strengthen what has been achieved so far. Our plan sets out the work we need to do to further develop the way we work together on our shared priorities to deliver key outcomes for local people. Herefordshire's priorities for the BCF 2023-25 include:

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

Herefordshire's BCF funding continues to be used for several key adult social care and NHS community services - operational social work, brokerage, integrated discharge, community health and care services, Deprivation of Liberty Safeguards (DoLS), urgency community response, falls prevention 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.

Detailed information regarding spend allocation for the BCF 2023-24 is available in the planning template. The table below provides a high level summary which highlights sources of funding and expenditure against them.

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,268,653	£2,268,653	£2,268,653	£2,268,653	£0
Minimum NHS Contribution	£15,988,427	£16,893,372	£15,988,427	£16,893,372	£0
iBCF	£6,782,841	£6,782,841	£6,782,841	£6,782,841	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£950,944	£1,584,907	£950,944	£1,584,907	£0
ICB Discharge Funding	£1,047,772	£2,221,943	£1,047,772	£2,221,943	£0
Total	**£27,038,637**	**£29,751,716**	**£27,038,637**	**£29,751,716**	**£0**

Key changes since our previous plan

In last year's plan we provided a summary of the arrangements in place for the BCF and wider services, including joint commissioning, partnerships, funding and strategies, lead commissioning arrangements and integrated approaches to training and market management

These arrangements continue, with a joint commitment that the BCF will support ways we can further integrate our services to support people, and focus on broader engagement and links with primary care and the voluntary sector. Responsibility for planning and delivery of the BCF will shortly transfer to the One Herefordshire Partnership within the Integrated Care System which will ensure jointly agreed and locally-focussed approaches to challenges and opportunities.

Several key 'place' level challenges are understood which partners are working together to address, for example, recruitment and retention of staff across the health and care sector and the increased cost of providing care in a rural community with an ageing, sparse and very dispersed population. There are many opportunities for further joined up working and the BCF will be central to delivery of Herefordshire's Health and Wellbeing Strategy (HWBS) and Integrated Place Strategy and Priorities.

Improved health and wellbeing will be achieved through better support and high-quality services, but also through preventing people from becoming unwell and supporting them to remain independent and live well in their communities. We recognise that we need to look beyond health and care services to understand the barriers and opportunities to living a healthier life and are committed to working with people and communities to address them.

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. Some of the key challenges for Herefordshire include 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.

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.

1. National Condition 1: Overall BCF Plan and approach to integration

Planning Requirement (PR1) - A jointly developed and agreed plan that all parties sign up to

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 BCF plan 2023/25.

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 the Community Partnership has enabled the VCSE sector to contribute to priorities and 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.

Bodies involved strategically and operationally 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 plan and for overseeing delivery through quarterly reporting.

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

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

This year, it is the intent that that Better Care Fund has the engagement of the One Herefordshire Partnership (1HP) to support the delivery of the plan. One Herefordshire Partnership is the vehicle by which Herefordshire Place partners work together at a strategic level and is a key enabler of the BCF plan delivery.

The establishment of a Memorandum of Understanding (MOU) has been agreed and signed by the four partners to provide a formal basis for the collaboration and working arrangements between organisations involved in the 1HP specifically to detail the collaborative approach to delivery and oversight of integrated health and care delivery in Herefordshire. The MOU sets out a framework of roles and responsibilities for the participants engaged in Place collaboration.

The four One Herefordshire partners are:

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

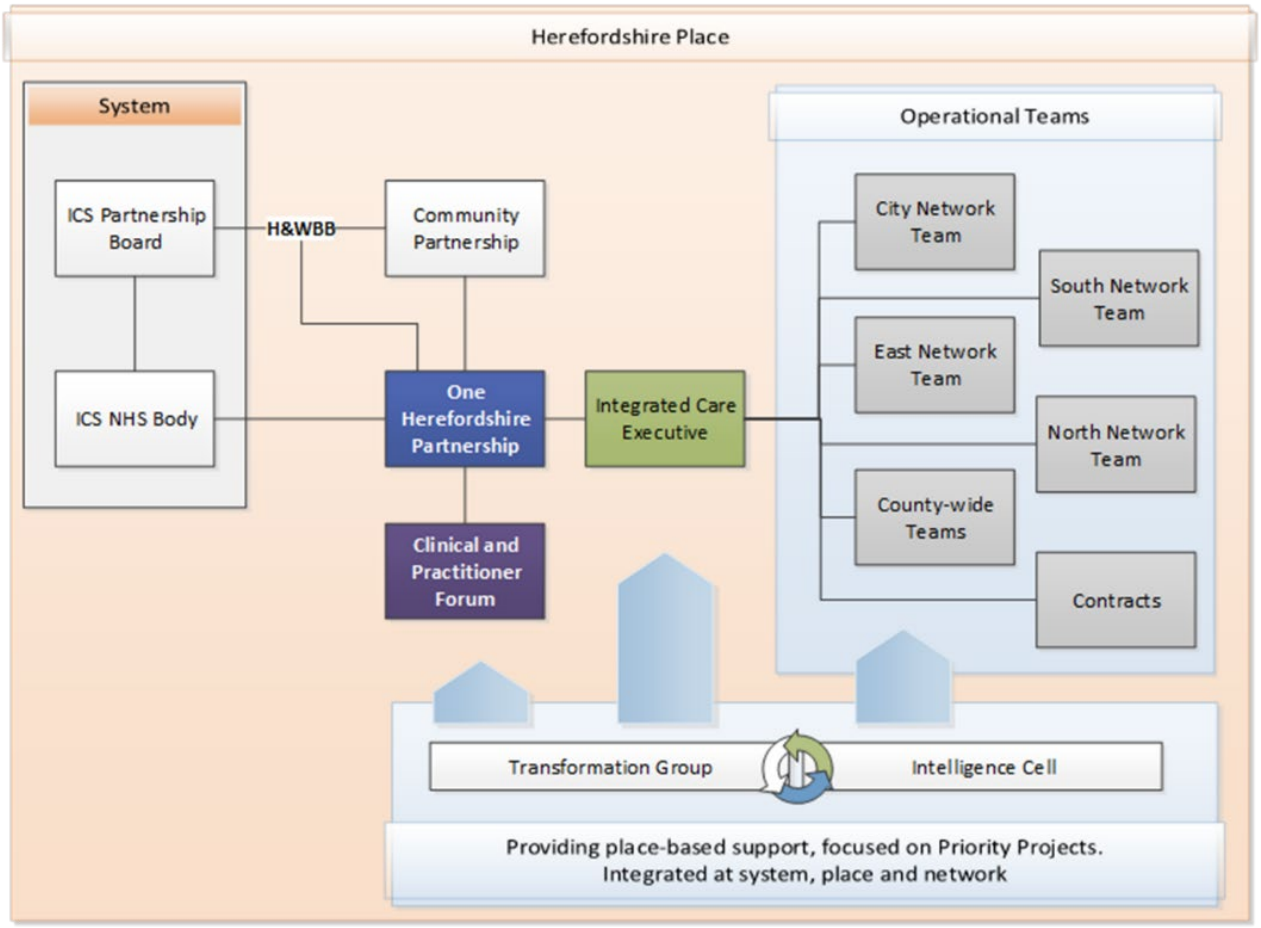
The following organisations are invited members of the Partnership

- Herefordshire Healthwatch
- 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.

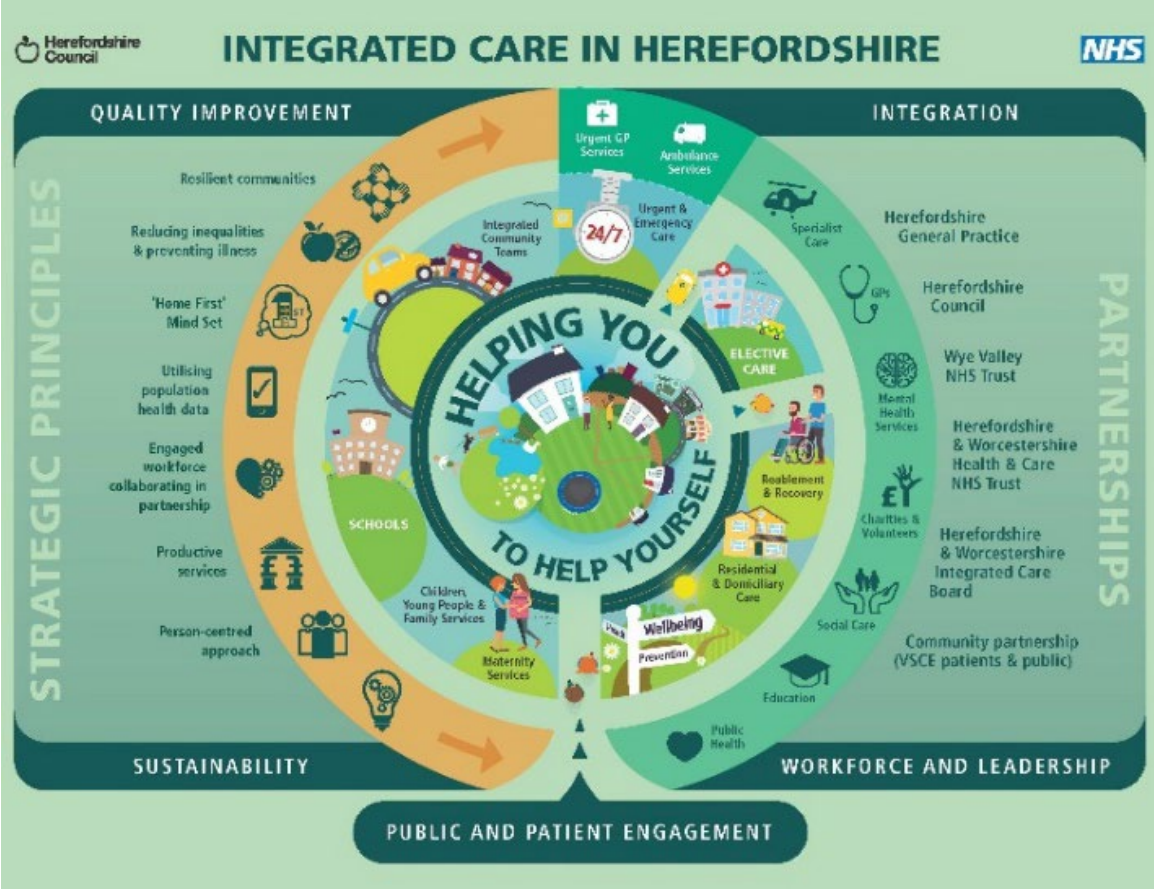
One Herefordshire Partnership will be held to account by Herefordshire and Worcestershire ICB for the day to day delivery of the Better Care Fund. A MOU has been established setting out the roles and responsibilities of local partners with the ICB. This has been developed to facilitate the objectives set out above.



Partners have agreed the 2023-25 BCF Plan and metrics following approval at relevant leadership and committee meetings.

Planning Requirement (PR2) - A clear narrative for the integration of health, social care and housing

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 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

PCN Development (including Fuller recommendations	• Development of PCN 'team of teams' • Population Health Management • Health Inequalities • Personalisation, Prevention and Well Being
Integrated Urgent Care	• GP Out of Hours Procurement • Implementing the 'blueprint'
Health and Wellbeing Strategy Priorities	• Best start in life • Mental Health and Wellbeing
Planned Care	• Long term conditions (Diabetes, HF, COPD) • Making Every Referral Count
Workforce	• Public Sector recruitment • Joint roles and Careers
Working with Communities	• Community Paradigm
Working Well Together	• Delivering against the secondary care asks identified in the Primary Care Recovery Plan

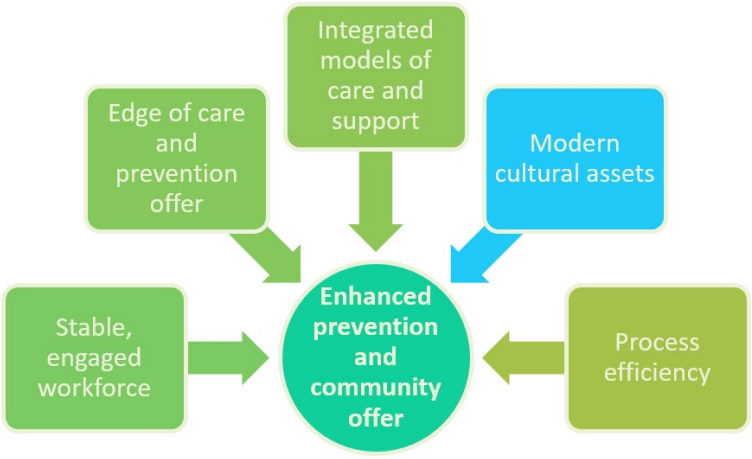
The following programmes of work and strategies set out a range of priorities, many of which are enabled by the BCF, connections and linkages are ensured via the 1HP arrangements.

Transformation

The aim of **transformation** in Community Wellbeing is to increase and diversify the prevention and community offer in order to reduce demand on formal services and offer quality and value, whilst ensuring that our internal processes operate at maximum efficiency. The principles that underpin the strategy are:

- Designing and delivering the solutions with the people who use our services, their carers and families, and the workforce;
- Integration with partners where that makes sense to do so; and
- Value for money and efficiency.

The Community Wellbeing Transformation Strategy will be delivered across five key work streams:



The Health and Care Act 2022 gave the Care Quality Commission (CQC) new regulatory powers to undertake independent assessment of local authorities' delivery of regulated care functions.

Strategic Housing - Housing and Health

National and international research has repeatedly demonstrated the importance of housing and a stable home in the maintenance of good personal health. Not only does poor housing, and indeed no housing, lead to poor physical health, it also leads to worsening mental health, increased rates of addiction, family break up and criminality. It costs society more; not just in terms of the impact upon citizens, but the fiscal impact and how society is viewed more widely. The personal impact is catastrophic. Rough Sleeping is proven to lead to early mortality, nearly 50% earlier in men and women, than the general population. The impact upon residents who live in poorly maintained housing stock places a greater burden on health services to treat the associated physical and mental health impact of the living conditions. The financial impact is significant. It costs society nearly six times more to provide services to our residents who are homeless. Finally, there are multiple national and international examples of how the reputation of a 'service' is impacted when services fail or things go wrong. It is difficult to recover from.

In 2020 the COVID-19 Pandemic and the 'Everyone In' program presented Herefordshire with an opportunity to embark upon a new pathway to achieve good quality housing for all its residents. This pathway built upon our 2018 thematic review of housing, homelessness and rough sleeping services in the county, drew upon best practice and guidance from across the globe and listened to the voices of people who use our services. This pathway became known as Project BRAVE – it set out three questions: -

1. How do we provide a safe and secure emergency accommodation for people required to be housed under the 'Everyone In' program? ;
2. How do we sustain people in this accommodation?; and
3. How do we support them to secure and sustain a long-term home?

Not only did this initiative seek to deliver a housing led model of accommodation for all its citizens, it also sought to develop a multi-agency and cross sector response to housing and homelessness. Project BRAVE facilitated a wide range of statutory and voluntary sector partners to work in concert to deliver services both through the pandemic and beyond. This approach delivered tangible results for people affected by poor or no housing. To list a few, they include: -

- All rough sleepers securing registration with and access to a GP;
- All rough sleepers and other homeless individuals being offered a COVID-19 vaccination;
- All rough sleepers and other homeless individuals being able to readily access mental health support services;
- All rough sleepers and other homeless individuals having access to and support from addiction treatment services;
- Accommodation being provided to over 300 people in the first six months of the pandemic;
- Demand for ambulances and access to A&E dropping by 90%;
- Reduced impact upon policing and the criminal justice system;
- Following a charitable donation of clothing from a national supplier, All rough sleepers and other homeless individuals having access to new clothing

A new model of partnership working in Herefordshire, recognising the specific needs of people with multiple complex vulnerabilities including, homeless and rough sleepers. This multi-agency / cross sector approach to a coordinated response to the provision of good quality accommodation with appropriate levels of support from health, justice and the voluntary sector is driving tangible change for Herefordshire and in the recent study of rural homelessness by the University of Kent has been recognised for its innovative approach to addressing these intertwined issues.

Rough Sleeper Accommodation Programme

The councils Strategic Housing team submitted a bid application to government for funding under their Rough Sleepers Accommodation Programme with the aim of purchasing 6, one bed properties. Following a successful bid of £423,360.00 together with additional funding of £535,040.00 from the council the properties

were all purchased by March 2023. Over the period January 2022 to March 2023 the council successfully purchased and refurbished the properties and made them available to clients that have a history of rough sleeping.

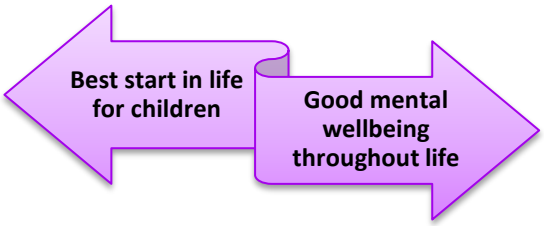
Herefordshire's Joint Local Health and Wellbeing Strategy 2023-2033 presents an outline for improving health and wellbeing of the population in Herefordshire over the next 10 years.

The strategy sets out how the Council and its local partners plan to address the health and wellbeing needs of its population (identified through the Joint Strategic Needs Assessment) and is a key document that is jointly owned and promotes collective action to meet those needs. The implementation of the Health and Care Act of 2022 and the consequent establishment of the Integrated Care System (ICS) for Herefordshire and Worcestershire provides a timely opportunity for this new strategy to deliver action by any of the partners within the Herefordshire and Worcestershire ICS or more locally within Herefordshire, according to what is most appropriate to the issue.

This new joined up way of working has enabled Herefordshire and the ICS to align our strategies, commit to those priorities that are jointly owned and contribute to the overall system goals. It is a significant statement of our intent to work together that the Herefordshire HWBS and the Worcestershire HWBSs have been incorporated into the Integrated Care Strategy document. This strategy will be accompanied by a monitoring and implementation plan, setting out the responsibilities of all partners. It is ambitious in aspiration but realistic and measurable in its objectives, demonstrating our intent that it will serve to make a tangible difference to peoples' lives.

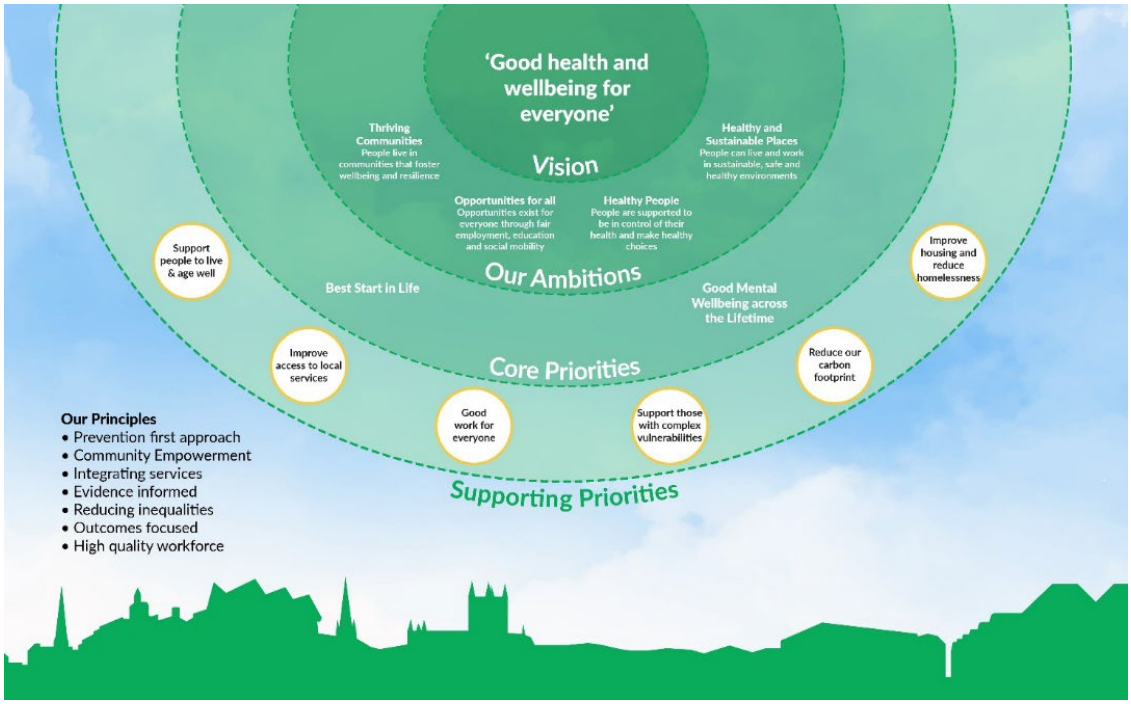
The strategy is developed in close collaboration and consultation with residents and local partners from health, social care, local authorities and voluntary sector.

Having taken into account the views and comments from residents and partners and what we know about the issues from our Herefordshire data, the central focus of the strategy at the beginning of this ten year period will be:



In addition to these core priorities, a further six supporting priorities have been identified recognising that they are also critically important in how they affect our broader wellbeing, but that they also support and contribute towards giving children the best start, as well as the development and retention of good mental health.

All of the six supporting priorities have a role in reducing inequalities by addressing the wider issues that affect health, including housing, employment, and crime. Employing community-based approaches need to be driven by partnerships at a place level involving the council, health services, the voluntary sector, police, public sector employers and businesses.



Community Paradigm

Herefordshire is actively developing a new approach of working in partnership with its communities, building on the strong ethos of community that exists in the county. It is doing this because public sector services alone will never be able to create a state system big enough to address demand now, or in the future. The aim of the work is to reduce demand, intervene sooner with community led solutions, and invest in prevention for better wellbeing outcomes.

Taking the work of New Local Community Paradigm, Herefordshire is making a fundamental change away from doing *TO* people, to building a relationship *WITH* people, to develop community solutions. Clearly, this isn't a quick fix; this is a long-term way of working and the approach is probably best known through The Wigan Deal which made savings and invested £15m over five years. This funded over 500 projects in communities, coproduced by communities, increased healthy life expectancy by 7 years and is continuing today. Whereas the Wigan Deal was started within the council and then extended to other public sector bodies, Herefordshire is pioneering this work through a cross sector approach.

An initial summit has been held and stakeholders and partners working together to develop this approach and this will grow throughout the duration of the 2 year plan.

How is our BCF 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.

A new Inequalities Strategy 2023-2026, developed by a sub-group of the One Herefordshire Partnership with full engagement across the partnership, was approved by the Health and Wellbeing Board in March 2023. The strategy aims to create a framework to shape the direction and the objectives of work over the next three years to reduce inequalities across the county.

There are three over-arching objectives that the strategy seeks to confront:

1. **Digital and health literacy:**
   i) There is a lack of digital and health literacy at a time when accessibility to services has become increasingly digitalised.

ii) A key aim of the strategy is to help staff to improve their digital and health literacy so that they can assist patients and the public and in turn, reduce inequalities.

2. **Empowering workforces:**

i) This objective seeks to ensure that staff understand what is meant by health inequalities, how they approach them, and ultimately reduce health inequalities amongst the workforce.

3. **Reaching our communities:**

i) There is already a lot of work being done in the county, which is reflected in the plan at the end of the strategy.

ii) The work of the Community Partnership, led by Herefordshire Healthwatch, who have looked at the factors driving health inequalities and consider what can be done by partners in the statutory and voluntary sectors, together around that.

iii) The work of primary care networks of general practice, community staff, and social care workers is also important to understanding the needs of their population, in addition to dealing with those needs in defined areas and in defined ways.

Plan on a Page

Vision;	Herefordshire residents are resilient; lead fulfilling lives; are emotionally and physically healthy and feel safe and secure.		
The Challenge	Requires inequalities in health outcomes between different groups of people to be reduced. This necessitates a mix of short, medium and long term action including upon the wider determinants.		
We will focus on;	Reducing health inequalities across the population, particularly within:		
	Rurally dispersed	**Travelling Community**	**Unregistered individuals**
To do this we will;	Work in partnership to develop local solutions, using national frameworks and best practice, which encourage and empower people of all ages and abilities to reduce inequalities and improve health and wellbeing; focusing on;		
1.	Engaging healthcare professionals to improve digital and health literacy		
2.	Empower and support workforces to understand and deliver equitable services that reduce inequalities and address workforce inequality and training needs		
3.	Reaching communities to work in partnership to reduce inequalities		

In July 2022, the Health and Care Bill came into force which saw the establishment of Integrated Care Boards (ICBs), taking on the commissioning responsibilities of Clinical Commissioning Group and bringing a wider focus on the delivery of improved health, care and wellbeing outcomes. The 42 ICBs across England sit within wider Integrated Care Systems (ICS) which bring together partners from across health and care enabling mutual support between different parts of the system to further integrate the provision of care, reducing health inequality and unwarranted variation and give a shared focus on delivering improved outcomes.

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.

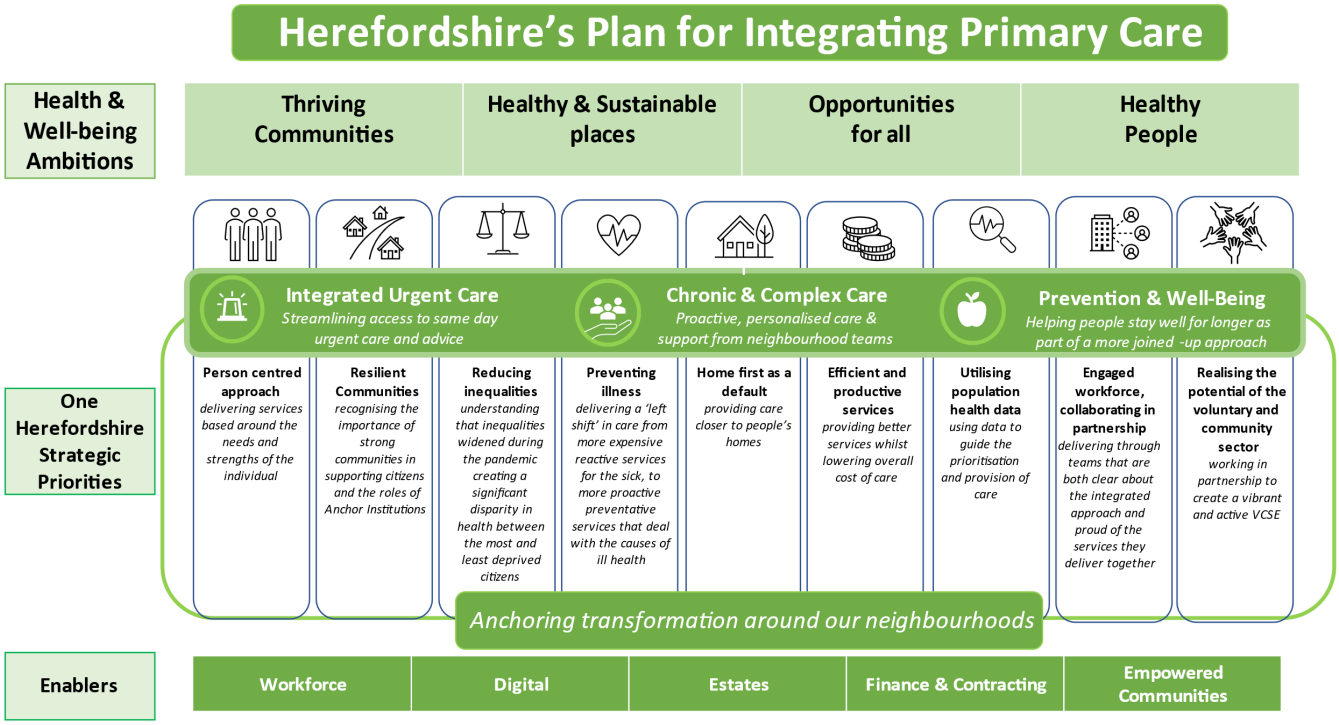
Partners across the system are coming together at the Herefordshire and Worcestershire Integrated Care Partnership Assembly to develop and agree an Integrated Care Plan which will share the vision for integrated care, improved health and care outcomes and a reduction in unwarranted variation in outcomes. 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.

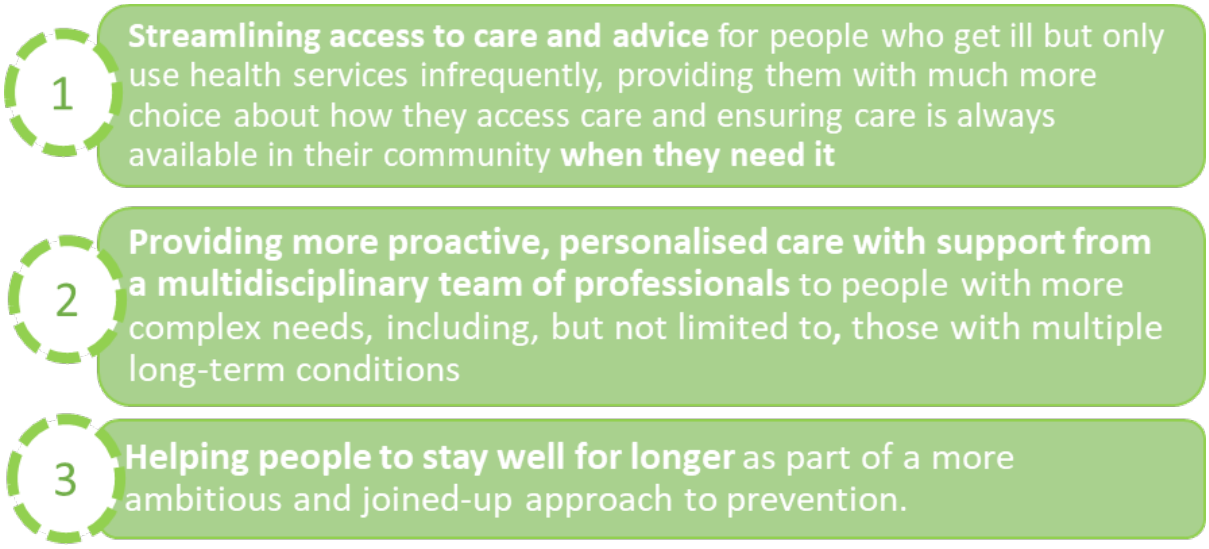
In order to address variation in outcomes in these 5 clinical areas, Herefordshire & Worcestershire ICB has invested over £4.3m within Primary Care Networks (PCNs) to deliver improved outcomes. All PCNs have worked with councils, voluntary sector and communities, implementing initiatives which support 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.

Integrating Primary Care – Anchoring transformation around our neighbourhoods

One Herefordshire partners are working together to build on the quality of care already provided in the county by primary care colleagues and ensure care for key communities is joined up, ensuring access to services and support when its need and sustainable services for the future.



The Fuller Stocktake, published in May 2022, sets out a vision to improve access, experience and outcomes for people and communities, the recommendations from which form a key part of our strategy and plans going forward. These recommendations centre around three essential areas.



Reporting to the One Herefordshire Partnership, senior managers from across the county are working together to develop detailed delivery plans based on the following principles and priorities:

Key Principles

- Reduce demand on statutory services
- Reduce duplication
- Clear pathways
- Empower residents to manage their own wellbeing
- Community driven and development focus
- Improved relationships between teams, improved job satisfaction, staff retention and wellbeing

Key Priorities

1. **Integrated Neighbourhoods Teams –** developing and supporting services delivered at a neighbourhood level

    a) **Community health & social care teams** – District nurses and social workers co-located alongside General practice teams where possible, with integrated access points, assessment processes and efficient, streamlined communication.
    b) **Safeguarding teams** - multi-agency professionals working together at the point of referral, with common values that respect professional expertise and perspectives, and is integrated into everyday practice.
    c) **Proactive care teams** - working alongside the developing INTs, there will be a focus on developing proactive care for patients with 2 or more long term conditions at risk of deterioration in the next 12-24 months. A single point of access will be developed so that patients are able to be supported with continuity of care from an identified group of professionals to meet their needs across a clinical and non-clinical team. This team will include well-being, such as social prescribing, to link the patient with community groups following a personalised care planning discussion. This will ensure a 'what matters to me' approach is followed to empower the patient to manage their well-being. The ambition is to align the team with CIRH so seamless care can be provided if the patient deteriorates further and is at risk at hospital admission. The aim is to support the patient to remain well, at home, with the right care, in the right place, by the right person for as long as is appropriate. It is hoped that this will improve outcomes for patients as they're able to remain at home within their community, whilst reducing pressures on general practice and secondary care.

2. Joined up approach to prevention & Well-being

a) **Strengthening community-based Well-being support,** such as Talk Community Development Officers, PCN Well Being teams, MIND link workers and more, enabling teams to work better together, removing duplication and optimising outcomes by developing clear pathways, processes and team working.
b) **Talk Well-being Integrated Outreach** – working to engage with underserved communities and addressing the wider determinants of health across Herefordshire to increase health checks and other screening tests to ensure earlier identification of otherwise undetected/unknown health conditions and increasing patients registered at a GP practice. This will be through outreach clinics, mobile approaches and working with community champions to identify areas to target where our population are facing barriers to accessing care, including registering with a GP practice. The team will clinically-led, but also include social prescribers and will collaborate across other organisations also providing outreach services to ensure all teams are making every contact count. This is a strength based, personalised care approach to empower patients to better manage their own health and well-being.

Planning Requirement (PR3) - A strategic, joined up plan for Disabled Facilities Grant (DFG) spending

Herefordshire's 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.

Supported Housing

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. Tillington Road is a collection of 6 newly built houses. The purpose of the accommodation is to enable people with enduring mental health conditions to be able to step down from more supported accommodation, into their own houses with floating support available. Residents moved into the houses during August and September 2022, and all have maintained their tenancies. Each person has the availability of up to 14 hours support each week by Lifeways SIL.

Older Persons

An 80 bed care home to be delivered as 100% affordable housing with Platform Housing has achieved planning permission in Hereford. Contractors are currently on site building out the development with the apartments due to complete in spring 2024. All apartments will be for those aged 55 and over and have a local connection to Hereford.

Veterans Self-build

19 high quality affordable homes have been developed with a housing association and contractor on a former site of a 16-flat housing association scheme built in the 1970s and adjacent land that was donated by Herefordshire Council. The scheme is the first self-build veterans' development in the County and has been highly commended. Taking over four years to deliver, collaboration was key to its success. The project involved developing strong partnerships with the local planning authority, self-build specialists, armed forces charities and contractors; as well as winning the local community's support. The council also supported a grant funding application to Homes England and provided additional grant funding. The first keys were handed over on 17th December 2020 and all units occupied by February 2021; the scheme continues to succeed.

Disabled Facilities Grant (DFG)

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 council's Housing services we 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.

Herefordshire Council's DFG allocation is £2,268,653m for 2023/24. The table below shows the funding split. The target remains as previous years being to complete 200 mandatory DFG grants and 20 discretionary DFG or assistance grants in the financial year.

2023/24 DFG Grant	**£**
DFGs	1,236,658
Discretionary DFGs	7,597
Discretionary Fast track Adaptations	3,590
Emergency Repayable Grant	16,590
DFG - Strategic Housing	63,790
Staffing Costs	310,618
Professional fees	9,468
NRS assessments	39,708
Digital Switchover	4,299
Rough Sleepers Accommodation Property	276,335
ICES Recharge	200,000
Telecare Recharge	100,000
Total Expenditure	**£2,268,653**

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.

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 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.

This is in line with government guidance on use of DFG to support capital projects that benefit social care.

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.

2. National Condition 2: Objective 1 – Enabling people to stay well, safe and independent at home for longer

Planning Requirement (PR4) - A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home

The Council's transformation agenda sets out as a priority that opportunities for integrating care and support will be identified and followed through. We have increased the number of social workers in both the discharge team and the Care Act assessment team to support a person-centred approach which adheres to individual's needs. Pathways to services are reviewed to ensure the quality of discharges and that patients are discharged safely, in a timely way.

Activities which are in process include:

- A review of Herefordshire's Discharge to Assess (D2A) model is being undertaken, reviewing the service model for integrated discharge services, KPI's and processes; considering quality of

outcomes, timeliness, effectiveness and affordability. An integrated D2A board has been convened and commenced in May 2023. A workshop is scheduled for 19th June 2023.

- Support is delivered at place via locality teams within Primary Care Networks and greater steps towards integration have been taken, which support the D2A pathway. A lead post has been developed to include District Nurse provision within the PCN.
- A new Learning log concerns form has been specifically devised for professionals to identify areas of process or practice that need to be improved that have been identified from complaints or concerns relating to a discharge process.
- Central referral points for therapy and urgent response allows for holistic review at triage and access to multi agency services locally is in place.
- Long Term Condition pathway and service is available working with and aligned with community teams.
- Implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches.
- Alternative models of delivery for occupational therapy are currently being considered, including a potential integrated model across health and social care. Reviewing establishment of a joint post – aiming for September 2023.
- Within the Council's housing solutions team the post of Housing Discharge Officer provides an early point of contact to create and maintain pathways to ensure that no one is discharged from hospital without accommodation being available to them where possible.
- The provision of a Service Manager, social care delivery – Urgent care/Initial contact manager is being proposed to lead the front of house urgent care and initial contact services. It is envisaged that this post will manage Care Act responsibilities in relation to Discharge to assess social care pathways including initial assessments; Advice and Guidance and signposting and Safeguarding referral and triage hub. The service manager will form close operational links with the Wye Valley Trust (WVT) Operations manager for urgent care and key partners which support operational pathways for urgent care and support services in WVT and in the community:
    - Hospital liaison workers who form part of the integrated discharge team.
    - Care Act assessment team who manage the pathway. (CAAsT)
    - Safeguarding concerns - to be developed into a multi-agency safeguarding service.
    - Adult advice, referral and signposting team (ART) which includes Community brokerage services and has direct links with CIRH.
- A Senior Social worker- hospital avoidance post is also being proposed within the CAAsT team with close links with the integrated discharge team and CIRH, ART and Community resources. This new post will lead on working with key professionals in A&E to identify individuals who do not need to be admitted and work with all agencies to seek appropriate care and support options. This will be a key post to provide professional Social care assessments of individuals who do not need to be admitted and ensure plans are in place to return home or to an appropriate care setting. Additionally this post will develop reports to understand social reasons for admittance and to identify gaps in provision in the community response. There is potential that this post can also provide liaison support with people admitted from Out of county by liaising with other Local Authorities and agencies.
- Resource from both health and social care teams is being used to ensure there is increased opportunity for discharge home. A NHS bridging team was established in March 2023, as an interim measure, to support reablement and increase capacity. Care support workers (attached to Hospital @ Home) will be employed to support discharge from hospital where Home First do not have capacity available. This bridging team will hold the cases and handover to Home First or most appropriate other service when capacity is available and where reablement is the appropriate pathway.

- Age UK (Scheme 401) have been commissioned to pilot a Hospital to Home Discharge Service providing a facilitative service to support the local health and social care system on discharges (pathway zero). The pilot runs from April–July 2023. Monthly monitoring and an evaluation of the pilot will be undertaken. The first 3-4 weeks were carried out by 2 paid staff, 3 volunteers and have delivered 33 hours of support. It is early in its contract so it is anticipated will grow steadily. The support offered can include low level tasks including food shopping, home and welfare checks and signposting to other agencies.

Planning Requirement (PR5) – Additional discharge funding - An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.

Additional Discharge Funding

Allocation of the Adult Social Care Discharge Fund has been agreed by partners.

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Herefordshire, County of	£950,944	£1,584,907

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Herefordshire and Worcestershire ICB	£1,047,772	£2,221,943
Total ICB Discharge Fund Contribution	£1,047,772	£2,221,943

ASC Discharge funding will be used alongside other BCF funding and other funding from partners to ensure that there is sufficient capacity to meet discharge requirements.

Herefordshire integrated discharge services comprise:

- Home First (rapid response and reablement at home services provided by Hoople Ltd)
- Hillside Care Centre (bed-based residential reablement provided by Hoople Ltd)
- Hospital @ Home (provided by WVT)
- Ledbury Intermediate Care Unit (bed-based short-term nursing provided by Shaw Healthcare Limited)
- Integrated Discharge Team (multi-disciplinary discharge team with staff from WVT and Herefordshire Council)
- Care Act Assessment Team (CAAsT) (Herefordshire Council social workers focussed on discharge)
- Herefordshire council All Age Commissioners
- D2A therapy (therapy across all discharge settings provided by WVT)
- Voluntary sector services (provided by Age Concern and through Talk Community)
- Short-term nursing and residential beds contracted and spot-purchased from a number of Herefordshire providers
- Home care placements spot-purchased from a number of Herefordshire providers

Herefordshire has recently incepted an Integrated Discharge Board for local system partners to work together for sustainable improvement for patients and to draw planning and delivery of all discharge services into a single board with representation from all relevant local partners.

The Board has four strategic aims:

1. Increase the number of people receiving rehabilitation and recovery services after an acute hospital admission, increasing people's functional outcomes and ability to remain independent at home.
2. Decrease the need for long-term care by decreasing need.
3. Reduce length of stay and bed days lost by decreasing the number of people staying in an acute hospital who should be at home or in more appropriate community bed-based care.
4. Provide an integrated system approach to the development of new models of care to address challenges within the current model.

The Integrated Discharge Board will lead the review of the service model for discharge. In June 2023, a One Herefordshire Partnership strategy forum will focus on understanding the issues in home care, followed by inaugural further meeting of the Integrated Discharge Board and an integrated discharge service model workshop. The new service model and pathways should be more effective and should reduce the current reliance on spot-purchasing short-term care in the local market, improving both outcomes for service users and financial sustainability. A workshop is scheduled for 19th June 2023, with an intended revised service model agreed by the end of June 2023. Transition to the new model will commence in July 2023 and it is anticipated it will take a few months to embed.

Capacity and Demand

Demand and capacity planning is based on previous patterns of activity adjusted for projected local population growth and demographic change.

Demand, expressed as number of discharges from acute beds, is assumed to be stable, neither increasing nor decreasing appreciably in the planning period, reflecting the system's current focus on improving discharge services. Once the improvements in discharge services are embedded then the system may be able to shift focus to admission prevention, but this is unlikely to have a significant impact until much later in the planning period.

Capacity is based on the current service model; the reorganisation described above should see changes in capacity requirements, with use of some services increasing and use of some services, particularly spot-purchased care, decreasing; however, as with any transformation it will take a little time for the results to be seen and transition to new ways of working to be effected.

Analysis of discharge activity across 12 months has identified a number of learning points:

Referrals and Assessments

- 20% of pathway assessments need no further support upon discharge, suggesting risk-averse behaviour in initial discharge planning and referral to the integrated discharge service
- 52% of pathway assessments are assessed as needing reablement or rehabilitation at home
- 28% of pathway assessments are assessed as needing short-term residential or nursing care. In part, this very high proportion of patients moving to bedded care will be due to Herefordshire's demography, but it also suggests an over-reliance on bedded care in the integrated discharge model and is a key area for further analysis.

- 32% of patients assessed as requiring reablement or rehabilitation at home are subsequently discharged by the Home First team as needing no further support, suggesting an over-prescription of care and a disparity between the assessment model used at discharge and the assessment model used by Home First.

- 25% of patients assessed as requiring reablement or rehabilitation are referred to other services due to lack of capacity in the Home First service. Increasing the capacity in Home First through recruitment and improvements in productivity is a key priority of the Integrated Discharge Board. Resolving this capacity issue will reduce or remove completely the need to purchase short-term care in the homecare care market. As an interim measure a bridging team is being provided by Wye Valley Trust NHS to pick up the excess demand. The plan to reduce the capacity gap is to increase both staffing numbers and productivity in the Home First service. The recruitment aspect of this plan has been in place throughout 22/23 and the service is approaching full establishment of reablement workers.

Discharge Services Provided

- 52% of service users received reablement or rehabilitation at home
- 18% of service users received short-term residential home care
- 29% of service users received short-term nursing home care
- The average length of stay in discharge services is 39 days, but there are a number of service users with very short and very long lengths of stay

Discharge Destination

After receiving short term discharge services:

- 23% of service users need no further long-term service

- 11% of service users are readmitted to hospital
- 19% of service users go on to a local authority funded long-term placement
- 4% of service users go on to an NHS funded placement
- 22% of service users fund their own long-term placement
- 6% of service users pass away while receiving discharge services

The Herefordshire system can experience difficulty in finding long-term placements in the care market, especially for more complex needs. This can lead to delays in moving on service users from their short-term discharge service and cause 'silting-up' of the discharge system.

Re-commissioning the integrated discharge service model to reduce the need for short-term placements in the market will release some capacity for long-term placements; but the difficulty in recruiting care workers in the local labour market, and a strong self-funder market for care will continue to present challenges to increasing the capacity for local authority or NHS funded care at sustainable prices.

3. National Condition 3: Objective 2 – Provide the right care in the right place at the right time

Planning Requirement (PR6) –A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time

We will continue ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the government's hospital discharge and community support guidance.

A number of actions continue to support recruitment and retention of staff. Additional staff have been recruited to the CAAsT responsible for assessing all patients who have been discharged under D2A to pathways 1 2 and 3.

Ward discharge coordinators are now in place at the acute hospital to support the Multi-Disciplinary clinical teams' decision making with a focus on Pathway 0; this team are part of our Integrated Discharge Team which comprises health and social care staff working as one team. Where the patient requires additional support on discharge, an assessment of need is undertaken to identify the most discharge appropriate pathway.

Joint roles allow for timely escalation regarding delays and immediate action required. Utilisation of commissioned services in Pathway 1 is a priority along increasing provision by with the voluntary sector.

Other systems responses:

- Additional block discharge provision for discharge to assess domiciliary care.
- Additional funding to fund 12 beds in nursing and residential settings to provide for Pathway 3
- Provision of spot beds as over flow.
- 24 hour Integrated urgent care response currently in the planning stages.
- System calls in place for both in and out of county actions regarding delays.

Short term block purchased beds pilot

The Council set up 12 short term block purchased D2A beds from January – 31 March 2023. This has been extended until June 2023 in a bid to support the local system. It has been well utilised at over 95% and supported discharges during the peak winter pressures. On the back of the above pilot the council are going out to tender in early summer 2023 for a long term block beds service which will take referrals from the community and D2A. This will enable greater capacity and control over provision as well as reducing costs compared to spot-purchased beds.

Herefordshire and Worcestershire is developing a joint contract between Herefordshire council, Worcestershire council and Herefordshire and Worcestershire ICB for residential and nursing care home placements. This will provide a collaborative approach, consistency and revised specifications including for

complex care. It should also give greater control over spot purchase fees. The new joint contract should be in place in by early 2024.

Herefordshire Council is embarking on an ambitious transformation programme for social care and community services and is actively exploring alternative models of care and support. These options include:

- Consideration of council owned provision
- Additional extra care housing
- Supported living transformation programme
- Moving away from traditional bed based residential provision
- Maximising the use of digital and technology to support more people to remain in their homes
- Enhancing the shared lives model to ensure choice, quality and cost effective delivery.

For Home Care these options include:

- Building capacity with providers to develop rounds
- Development of Personal Assistant (PA) provision
- New models of care delivery
- Community support for customers and care staff

Herefordshire Home Care Framework was launched in November 2021 with 11 local providers across 4 locality areas. Due to the increased demand for more capacity in the market from hospital discharges and the community the framework has been re- opened to allow a secondary tier of providers.

Herefordshire Council is taking action on areas to improve market sustainability across home care, D2A and Home first, in order to improve waiting times, capacity and flow, support discharge and support the workforce challenges. The table below sets out our plans:

Commissioning Activity for homecare	Outcomes	Timescales
Engagement with the care at home sector	An engagement forum in now in place. This is enabling the council to expand its capacity and build relationships	November 2022
Workforce challenges	Fee rate of 8.7% applied to domiciliary care market The Herefordshire Cares website (recruitment)	April 1 2023
Secondary Provider framework for Home Care reopens	Additional providers on the framework will increase capacity to deliver homecare and reduce waiting lists and improve capacity and flow.	April 2023
Expanding the Herefordshire Talk Community offer to support people to live in their communities and receive informal support	Linking care at home more with Talk Community, so local residents are aware of the local offer	2022-23
Develop a Shared Living model	Opportunities for vulnerable people to share their homes in return for support and companionship	2023-24
Expand Shared Lives Options	Can provide additional safe and secure homes for vulnerable residents, including older people.	2023-24
Telecare and improving outcomes Improving digital offers	There are plans in place to increase the capacity of models such as Prevention and Predict telecare. This model can support people to remain independent for longer. It focuses on preventative data in the following areas • Falls • Dehydration • Reduce the need of care calls	2023-24

A block purchase arrangement for Discharge to Access (D2A) home care has been operational from April 2022 to May 2023. As part of the review of D2A provision, the council is exploring alternative ways of increasing capacity in areas where there is limited capacity and potential growth with current providers. A block purchase approach is being considered which would go out to tender through the council's procurement portal. In addition to this, as part of the council's transformation plan, a wider review of home care solutions, including geographically based personal assistants and micro providers will be completed during 2023/24.

Shared Lives (Scheme 154) is funded through iBCF and the expansion of the service is a priority of the Council's transformation agenda. Shared Lives Plus has been commissioned to support us with a review of how to take forward expansion opportunities. It will review what is feasible and how much would we need to expand the team to accommodate the new initiatives.

The following are being considered:

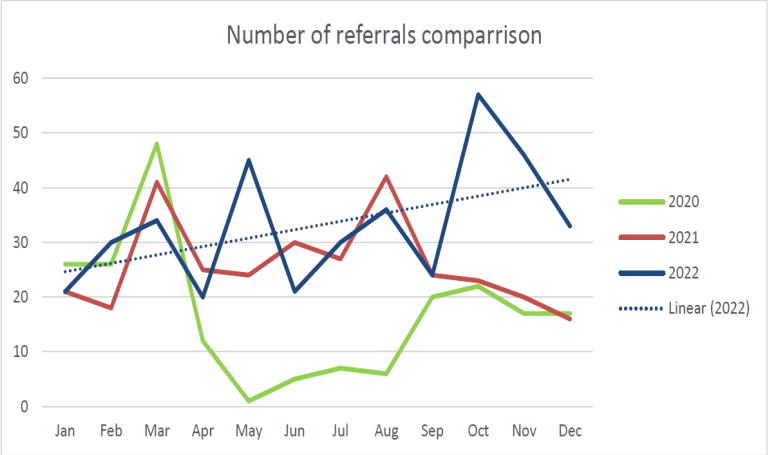
- Home Share, a matching service where an adult can offer accommodation to someone who can offer support and companionship.
- Discharge offer of short term accommodation, for people who need a step down from hospital but are not quite ready to go home.
- Expanding shared lives to people who are 16 plus or parents with a child for short term housing arrangement.
- Day support and care opportunities, including carer breaks.

The **Care Home Clinical Practitioners (CHCP)** (Scheme 156) continue to be funded via iBCF. The CHCPs work within the Integrated Care Division, WVT and in close partnership with Herefordshire Council (HC) Quality Assurance team.

The underpinning work has been guided by HC Quality Assurance and ICB who have identified homes requiring additional support. The team respond to individual provider needs as required and requests referred from the HC QA team. Educational sessions to care homes within Herefordshire are developed to provide training which is underpinned by evidence based, gold standard practice for clinical skills which includes the initial training followed by any assessment of competencies.

- Overriding long term aims are to support home staff within 5 key areas:
- Recognising the deteriorating resident
- Respiratory support
- Slips, trips and falls
- Continence
- Tissue Viability

The **Trusted Assessor** (Scheme 152) model funded via iBCF, continues to be a valued resource in helping to reduce the number of delayed discharges and supporting individuals to be discharged to an appropriate care home. A further aim of the service is to improve the patient experience by reducing unnecessary days spent in hospital and by ensuring that they are accurately placed.



The service received 397 referrals in 2022, a 29% increase from 2021 (308).

Workforce, Recruitment and Retention

Recruitment and retention of the workforce, both within the community wellbeing directorate and also within the wider care sector, is challenging. General workforce shortages, coupled with pay inconsistencies and geographical distance, cause significant challenges.

In the wider sector, there are capacity shortfalls in care homes and particularly in homecare. Retail outlets offer significantly greater hourly rates and more flexibility around working hours. The lack of homecare capacity in particular has led to a significant number of people waiting in the community for commissioned homecare packages and an over-reliance on the reablement provision to cover the shortfall. There is limited new intake into the sector – where there is movement, it tends to be the workforce moving from one provider to another.

The Herefordshire Cares (Scheme 156) website and social media campaign is funded through iBCF. 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. The team are also linking with Skills for Care, local colleges and ICS on system workforce training and requirements.

Establishing a stable and engaged workforce is a key work stream of the council's Transformation plan. Key transformation activity for 2023/24 includes:

- Launch **Community Wellbeing recruitment microsite**
- Develop and implement a **directorate workforce strategy**
- Maximise opportunities to work with the **Integrated Care System** on wider recruitment and retention initiatives in social care and wider and to support multi-agency sector workforce planning
- Design and deliver an **entry level apprenticeship** scheme in the directorate
- Proactive campaign and promotion of **Herefordshire Cares**, including alignment with Talk Community and Integrated Care System.
- Delivery of **training activity to the care sector** (All Age), including carers and PAs, to support retention and high quality workforce

Implementing Care Act Responsibilities

The Health and Care Act 2022 gave the Care Quality Commission (CQC) new regulatory powers to undertake independent assessments of local authorities' delivery of regulated care functions.

Local authorities will be assessed against part one of the Care Act 2014, which has a different set of statutory duties than the Health and Social Care Act, used to assess care providers and integrated care systems.

The CQC local authority assessment framework has been launched and comprises of 9 quality statements mapped across 4 overall themes:

1. How local authorities work with people
2. How local authorities provide support
3. How local authorities ensure safety within the system
4. Leadership

To prepare for the implementation of the CQC Assurance framework, the council has completed a self-assessment (mapped against the framework) and is developing a range of improvement plans. Council officers are part of the ADASS CQC Assurance work group and are taking part in the ADASS readiness review process.

In relation to BCF spend to support the implementation of care act responsibilities, similar to previous years, a number of service areas that fulfil Care Act responsibilities are funded through the BCF. For example, the

Carers Support Contracts, Deprivation of Liberty/AMHP and the advocacy contract. The council's CAAST is part-funded by BCF (£229K).

CAAST (Scheme 52) 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.

The contract to provide a range of advocacy services for adults is via Onside Advocacy (Scheme 151). The provision of adult advocacy promotes individual autonomy, protects against abuse/exploitation, empowers decision-making, supports individuals in understanding their rights, and ensures fair treatment and continuity of care for those who may require additional support in mental health or decision-making processes.

The council has a statutory duty to provide independent advocacy under the Care Act 2014, Mental Health Act 2007, Mental Capacity Act 2005 and the Health and Social Care Act 2012. This requires the provision of;

- Independent Mental Capacity Advocate (IMCA)
- Independent Mental Health Advocate (IMHA)
- Care Act Advocacy
- NHS Complaints Advocacy

The High Impact Change Model (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 HICM has been reviewed and updated.

HICM KEY:
Not yet established - Processes are typically undocumented and driving in an ad hoc reactive manner
Plans in place - Developed a strategy and starting to implement, however processes are inconsistent
Established - Defined and standard processes in pace, repeatedly used, subject to improvement over time
Mature - Processes have been tested across variable conditions over a period of time, evidence of impact beginning to show
Exemplary - fully embedded within the system and outcomes for people reflect this, continual improvement driven by incremental and innovative changes.

The table below provides an overview of Herefordshire's local, joint self-assessment.

High Impact change Model - Herefordshire self assessment and improvement plan

June 2023

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	**Established**	Herefordshire's Integrated Discharge Team continues to facilitate discharge planning. Plans in place to look at the elective pathway from pre-op through to discharge. The Red Bag Scheme is currently not active. Introduction of Ward Discharge Coordinators across 5 wards at the acute hospital is providing opportunities for earlier discharge planning. Improvement programme launched to improve EDD setting across teams to better estimate discharge dates to support teams to prepare for discharge timely. Additional social worker to support the understanding and responsibilities for social care, based with the discharge team. A hospital to home pilot has been introduced with Age UK to support those on pathway zero. This pilot is looking to support earlier discharges.
Change 2: Monitoring and responding to system demand and capacity	**Established**	System partners continue to work together to monitor and respond to system demands. A Point of Prevalence audit took place in September and a demand and capacity dashboard has been developed. Discharge-System partners continue to work together to monitor and respond to demands, however capacity within home care market continues to impact ability to respond to demand in a timely way. System plan in place for a D2A review of model including capacity per pathway (June 2024) and to capture activity through a dashboard. Development of a D2A board. New post to be established based in A&E, making sure the right capacity, right resources, are in the right place to support D2A services and care act compliant. The council developed its market sustainability plan which has focussed on capacity and responding to market changes. It sets out the 2 year plans which include some service redesign of existing care facilities to increase blocked beds and some further dementia beds.
Change 3: Multi-disciplinary working	**Established**	The Integrated Discharge Team continues to develop and evolve. Partners work closely together throughout the Urgent Care Pathway including daily huddle meetings, where patient trackers and progress are discussed. Invested in additional management staff to support social care pathway out of hospital - recruited interim into post.
Change 4: Home First D2A	**Mature**	Wherever possible, people are supported to be assessed in their usual place of residence. The CAAST team, who complete Care Act assessments once people have been discharged, continues to respond to demands. Increased the staffing to facilitate the assessments. 80-85% of all discharges and pathways are assessed by CAAST - investment in our own staff. A new SLA, KPIs is being developed with the existing D2A service and Homefirst.
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. People are safe and having assessments in a timely way.
Change 7: Engagement and Choice	**Mature**	Admission advice and information leaflets are readily available, including web based information. Alternative languages and accessibility options are currently being explored. The council 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. Talk Commuhity Hubs 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**	Care Homes are encouraged to access clinical support via the Community Integrated Response Hub. 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. There are early discussions on developing a provider portal whereby all future integrated information can be brought together on one portal. Information will include high level information from the council, PCNs and WVT.
Change 9: Housing and related services	**Mature**	Referral pathways to Home adaptations, equipment and telecare services are well established and services are delivered promptly. 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.

4. National Condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

Planning Requirement (PR7) - A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution

Planning Requirement (PR8) - Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?

Herefordshire Council is working collaboratively with commissioning partners across the system in order to further develop integrated approaches to commissioning

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.

Falls responder service

The team responded to just under 1000 calls by the end of quarter 4 (2022-23). There were 187 repeat fallers and the last quarter fell to 39 in comparison to 54 the previous quarter which was the lowest quarter of the year. Referrals to the falls responder services continue to be made by all agencies but in the main by adult social care: Falls navigators – 111; Adult social care – 68; GP notification (3rd fall) 47; Telecare 34; Community Integrated Response Hub - 32

Falls Care Navigator service

Performance data shows the service continues to achieve outcomes and it plans to build upon this by undertaking a Predict and Prevent pilot in 2023. During 2022-23 there was a significant reduction in people with repeated falls across a 3, 6 and 9 month period. This equated to ranges of 40-60% in some cases. There was 127 repeat fallers of which 94 took up the offer of a service with the FNS. 100% of all individuals had an active support plan in place and were being supported to achieve their outcomes.

Pilot for Predict and Prevent model

Whilst the Falls Care Navigator (FCN) service yielded some excellent outcomes it works as a reactive service. The council's longer term plans include greater preventative work such as the Predict and Prevent model. This digital software uses monitoring and data to inform the existing falls responders and falls care navigators before falls occur.

The pilot will run for 6 months from April 2023 with the provider of the FCN service. The current service works specifically with repeat fallers and minimises the likelihood of further falls, but would benefit from understanding falls by analysing data much sooner and reducing unnecessary call outs of the falls responding service. This preventative model highlights high risk fallers before they present to services. It is anticipated it will contribute to hospital avoidance and more cost effective delivery.

The Predict & Prevent services use technology to monitor everyday activities such as movement, temperature, night-time activity and eating and drinking habits and using the data captured creates a baseline of each individual service-user's normal pattern of behaviour in their home. When a person's behaviour deviates from that baseline, such as a decrease in movement or reduced fluid intake, it may be an indication of a possible deterioration in health or wellbeing and increased risk of a fall. It is then that the falls team make contact, before the individual falls. With the deviation flagged, alerts can be sent to the team with reports of behaviour and insights into any changes, enabling follow-up interventions to be made quickly by appropriate staff. This

highly personalised approach means that the solution is uniquely appropriate to the individuals needs which enables prolonged independence at home for service users. The pilot will enable commissioners to understand the impacts on hospital avoidance, reduction in A & E admissions and costs to health and social care system

The data generated is key to supporting front-line care resources, allowing them to manage those that need care much more effectively and safely. Firm evidence allows more effective allocation of resources, which ultimately leads to an increase in the number of people that can be cared for without reducing the quality-of-care provision in any way. This pilot is an intervention that promotes the preventative agenda in falls and it is the ambition that this technology will be used by the existing falls team to strengthen the approach taken which focuses on prevention rather than reaction. It is the intention to re-design the exiting care navigator, fall responders to include a greater preventative approach by using digital data.

As part of several of the Predict and Prevent test and learn projects which there is falls equipment being trialled. This will be going live approximately August / September 2023. Some of the falls sensors are wearable but the one currently being looked at provides non-wearable imaging technologies. The non-wearable falls detection system uses radio waves to detect if a fall has occurred, the system will therefore pick up all types of falls and as it is non wearable can be used by anyone. Not only can it alert if the user has had a fall, the system will also provide data that will allow the identification of factors such as reduced mobility which increases the risk of falls allowing interventions to take place before the fall occurs.

Herefordshire council is undertaking a falls review and re-designing services within the pathway during 2023-24. This builds on the work last year undertaken 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.

Hillside

Hillside Care facility is currently fully funded through BCF as a bedded assessment and reablement service. Hillside's current primary function is to support hospital discharges as part of the Herefordshire system agreed D2A model. Additionally when there is capacity community teams can also access bedded reablement for people in the community in order to ensure access to therapy and care which prevents an unnecessary hospital admission or admission to nursing and residential beds where reablement is not readily available.

Hillside has 22 beds and is supported by a team of staff employed by Hoople Care with access to therapy services, medical cover and social work services. People will access this support for a period of up to 6 weeks.

The long term delivery model for the provision at Hillside will be established and approved during 2023/24.

Community commissioning

The community commissioning team manage a portfolio of commissioned services and associated programmes and projects focussing primarily on preventative interventions including; mental wellbeing, S117 provision, dementia, advocacy, suicide prevention, multiple complex vulnerability, high intensity, placement support, supported accommodation, domestic abuse, refugee resettlement, community equipment, technology enabled living, community and cultural services and voluntary sector infrastructure and systems.

Of these services and programmes several directly support discharge from hospital or admission avoidance including the provision of community equipment and technology enabled living whilst others have a more indirect but nonetheless meaningful impact. Indirect services and programmes include community and cultural services, voluntary sector infrastructure, mental wellbeing, dementia and supported accommodation offers for those with multiple complex vulnerabilities.

The programme of work to deliver improved care and support service provision within the adult Supported Living and Community Activities market demonstrates positive progress in terms of the supported living review, market engagement and a new community activities service specification, however further work is needed to deliver a new procurement framework, service improvements and system benefits.

The proposed approach is to bring together two areas of work and build on progress made in 2022 to implement new arrangements for Supported Living and Community Activities by reviewing and retendering services. This will:

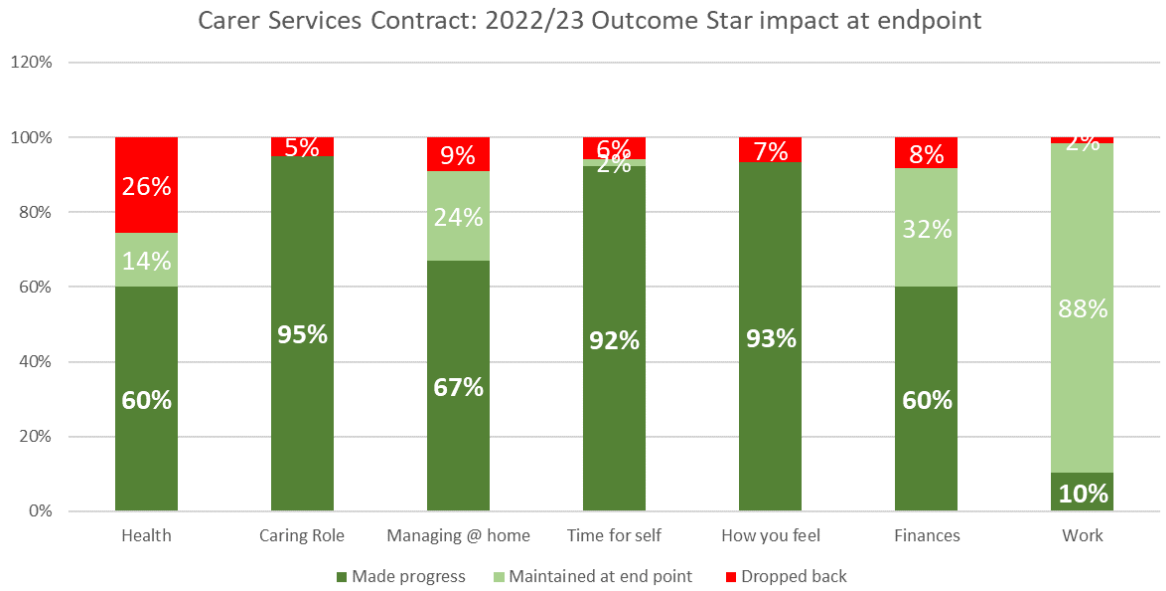
- Provide a strategic approach in line with the Herefordshire Learning Disabilities strategy (2018-28) which sets out a collective ambition to move away from the idea of separate services and fully adopt the principle of supporting people with learning disabilities to successfully integrate, including where they live, where they work and spend their days.
- Ensure new arrangements are fit for purpose in line with customer needs and aspirations, innovation and best practice, sustainability and market stability within resources available.
- Opportunity to plan future needs, demand and capacity within a progression model of support providing increased opportunities for people with a learning disability to lead more independent lives including training, personal skills development, vocational training and paid and voluntary work opportunities which extends beyond the current offer in Herefordshire.
- Make better use of resources with the option of a single flexible framework agreement with new categories (lots) within a 'progression model' aligned with more effective market management. This will provide the opportunity for a more targeted commissioning approach and development of a 'progression model' based on individual needs and helping individuals realise their own potential for progression towards more independence.

Supporting unpaid carers (Scheme 57)

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.

The Council commissions a Carer Services contract. The service worked with over 300 carers in 2022/23 to provide a range of outcome focussed information, advice and support relating to:

Health	Carers journey/experience with managing their own health and the person they care for
Caring Role	How they cope with their caring role
Managing at Home	How they cope with managing the day to day running of their home
Time for yourself	Do carers have enough time to have a break from their caring role
How You Feel	How the carer feels about their caring role and any other aspects of their life that may be affecting them
Finances	How they manage bills, earning, benefits, saving etc.
Work	How they balance the demands of caring, working or training



At end the of the support period, most carers report a positive impact across most outcome areas, above. There does appear to be more to achieve across the sector to support carers achieve good outcomes in relation to work and maintain and improve outcomes in relation to health. It is proposed that these should be areas of focus in the refresh of the Carers Strategy, which will be co-produced with Carers. While the strategy is being developed, it is intended to extend the current contract subject to the Council's governance and contract procurement rules, which will enable a review of the service scope and specification against the strategic priorities to ensure that the service remains fit for purpose over the next years.

The ICB continue to support carer's breaks through the BCF 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.

St. Michael's Hospice Carers Support (£261,345K) provides an integrated hospice at home service model for high-quality end of life and palliative care for people identified at end of life. The model provides planned day and planned night care services along with an urgent care service across a 24/7 period: 365 days a year. This is underpinned by clinical care coordination where patients and family's needs will be assessed, and care planned on an individual basis with on-going case management. The hospice at home clinical care coordination function will support development of an electronic end of life care plan and a palliative care register.

Acorns Childrens Hospice (£32,154K) provides planned and emergency respite care for babies, children and young people up to 18 years of age who have a life limiting, life threatening or end of life care needs. Approximately 20 babies, children and young people annually receive support. In addition to inpatient care an outreach service enables support to be provided to families in their own home, working with parents, the patient and siblings to live with the challenges of terminal illness. Transition support to enable a phased and personalised approach to accessing adult services commences at age 16yrs and builds on local community services, family strengths and adult hospice care to facilitate this stage of the young person's life journey.

Transforming the offer for carers, including respite provision and the development of an All Age Carers strategy is a key priority within the council's Transformation strategy and significant progress will be achieved during 2023/24.

(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.

Putting communities at the heart of all that we do

We recognise that that our communities have a vital role in improving health and wellbeing, where the solutions to health problems are not solely about the provision of formal health and care services. A cornerstone of the programme is our Talk Community Hubs which are located across Herefordshire and provide a safe place where people can access up to date wellbeing information and signposting to local and national resources. They also connect people to services, groups and activities, either within the local area or across the county, which can help them support their own wellbeing and independence.

Super hubs

Building on the success of the Talk Community model, capital funding is available to enable our hubs provide a 'one stop shop'. With an all ages approach to support local residents to access services within their local communities. Community led and driven with a focus on individual community need, allowing communities to design, own and deliver a Super Hub that meets the needs of their community.

5. Metrics

Planning Requirement (PR9) - Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?

System partners are working together to ensure that robust metrics are in place; and continues to work collaboratively to maintain performance in each area. The responsibility to monitor performance will be moving to the Integrated Care Executive (ICE) therefore looking to examine performance against metrics throughout the year. ICE will consider and agree local metrics, for example, falls outcomes and incidence, D2A capacity is fully utilised and meets Length of Stay targets, expenditure/impact of DFGs.

Metric	Detail
Admissions to residential care homes	Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.
Avoidable admissions to hospital	Unplanned hospitalisation for chronic ambulatory care sensitive conditions.
Falls	Emergency Hospital Admissions due to falls in people over 65.
Discharge to usual place of residence	Improving the proportion of people discharged home, based on data on discharge to their usual place of residence.
Reablement/Rehabilitation	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

Appendix 1: Planning template

Appendix 2: Demand and Capacity template

Appendix 3: ICB Discharge Funding Template