Item 4- Appendix 1

1. Hertfordshire's Better Care Fund plan for 2019-20

For the BCF 2019-2020 submission, NHS England have requested that Hertfordshire provide the following information:

- Strategic Narrative on Integration priorities. These are exam style questions and our main opportunity to evidence how we will continue to integrate services over 2019/2020. There are 4 questions in total and each focus on a specific subject area including:
    - Integrating care around the person
    - Integrating services at a Health and Wellbeing Board (HWB) level
    - Integrating with wider services (housing)
    - Integrating at a system level
- Narrative outlining our approach towards embedding the High Impact Change Model and tackling current performance issues
- Income and expenditure for the 2019/2020 financial year
- HWB plans for meeting performance metrics

The sections below outline Hertfordshire's response to these questions. Please note for the strategic narrative section NHSE has imposed wordcounts on answers. Answers mainly relate to the work Hertfordshire is doing.

The Health and Wellbeing board should note that these plans are subject to national approval and regional assurance by NHSE and other departments. Approval letters giving formal permission to spend (CCG minimum) are due to be released the week commencing 18th November 2019.

At the time this report was submitted to the HWB (25th September 2019) the plan was also due to go through other CCG boards for sign off.

2. Section one: Hertfordshire 2019-2020 Better Care Fund Plan- Strategic Narrative

Please outline your approach towards the integration of health and social care:

When providing your responses to the below sections please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

2.1 Your approach to integrating care around the person

A key success measure for health and social care integration must be the extent to which patients and service users experience more joined-up care and feel able to exercise choice and control. In line with the NHS Long Term Plan's ambition that *'people will get more control over their own health and more personalised care when they need it'*, Hertfordshire's BCF plan for 2019/20 maintains its focus on the on the seven 'I 'statements for person-centred co-ordinated care (Social Care Institute for Excellence 2017), which place the experience of the service user at the heart of what we are trying to achieve.[1]

[1] See Appendix 1

2.1.1 Tools to support person-centred care

A strategic focus for the Hertfordshire system- The Herts and West Essex STP Personalised Care Programme aims to improve patient experience by offering new opportunities for choice and control over health and social care needs. One key achievement has been the development of '*My plan'* a patient held document which has been co-produced by professionals, service users and carers to support person-centred conversations.

For 2019/2020, '*My plan'* will be adopted in a phased roll out by multi-agency teams including patients with Frailty and Dementia. It is intended that this will also be available for frequent attenders in A&E to help prevent unnecessary admissions.

The personalised care programme is driving work to increase the availability of Personal Health Budgets (PHBs) within Hertfordshire. PHBs are now available in Mental Health, Transforming Care, Personal Wheelchair Budgets, Children's Continuing Care and Education, Health and Care plans. Work is underway with providers and commissioners to develop further PHBs, with anticipated new offers being piloted by March 2020. With support from NHS England progress is also being made to develop a default offer to all CHC eligible patients receiving packages of care in their own home, with an aim of being fully compliant in this by the end of April 2020.

In 2019/20, the Personalised Care Programme will drive the development of Integrated Personal Budgets, bringing together social care Direct Payments and PHBs to better support people with complex health and social needs. This should also provide them with greater control over the care they receive. As part of this work, there will be an additional focus on points of transition between social care and health and how joint-funding and PHBs could better support this cohort. Work is underway to identify solutions to improving processes and expediting payments through the development of a PHB hub.

The importance of self-management and prevention also underpins the STP approach to Frailty. The STP Frailty programme has three key themes, identification, management in the community and management in the acute. Over the course of 2019/20, this workstream will design the means through which those most at risk can be identified and supported across all services. Standardised approaches and pathways will be signed off by all relevant organisations and operationalised through the emerging Primary Care Networks (PCNs) and locality structures. Frailty awareness sessions will also be delivered across providers including social care, mental health, primary care, hospices and care homes, to provide consistent messages to all involved in person centred care.

2.1.2 Resources to support person centred care and prevention

Hertfordshire continues to develop and invest in processes that enable our staff and practitioners to support patients as a whole-system. Ever since the first BCF plan, Hertfordshire has invested in a Multi-Speciality Team (MST) approach which enables professionals to come together to assess and deliver action plans with the person at the centre. Since 2017, MSTs have been rolled out across acute and community settings. Our Integrated Discharge Teams at both major acute hospitals bring together Discharge Planning Nurses, social workers and voluntary and community support services to better support people leaving hospital in a safe and timely way. Our community teams, including nurses, physiotherapists, mental health nurses and social workers regularly come together to support GPs in reducing acute admissions and provide proactive, multi-agency case management. For both CCGs the ambition is to align community teams with the development of PCNs and move towards an integrated Multi-Disciplinary Team (MDT) model which will expand beyond frailty to include frequent attendees or people faced with homelessness/drug and alcohol addiction.

In 2018/19, a system-wide piece of analysis, undertaken by Newton Europe identified that coordinated support across health and social care would enable more patients to be supported in the most appropriate setting. The study also demonstrated that this approach would improve patients' outcomes and ability to manage their own care. These findings have informed our thinking around the development of Discharge to Assess (D2A) in Hertfordshire and explicitly how we coordinate health and social care support to maximise individual's recovery and independence.

For the STP D2A programme team board, priorities for 2019/2020 include standardising D2A pathways and ensuring that models designed in each locality are holistic, prioritise prevention, recovery, and integrated working; making full use of all sectors via local operational groups. An additional key priority for the D2A programme is that any model agreed needs to work for discharge from the acute, as well as, step up from the community.

Furthermore, Hertfordshire has invested in an Enablement Occupational Therapy Team to work with care providers and to complement health Occupational Therapists and Physio Therapists. In 2019/2020, this service will upskill bed-based settings to ensure the care provided is enabling and successfully supports the transition from hospital to home. There are also plans to explore technological solutions to enable independence, as well as focusing on enabling those with more complex and/or cognitive needs.

The ACS Connect Gateway programme is also is exploring a whole range of activities to prevent, delay or reduce need for social care and enable independence. This includes service delivery, commissioning of preventative/enablement services and developing partnerships to deliver more effective prevention. They plan to use a multiagency and integrated approach to deliver some of these outcomes which include:

- Linking access to social care with access to integrated locality teams and frailty pathways to ensure people only tell their story once and receive a co-ordinated response
- Ensuring the roles of ACS Occupational Therapists and NHS therapists are complimentary to one another, particularly around intermediate care, enablement, Prevention of Admission and D2A pathways, to help people reach their optimum level of independence
- Exploring how the ACS information and advice offer and commissioned voluntary sector services can be integrated with the social prescribing offer to support a "no wrong door principle" in information and advice services
- Providing more timely access to equipment and housing adaptations to enable people to stay in their own homes for longer and reduce the risk of falls
- Exploring Assistive Technology solutions and their role in identifying those at risk of a deterioration in health

2.1.3 Delivering positive health outcomes

In comparison to other areas of England, Hertfordshire compares quite well with health inequalities at macro level, but there are significant pockets of inequality and unwarranted variation in primary care outcomes. Rates for smoking and obesity are lower than the national average. Life expectancy is also improving, although continues to be higher for women than men. Within the county principle causes of death include heart disease, stroke, dementia, Alzheimer's, cancer, and respiratory diseases.[2] These conditions are also principal causes of disability and ill health. It is recognised that there is a growing number of Older People living in Hertfordshire with a physical or learning disability and increasing rates of multimorbidity.

In our 2019/2020 BCF plan, Hertfordshire will continue to address health inequalities and work to ensure that people have the most positive health outcomes. We are continuing to produce population statistics, Joint Strategic Needs Assessments and are also working to deliver a Population Health Management Approach. This will focus on stratifying and segmenting the population by risk, disease severity, disability, care need, and outcome. This data will enable us to focus on cohorts who:

a) cost the system most and have most need for care

b) those whose severity is escalating preventatively to improve health and quality of life outcomes.

This approach will enable, at an individual and cohort level, clinicians and care managers to personalise interventions and care packages to need. At a population level, it will provide data analysis to better design and commission services by population cohort.

All integration projects will continue to have an Equalities Quality Impact Assessment (EQIAs), to ensure they do not discriminate against the disadvantaged or vulnerable. In 2019/2020 a new Project Manager has been recruited to join the BCF Integration Team and will be focusing on reviewing integrated pathways including Frailty, Dementia, Housing, Long-term conditions and Prevention of Admission, to ensure they can be accessed by people living with a Physical or Learning disability. Another area of focus for this role will be on Deprivation of Liberty preparation and LD nursing, as well as looking at how we can develop plans to improve outcomes from the Learning Disabilities Mortality Review (LeDeR).

2.2 Hertfordshire's approach to integrating services at a HWB level (and neighbourhood where applicable)

2.2.1 Integrated commissioning priorities

Hertfordshire has a strong Health and Wellbeing Board (HWB). Through its HWB Strategy and system leadership it provides, the Board continues to influence the strategic direction for the commissioning of services that relate to the health and wellbeing of the population. In 2019/20 the HWB will work closely with STP colleagues to establish its role in relation to the development of Integrated Care systems (ICS) and Integrated Care Partnership (ICP) arrangements, clarifying what services and functions are best delivered and at what scale.

Collaborative and joint commissioning is established in Hertfordshire with the Council and CCGs securing partnership agreements and joint contracts (i.e. Nursing care beds). Mental Health, Learning Disability and CAMHs are jointly commissioned by the Council and the CCGs and 2019/20 will also see further progress in how the Council and the CCGs work together in the commissioning of Children's Services and some public health interventions.

[2]Taken from the 'Health and Wellbeing section' of the 'Community Profile for Hertfordshire' http://atlas.hertslis.org/profiles/profile?profileId=280&geoTypeId=16&geoIds=E10000015#

To enhance care in care homes, joint training and health campaigns, including a falls campaign for home care and care homes, have been jointly commissioned through *Hertfordshire Care Providers Association* (HCPA). These are delivered across Hertfordshire and require close working arrangements with both CCG's in order to target where the interventions will have the biggest impact.

Plans are underway to increase the level of integrated commissioning between health and social care partners. One priority for 2019/20 in East and North Herts (ENH) is to develop a partnership agreement and legal framework for Continuing Health Care between HCC and ENHCCG that can operate from April 2020. Furthermore, a joint Nursing and Care Home specification is being developed which subject to approval will see the Local Authority and ENHCCG jointly contracting for standard nursing care from April 2020. From October 2019, Adult Community Health Services in the Herts Valleys area will be provided by Central London Community Healthcare. The Council and Herts Valleys (HV) CCG have worked closely together to ensure that integration is a priority within this contract and have identified a programme of work to ensure better connection and joint working between all community teams. In ENH, the Council, HPFT and HCT are evaluating its Integrated Care Service, with a view to exploring further opportunities for integrating services to meet the demands of the frail and elderly population.

Through our continued partnership working with HPFT our focus for 2019/2020 will be delivering a CAMHS Transformation Plan, a new joint Learning Disability strategy and plan for delivering Mental health and learning disability aspects of the NHS Long Term Plan.

2.2.2 Locality development and PCNs

A major development since the 2017/2019 BCF plan has been the development and evolution of PCNs and Local Delivery Boards. Each CCG area has a Local Delivery Board which is focusing on using a place-based approach to deliver care. These boards encourage strategic leaders from across the system to identify local priorities and action plans needed to transform services to meet these needs.

A recent focus across all Delivery Boards has been aligning with PCNs. In Herts Valleys, PCNs have been instrumental in the development of ambitious, multi-agency locality plans, identifying shared priorities across different statutory organisations. These include developing the locality approach to multi-disciplinary teams, with a particular focus on maintaining a person-centred approach for people with complex needs, including Frailty. In ENH there is ongoing work with the CCG to specify activities to be completed by PCNs. Projects have also been planned by the Integrated Care Delivery Boards. For example, memory cafes are being implemented across multiple localities, which provides a safe space for people concerned about their memory/carers concerned about their loved ones developing dementia. There are also plans to extend MDT Frailty Clinics following a successful pilot in Letchworth.

2.2.3 Integration with the Voluntary Sector

Hertfordshire benefits from a vibrant and engaged voluntary and community sector. They sit at the heart of the county wide Hospital and Community Navigator Service (HCNS). This service works across hospital sites and in the community and delivers social prescribing services to support services users on discharge from hospital and enable them to access wider services.

For 2019/2020 we will continue to focus on making social prescribing and community-based support 'business as usual'.[3] This includes expanding the 'social prescribing' model to incorporate the NHSE PCN Social Prescribing Link Worker roles via a third sector organisation, to reduce, delay or prevent the need for further health and social care intervention with additional support from Delivery boards.

Plans are underway to use feedback from social prescribers to identify gaps in VCS provision, which may relate to type of service or location. This intelligence will be used to stimulate appropriate new services.

To further align with the Voluntary Sector, the HWB has recommended that its membership extends to the Hertfordshire Compact Steering Group, to ensure the voluntary sector voice is included in strategic decision making and plans.

2.3 Your approach to integration with wider services e.g. housing

Hertfordshire's approach to integration recognises the role played by partners and wider services, outside of the health and social care organisations. Hertfordshire has 10 District/Borough councils whose services have a direct impact on the health and wellbeing of the Hertfordshire population. Both CCGs and the County Council have regular interactions with the Districts/Boroughs. During 2019/20 further work is required to understand how best to involve these key partners (and their wider network of stakeholders) in STP developments, specifically the development of ICPs and locality working.

A key area of overlap with the District/Boroughs is housing. The Adult Care Services' 3-year plan sets out an ambition to develop 3000+ units of supported accommodation and to support more people to live in mainstream housing by 2021.[4] Adult Care Directors at Hertfordshire County Council, chair Strategic Supported Accommodation Boards with each of the Districts/Boroughs and the Director of Adult Services co-chairs the Hertfordshire Strategic Supported Accommodation Board. These boards discuss local housing issues for adults with care and support needs, including older people and have a number of individual projects and workstreams which are leading to improve outcomes for people with disabilities or age-related conditions. Some recent examples include:

- The provision of six new-built fully accessible wheelchair flats though the Council's developer arm as part of a wider housing development
- Four move-on accommodation flats developed by the borough council for adults with learning disabilities approaching independent living
- A memorandum of understanding to help adults with disabilities into general needs housing more easily
- A new extra care housing development strategy to improve care and health outcomes. This will also help with pressures on the wider housing market, increasing affordable housing options for older people approaching retirement.

There is also joint working taking place between the County Council and Stevenage Borough Council in developing a joint Older Persons' Housing Strategy.

Additional Winter Monies, included through the BCF, have also been allocated via a working group of the County and District councils to support the hospital Community Navigators to

[3] 'Introduction, Social prescribing and Community-based support summary guide' Page 4, https://www.england.nhs.uk/wp-content/uploads/2019/01/social-prescribing-community-based-support-summary-guide.pdf

[4] 'Valuing Independence', Hertfordshire Adult Care Services 3 year plan, Page 5, https://www.hertfordshire.gov.uk/media-library/documents/adult-social-services/acs-3-year-plan.pdf

deliver specifically housing related services to people coming out of hospital to aid reablement and swift discharge back home.

Further work is required in 2019/20 to consider how Hertfordshire works with housing authorities and the local Home Improvement Agency to consider the provision of information and advice, particularly around housing issues.

2.3.1 *How* Hertfordshire is using the DFG to support the housing need of people with disabilities or care needs

A significant element of DFG funding is allocated directly to the Hertfordshire Home Improvement Agency (HHIA). 5 of the 10 District Councils within Hertfordshire are affiliated with this service. Work is underway to improve and expand the HHIA following its implementation. The HHIA helps to provide home adaptations, such as stair lifts and access improvements, to Older people and people with disabilities, to help them remain independent at home. It is a service made up of caseworkers, trusted assessors and technical teams who offer information, advice and assistance to service users throughout the process of home adaptation work.

Currently, a review of the Regulatory Reform Order Discretionary Policy is taking place to look at how the services the HHIA delivers could be expanded and how the DFG can be used more creatively. This will look to enhance funding for, and speed of provision of, adaptations for those with acute needs e.g. disabilities acquired as a result of accidents. It will sit alongside a new Framework for Contractors, which will remove the need for a lengthy tender process for some of the simpler adaptations (e.g. ramps), ensuring that the pathway for DFGs is quicker and smoother.

The pathway for both application, approval and completion of DFG works is also under review, with a clear focus on the reducing the time it takes to undertake DFG works. It is anticipated that this will enable greater focus on the ability to meet the needs of those requiring adaptations as part of a hospital discharge package, for example, stair lifts or ramping.

Hertfordshire is also working with technology providers to trial and pilot how assistive technology can be used to support vulnerable service users and improve their outcomes. Work will take place across the CCGs and HCC in 2019/20 to consider opportunities and priority areas for such investment and how this can help deliver a joined-up and integrated experience for the patient/service user.

2.4 How Hertfordshire's' approach to integration aligns at a system level

2.4.1 How the BCF plan and other plans align to the wider integration landscape

In April 2019, Hertfordshire and West Essex STP released its integrated Health and Care Strategy for a Healthier Future. The strategy is built around the principles of population health management and promotes the need to target collective resources where they will have the greatest impact, improving the quality of care through improved and affordable services. Its key priorities include:

- Meeting people's health and social care needs in a joined up way in their local neighbourhoods
- Prioritising those with the highest levels of need, reducing the variations in care
- Placing equal value and emphasis on people's mental and physical health and wellbeing

The BCF plan aligns with these priorities and see them as important areas of focus. The strategy also outlines how we will need to ensure that we have the workforce, technology, contracting and payment mechanisms in place to deliver health and care efficiently across organisational boundaries. Recently the STP released its Health and Social Care workforce strategy for 2019 which recognises how in order to deliver high quality, person centred and proactive care, there needs to be a clear focus on the health and social care workforce. The strategy will act as a guideline for the STP and organisations within it to support and develop its workforce.

This BCF plan fully aligns with the STP priorities and supports the latest thinking and developments around the ICS and the ICP. Our BCF vision incorporates the 'challenges' of the **Sustainability and Transformation Plan,** which will improve care delivery for Hertfordshire residents over the next five years. The STP focuses on four key challenges:

1. Living well and preventing ill-health
2. Transforming primary and community services
3. Improving urgent and hospital services
4. Providing health and care more efficiently and effectively

Many of the programmes and projects advanced by the STP either originated from BCF-funded activity or are managed and supported by the BCF-funded Integrated Care Programme Team. This helps to ensure that the BCF is supporting system priorities but also that integration between health and social care sits at the heart of STP activity. Specific areas of overlap between the BCF and the STP include the personalised care workstream, Frailty, Technology and D2A.

Priorities for Personalised Care, Frailty and D2A services have been referenced elsewhere in the plan. For the Technology workstream, four key programmes of work have been identified to meet the national requirements of the NHS Long Term plan. Objectives for these programmes are outlined below:

- Interoperability: Improving the sharing of data across health and social care settings and enabling professionals to access patient records wherever they are
- Urgent Care: Implementation an Urgent Care Dashboard that displays live, automatic, integrated hospital and social care activity to support system resilience across the STP.
- Primary Care: Developing digital solutions for primary care
- Long Term Plan – Citizen Focus: Creating technological platforms that allow citizens to manage their own health and wellbeing and access the right information

Our BCF plan has a number of priorities that support the Technology Programme's objectives. One example is the development of a Medical Interoperability Gateway (MIG) solution. This tool presents key primary care data directly into the contextual view of the social care information system, matching the service user to their GP record to display a combination of health and social care data in a single setting to support more effective data sharing and support development of a Shared Care Record. Another priority in our 2019/2020 plan is continuing to develop and imbed a new Urgent Care Dashboard, through Transforming Systems SHREWD software. This displays real-time data from all operational partners across the STP to demonstrate pressures across the system, enabling more meaningful day to day operational decisions to be made. Since implementing the system, the data displaying in SHREWD continues to gain confidence and is being configured within each locality. It is expected this dashboard and the accompanying Escalation indicators will be fully operational across the STP in time for this year's winter pressures.

Alongside the Integrated Health and Care Strategy, we have ensured that the BCF plan aligns with specific organisational priorities and goals and that integration, in turn, features within their own strategic planning. Our BCF plan brings together national, local and adult care specific strategies where health and social care integration is necessary for service transformation (click here for more information- please note some of these strategies are due to be refreshed).

A number of additional strategies and work programmes have also developed since the previous plan was submitted, including the Adult Services 15-year plan. This has 4 strategic ambitions, Information and Advice, Community First, Valuing independence and Caring well, each of which is underpinned by integration priorities across health and care services but also predicated on wider integration with local communities and providers.

The plan specifically identifies its ambitions for integration, noting that in 5 years' time, the County Council aspires to:

- Being fully integrated with partners, allowing individuals to access their health and care records
- Have a joined up approach to information and advice which fits seamlessly with partners
- Be fully joined up with health services to tailor support that will support people to get well and prevent readmission to hospital

We will continue to ensure our BCF priorities support these aspirations over the 2019/2020 year.

2.4.2 Integrated Care System Arrangements

Currently the Herts and West Essex system is in the process of developing its 5-year plan. Work is also underway to support the health and social care system towards shadow ICS and ICP arrangements from April 2020. The membership of the Health and Wellbeing Board has recently been updated to include the STP's independent chair as a member and may be revised again later in 2019/20 following the appointment of a single Accountable Officer for the three CCGs and the development of single CCG executive management structure.

The specific role of local government (both County and District/Borough Councils) in these arrangements and in the development of the ICPs is still to be determined. The County Council is fully involved in these conversations and is considering how best to represent all its diverse functions (Adult Services, Children's Services and Public Health services) in the future arrangements. The leadership of the Herts and West Essex STP is currently shared between the Director of Adult Social Services and the Chief Executive of East and North Hertfordshire CCG, providing a visible example of joined up thinking and planning across the system.

2.4.3 Joint governance arrangements for the BCF plan

Governance of the BCF for 2019-20 will use the same mechanisms developed in the previous plan. Performance of individual projects will be monitored within respective project groups which in turn report into relevant CCG programme boards and/or the Adult Care Services Management Board. This is also an escalation procedure for identifying and addressing underperforming schemes. If required, performance monitoring of significant decisions regarding service design or operation may be escalated to CCG-HCC Strategic Partnership Boards (previously known as Joint Executive Boards).

The BCF Plan is also supported by the Section 75 agreement which outlines the legal risk management and risk sharing arrangements between HCC and the CCGs for the pooled funds. The current Section 75 agreement was sealed in April 2019.

Keeping the patient at the centre of everything Hertfordshire does is reflective of the person-centred joined up care framework that forms this Plan's vision. Priorities have been shaped by BCF engagement events used to inform previous BCF Plans, as well as existing health and care plans based on patient and carer engagement such as the STP, HV's Your Care Your Future, and the Health and Wellbeing Board Strategy. Hertfordshire Healthwatch is also a key member of the HWB. Within Hertfordshire, there is a strong commitment to strategic co-production and a recent review has resulted in the development of a number of new boards which aim to enable service users and carers a direct channel to voice their views and take part in key strategic and commissioning decisions. The personalised care programme has also established an All Age Personalisation co-production group. This is a group which covers Herts and West Essex (STP) who co-produce innovative and effective solutions to improve people's experiences of services and focus on making care more personalised. The group has worked on a number of projects which link to the BCF such as 'My plan' across Herts Valleys and East and North Herts and is also working to look at how to improve the personal budget process.

3 Hertfordshire 2019-2020 Better Care Fund plan: High Impact Change Model

Explain your priorities for embedding elements of the HICM for managing transfers of care locally:

Since the 2017/2019 submission there have been significant developments in progressing the High Impact Change Model. Systems to Monitor Patient flow has moved from 'plans being in place' to becoming well established and MSTs, Trusted assessors and enhancing health in care homes schemes have become Mature. The table below displays where we currently are in September 2019.

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020
Chg 1	Early discharge planning	Established	Established
Chg 2	Systems to monitor patient flow	Established	Established
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature	Mature
Chg 4	Home first / discharge to assess	Established	Established
Chg 5	Seven-day service	Established	Established

Chg 6	**Trusted assessors**	Mature	Mature
Chg 7	**Focus on choice**	Established	Established
Chg 8	**Enhancing health in care homes**	Mature	Mature

We anticipate that High Impact changes will remain at their current levels of either established or mature by April 2020 and plans are in place tackle current challenges and embed the changes further. Some of these are highlighted below.

3.1 High impact change 1- Early discharge planning

A big challenge facing early discharge planning is the lack of available homecare, therapy provision and residential placements over weekends. This has led to delayed discharges and has had an adverse effect on early discharge planning. A Project Group has been set up to look at options to address this challenge, in preparation for the winter. One area which has been discussed has been offering providers incentive payments to encourage them to take weekend admissions.

In East and North Hertfordshire, the Discharge Home to Assess initiative has seen the number of referrals increase by 50% through an integrated approach to supporting early discharges with care and therapy at home. One challenge facing early discharge planning has been issues in accessing IT systems. Clinical navigators have been unable to access health systems at Watford Hospital, which has led to delays and reliance on multiple systems in order to understand the patient's journey. A business case is currently awaiting review to tackle this challenge which if approved, would enable clinical navigators more access to the health patient database system.

In preparation for winter a bid has been put forward for more nursing staff within the Integrated Discharge Team (IDT) at Watford hospital. This should alleviate some of the pressure over winter, support prevention and assist with early discharge planning. Further social care and nursing staff have been recruited to support both Lister and Princess Alexandra IDT teams to support swift discharges across all pathways.

In the Acute, Frailty units are being expanded as part of the Integrated Urgent Care (ICU) requirements. This will lead to more comprehensive geriatric assessments being conducted and should help with discharge planning for patients suffering from frailty.

3.2 High impact change 2- Systems to monitor patient flow

Through the integration of our STP Technology and Urgent and Emergency Care workstreams, a bespoke dashboard product, SHREWD, was procured. SHREWD displays live, automatic integrated hospital, social care and community services activity to support system flow to reduce delayed transfers of care and increase efficiencies, filtering by CCG localities and individual metrics. As the SHREWD dashboard continues to be developed, it will replace localised dashboards currently used by individual teams and organisations, with data from these sources often being from the previous day, making "live" operational decisions near impossible. SHREWD will enable operational staff to view system pressures throughout the day, enabling a more proactive rather than reactive response in making key

operational decisions to better manage system pressures. The SHREWD dashboard is on course to be fully operational during winter 19-20. An additional component of SHREWD, Escalation will also be embedded. This will use defined metrics from the SHREWD dashboard to alert key stakeholders across the system when there are changes in system pressures and view what mitigating actions operational leads have (or have not) taken in response to these pressures, to further aid operational teams to anticipate and manage demand across the whole health and social care system and expedite patient flow.

The County Council currently commissions Herts Care Search to support families and professionals to identify where care homes have empty beds. This is currently being reviewed and compared against the NHS Capacity Bed Tracker to understand which system is best to support patient flow.

There is still a high volume of services users who remain on acute beds after 21 days. This has led to negative outcomes for patients due to deconditioning and impacts on system flow. One of the ways we are addressing this is through Long Length of stays reviews. Plans are in place to work with Emergency Care Intensive Support Team (ECIST) at both Lister and Watford General Hospitals as an accelerator site for the new long length of stay review process and coding. A second ECIST supported workshop is taking place in October to continue to explore joint commissioning opportunities for D2A.

3.3 High impact change 3- MDT/MST

There is a challenge, in the Acute Hospitals, to change long established practices and update operating procedures. We are working with our partners and wider stakeholders to embed MDT working, Doctors and Consultants to help them understand the role of the IDT team and ensure early discussions around discharge onto the correct pathway for their care needs.

As identified elsewhere in the submission there has been positive progress in embedding the community navigator service. One current challenge is that community navigators are not always included in existing MDTs and a challenge for 2019/2020 will be ensuring the voluntary sector has a voice. This could lead to a range of benefits including linking lonely people with local services and supporting the housing application process.

The development of PCNs has presented additional challenges for the community navigator service and there have been issues in retaining staff, leaving gaps in staffing. Across the STP a proposal has been developed to integrate the new social prescribing PCNs within the current community navigator set up which is hoped to alleviate some of this pressure. This will be a key priority for 2019/2020. The development of PCNs will also have an impact on MDTs because they will be moving resources from a locality level to PCN level. The STP have developed best practice for MDTs in the community and both CCGs are looking to implement this, working with their health and social care colleagues.

3.4 High impact change 4- Homefirst/D2A (including any changes in the context of commitments to Reablement in the NHS Long Term plan).

Hertfordshire re-ablement and domiciliary care contracts have been designed and commissioned to promote well-being, keep people safe, adopt an enabling approach and support people to live independently for longer. They are pivotal in implementing Discharge to Assess Pathway 1, the prevention agenda and ensuring a home first approach is adopted after a change in circumstance. These services mean people have the opportunity to re-able, recover and/or receive their care in their own homes rather than moving into a residential home, hospital, or other formal care setting.

One of the key challenges facing our home care market is capacity. Hertfordshire County Council is currently in the process of re-commissioning reablement and support at home

services into a single contract across 9 lot areas in the county. Under the new contract the service will operate using a different model, delivering outcomes focused support rather than time and task. It is intended that bringing these services together will develop a clearer pathway, with fewer transfers between services to improve continuity of care and flow between Reablement and Support at Home. Service Providers will also have greater flexibility and control to manage fluctuations in demand to meet assessed needs as defined by the Care Act 2014. It is intended that the new contract will allow more opportunities to develop initiatives from previous contracts to further align health and social care services

Another challenge is workforce and recruitment of staff. The new contract is set to alleviate some of this pressure through developing a robust financial model to aid providers in delivering growth and retention of staff within the care sector which aims to generate market resilience. Furthermore, plans are in place to incentivise staff through other methods such as closer MDT working with health colleague and upskilling/training such as the Physio Support Facilitator Role.

The NHS long term plan outlined a number of priorities for reablement. This included delivering more community and intermediate health care packages to support crisis care, as well as, how extra recovery, reablement and rehab support will wrap around core services to support people with the highest levels of need. Hertfordshire is addressing this challenge through ensuring the new contract is fit for purpose for both discharges from the acute hospital and step up from the community. In 2019/2020 priorities for this work will be to continue to develop a robust integrated offer that can rapidly wraparound people with varying levels of acuity e.g. D2A Pathway 1, Delirium Recovery Pathway, Stroke ESD pathway, Rapid Response, therapy led Specialist Care at Home.

3.5 High impact change 5- Seven day services

One of the biggest challenges we have faced since the original submission has been the lack of whole system approach to 7-day services. Hertfordshire County Councils Integrated Discharge Teams have been operating 7 days a week since February 2017, however other elements of the system are still providing weekend support on a voluntary basis or still operating as 5-day services. Across the system a response is being developed in order to understand how we can improve weekend discharges (as referenced under High Impact Change 1). This will also include extending the Frailty model within the front door of A&E to help prevent unnecessary admissions to hospital.

Internal pressures within trusts including doctor reviews, To Take Out medication (TTOs), discharge letters and lack of acute therapists have also presented a challenge in fully delivering this High Impact change. Key stakeholders are aware of this and are discussing ways to alleviate some of this pressure, such as expanding the acute therapist model at Lister Hospital.

A big challenge in progressing weekend discharges has been lack of availability in home care and residential packages. Discussions have taken place on how to tackle this challenge, for example offering incentives to care providers to take weekend discharges.

3.6 High impact change 6- Trusted Assessors

Although the Trusted Assessor High Impact Change has moved to Mature since 2017, there are still challenges in fully embedding this approach. Within the acute there are still multiple assessments taking place e.g. social care, community support. To address this challenge key stakeholders met to look at opportunities on how we can work towards a more streamlined model in Watford Hospital. It was discussed how we should be working towards a more ward based assessment model and with new community provider Central London Community Healthcare Trust due to take over in October 2019, it is intended that this will enable more trusted assessments to take place.

Furthermore, in 2019/20 we aim to review the number of professionals carrying out trusted assessments into single service. Currently assessments have been undertaken by in reach teams into community hospital beds, impartial assessors into care homes, acute facilitators into enablement care etc which has resulted in a multitude of paperwork. It is anticipated that through reviewing this we will be able to prevent duplication, embed multi-disciplinary working, improve patient flow and prevent the patient from telling their story more than once.

One of the current challenges with the Impartial Assessor Service is the capacity of assessments being completed each day within the acute. We have met with HCPA to set a target of 4 assessments a day and we are undertaking an evaluation of the service to see what challenges the assessors face and what improvements we can make to meet or exceed this target.

3.7 High impact change 7- Focus on Choice

One of the current challenges in embedding this High Impact change is preventing delays for self-funders going into care homes or receiving homecare. Across Lister and Watford there are currently services in place to support self-funders going into care homes/receiving homecare. These services have dedicated staff as a point of contact, who can offer financial advice and work with self-funders to enable safe and efficient discharges. During 2019/2020 the service will look to be embedded fully in current hospitals and we hope to expand the service to Princess Alexandra Hospital through a joint funding arrangement with West Essex CCG.

Balancing the need for safe and efficient discharges against enabling personalised care can be challenging. We are continuing to work on this, one example being through D2A. D2A pathways encourage staff to adopt a holistic approach and take positive risks. Via D2A Pathway 1 and 2 we are able to support service users to maximise their independence and return home or to their usual place of residence which in the majority of cases is their preferred choice.

The homecare contract is currently being recommissioned and changing to be an outcomes focused model rather than a time and task model. This should allow patients to have more choice in the care they receive and increase capacity within the system.

3.8 High impact change 8- High Impact change 8- Enhancing Care in Care Homes (including any changes in the context of commitments to Enhanced Care in Care Homes in the NHS Long Term plan).

Not all our care homes currently hold a secure email which creates delays in hospitals transferring discharge information and presents communication challenges to community and GP staff. A project has been running to deliver NHS mail into all care homes across Hertfordshire. This is due to end in October 2019. For care homes not in the current roll out, resources will be available to enable them to get their own NHS mail account in the future.

Oral health nutrition and hydration has been recognised as one of the priorities for the STP, building on the work of the Hertfordshire Malnutrition Collaboration Group. It is intended that we will be able to develop key standards from learning and guidance from this group, which can be shared with providers, as well as agree what training should go into care homes. Links have also been made with the oral health team in Hertfordshire and training will be delivered by the team through HCPA. To dip or not to dip is also continuing to be rolled out across Hertfordshire aiming to reduce misdiagnosing of Urinary Tract Infections (UTIs).

Community support in care homes (Nursing and GPs) continues to be an area of interest. We continue to fund within the CCGs care home Pharmacist teams. Across Hertfordshire there is the GP aligned scheme which involves weekly ward rounds and linked nurses to each home. In East and North Hertfordshire there is currently an evaluation of the GP and

community support that goes into care homes, building on the GP aligned scheme weekly ward rounds. This includes looking nationally and piloting different ways of working, including a care home MDT, frailty nurses for end of life care and enhanced GP ward rounds. An evaluation is due December with a recommendation for next steps.

One of the key reasons that care home residents end up in hospital are a result of falls. Through the BCF, HCPA have been commissioned to run a campaign focusing on falls prevention. This has included targeting 30 care homes who have a high number of falls to develop action plans and run exercise classes across community and care homes.

4 Hertfordshire 2019-2020 Better Care Fund Plan- Income and Expenditure

For the 2019/2020 submission, all HWB are required to provide information on income and expenditure for the BCF. Unlike previous submission, the 2019/2020 plan requires HWB areas to incorporate iBCF and Winter Pressures grants within the income section, in order to remove duplication and reduce the overall reporting burden. In the expenditure section, we are required to provide a breakdown of various schemes which are being funded through the BCF and indicate whether they impact on BCF metrics on either a High, Medium, Low or NA basis.

Appendices containing this information are to follow.

5 Hertfordshire 2019-2020 Better Care Fund Plan-Performance Metrics

For the 2019/2020 submission, all HWB are required to provide information on Performance Metrics and set out their plans for working towards targets. These have been outlined below:

5.1 Non-elective admissions (General and Acute)

Please set out the plan in the HWB area for reducing NEAs (Non-elective admissions), including any assessment of how the schemes and enabling activity for Health and Social Care integration are expected to impact on metric

Although the target for number of non-elective admissions per 100,000 population has risen to allow for a growing population and greater number of older and frail people, Hertfordshire has exceeded the target number of non-elective admissions since Q4 of 2017-18. Each CCG have developed respective plans to respond to this.

In Herts Valleys, plans for reducing NEAs include the development of Urgent Treatment Centre (UTC) co-located at Watford General Hospital which will act as the first point of contact for most patients. Patients will be triaged via primary care led services in the UTC and will receive treatment where appropriate followed by referral to the most appropriate department/service that can meet their health needs.

A coordinated UTC approach is also being developed at St Albans Minor injuries unit (MIU) which will build on the experience of the same service provided in Hemel Hempstead at the UTC there. In Hertsmere, work is underway with Barnet CCG to facilitate the development of RFL plans to introduce a co-located UTC at Barnet General Hospital. Throughout the country there is evidence that introducing an UTCs co-located with Acute Trusts reduces the pressures on ‘majors’ departments significantly and helps reduce pressures in the Emergency Department overall.

In tandem with the UTC developments Herts Valleys are expanding their demand management scheme ERM (Effective Resource Management) where GP practices and localities generate initiatives aimed at reducing attendances, admissions and high intensity users for their practice/locality. In 2019/2020 they will be extending the scheme to include a broader range of stakeholder providers via an ‘enhanced ERM’ where the development of

PCN and locality delivery plans will bring together more co-ordinated approached to demand management across all areas.

In East and North Hertfordshire, there are a number of ongoing projects in relation to admission avoidance. These include:

- The introduction of a Heart Failure Community Service for the management of complex/unstable heart failure patients in community clinics or through domiciliary visits. This is expected to reduce NEL admissions through more intensive support and patient management for unstable/complex patients.
- The implementation of a revised Integrated Respiratory Service supported by the implementation of a Spirometry Diagnostic service. This should support early identification, correct diagnosis and support admission avoidance for those with respiratory conditions, particularly COPD.
- Developing and embedding revised First Fit seizure and MND, Gastro and Respiratory management pathways to support the prevention of Neurological admissions

A review is also underway in the QEII hospital, to bring the service in line with national standards and guidance for UTCs, following a public engagement process. Patients will be sent to the service via 111 where possible and will receive treatment where appropriate. This will be followed by a referral to the most appropriate department/service that can meet their health needs. It is intended that this model will help to support the pressures faced by the Emergency department at Lister Hospital.

Across both CCG areas there is a focus on supporting Hertfordshire's older population living with frailty. This includes:

- Incentivising GPs in East and North Herts via the CCG's Consolidated Funding Framework (CFF) to pro-actively identify older people living with frailty within their practice and actively ensure care-planning is in place for these patients.
- In Herts Valleys, the 3-year GP enhanced commissioning framework includes a component to identify moderately frail patients. Payment for this is included in the GP unified budget.
- Both CCGs have implemented 'My Plan' a person held and owned plan, to support person centred care and help older people living with frailty and their carers to better manage their conditions.
- The Integrated Community Team (ICT) is a diverse group of professionals working in East and North Hertfordshire. It includes community nurses, community matrons, physiotherapists, occupational therapists, specialist palliative care nurses, mental health nurses and health care and rehabilitation assistants. They provide care primarily to patients who are housebound and need to be seen in their own homes including residential and nursing homes, working to keep people from needing to be admitted to hospital.

- EIV- Since 2017 the *Early Intervention Vehicle* (EIV) in East and North Hertfordshire has effectively supported some of our most complex service users. The service aims to keep people who are at risk of imminent crisis independent and prevent them from needing to go into hospital. Interventions span medical and social care, assistive equipment and technology, all of which are individually tailored, holistic, risk positive and encompass a Connected Lives and personalised approach. In the last year alone, 72% of people seen by the service remained in their own home. One of our priorities for 2019/20 is to deliver EIV in West Hertfordshire. Furthermore, a new dedicated Care Home EIV in East and North Hertfordshire is to be launched specifically for care homes utilising the *6 line. This will support residents that may

have had a fall or require non-urgent medical attention, aiming to keep them out of hospital.

- Community Navigators offer social prescribing services to people living with frailty and/or complex needs across the county. They provide support to enable people access to a range of services such as primary and secondary NHS services, voluntary organisations, social care and housing. The service helps to reduce inappropriate use of NHS services and social care whilst also helping people to access their own community.
- There is continual focus to implement new preventative strategies, such as the frailty and falls pathways. Benefits of these may not be seen immediately as they will need time to affect large-scale outcomes such as non-elective admissions.

5.1.1 Metric targets for total number of specific acute non-elective spells per 100,000 population for 2019/2020

Performance metric	**2017/2018 Target**	**2018/2019 Target**	**2019/2020 Predicted**
Total number of specific acute non-elective spells per 100,000 population	109683	112304	120701

5.2 Delayed Transfers of Care

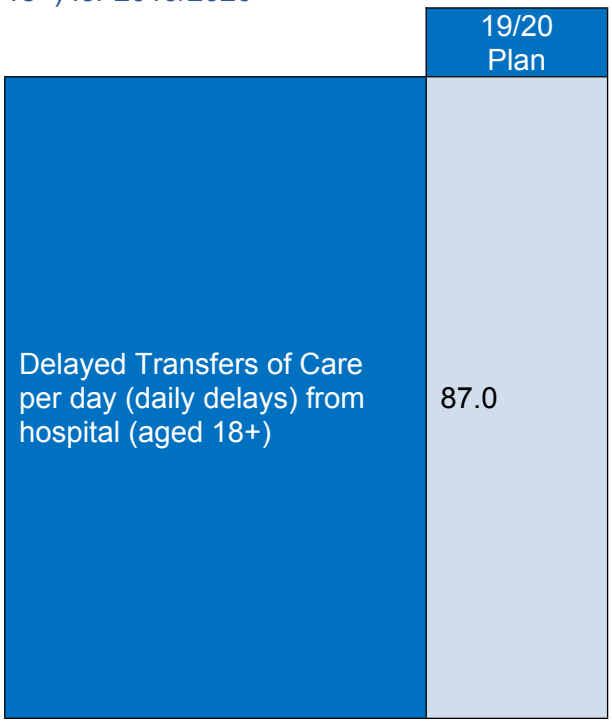
Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with reference to seasonal winter pressures.

At the end of 2018/2019 Hertfordshire faired positively compared to other Local Authorities with an average daily bed days rating of 11.2 (other local authorities came in at 12.1). For quarter 1 of 2019, the average no of daily DTOCs has slightly increased. A key influencer behind this has been the availability and flow through rehabilitation pathways in the discharge to assess model due to constrained home care capacity. We are continuing to work in close partnership to achieve a reduction in DTOCs. One of the main ways we are working to improve flow is through the retendering of Specialist Care at Home which is hoped to increase Home Care Capacity.

For 2019/2020, the winter pressures grant has been allocated to a number of new schemes which have been commissioned in order to alleviate pressures on NHS and Social care services, particularly over the winter months. Funding has been pooled into schemes to support Older Peoples services and a large proportion of these has been allocated to support Out of Hospital discharge pathways. This includes reablement/ intermediate care placements in residential and nursing homes, as well as funding to support reablement/intermediate care in people's own homes. For the latter funding has also been allocated to support additional Specialist Care at Home Capacity. It is intended that through investing additional monies into these schemes, there will be increased capacity in the care market to accept patients being discharged from hospital which will support flow from the acute into the community and prevent admissions. As referenced on the expenditure tab funding has also been allocated to support specialist placements in LD, Dementia and

Mental Health.
A proportion of the grant has also been allocated to support additional capacity and staffing within the system in anticipation of systems pressures over the winter period. Following the collapse of Allied Healthcare earlier in the year, an in-house homecare agency was established to alleviate pressures on the care market and meet demand. This new model allows Hertfordshire County Council to have a stake in the market, providing oversight and stability. A proportion of the Winter Pressures Grant has been allocated to support and establish this agency and assist with business continuity planning. A final way the grant has been used is to support the Hertfordshire Delirium Recovery Pathway. This pathway has significantly developed since 2017 and now offers service users 4 pathway options for discharge depending on the complexity of their delirium. The pathway intends to identify delirium earlier and ensure care is provided in the right time, right place to meet patient's needs.

5.2.1 Metric targets for Delayed Transfers of Care per day (daily delays) from hospital (aged 18+) for 2019/2020



5.3 Admissions to Residential and care homes

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Since 2017, the number of permanent residential placements has increased. The first half of 2018-19 remained low but rose substantially into the second half of the year. In quarter one of the 2019-2020 year the rate of permanent admissions per 100,000 population was 568, against the target of 515 per 100,000 population. Lack of capacity in the home care market is a key influencer behind the increase in short stay placements. The increasing demographic demand including an increase in demand from former self funders means a target of 515 has been set for 2019-20. Ensuring resource is available to offer service users the most appropriate pathway for their needs is acknowledged by all partners in the health

and care system. Progress is being made to develop the capability to support people at home from a short stay perspective.

Recommendations from the Newton consultancy work also identity this as a priority and planning is underway to develop this further. This is taking a system approach to support at home, shifting resources from acute and intermediate care settings, as well as working with our care providers to deliver enabling and rehabilitative services. Current STP work around Discharge to Assess is helping to quantify the number and usage of short stay beds across the system to allow for further consideration as to whether more of the patients/service users in these settings could have been supported at home with the right wrap-around, multi-agency support.

5.3.1 Metric targets for Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population for 2019/2020

* Please note that the utilisation of projected population as the denominator is in direct conflict with the logic used in ASCOF, from which this indicator is derived. ASCOF utilises the latest population estimates. Therefore, figures have been input to match local targets set out in the HCC Strategic plan.

Our Annual rate target for 2018/2019 was in fact 505 rather than 585. The numerator was also 1015 rather than 1,178. As the template provided by NHSE is locked we are unable to amend this.

		18/19 Plan	19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	585	515
	Numerator	1,178	1062
	Denominator	201,242	206,367

5.4 Effectiveness of enablement

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Performance against this target varied in over the last few years although in the first quarter of 2019/2020 this improved slightly and is nearer the target of 86%. These low levels of hospital readmissions suggest that the enablement support is successfully helping to prevent escalation of patient need. For 2019/2020 there will be a continual focus on reablement pathways following hospital discharge including Specialist Care at Home and Discharge Home to Assess. An aim is for these services to evolve and support more clients, including those who have intensive support needs. The work of the Hospital and Community Navigation Service and the Link workers should also complement the statutory services, providing wider support to help people to maintain their independence and avoid the need to return to hospital.

5.4.1 Metric targets for proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

*Please note that the numerator and denominator are representations of expected activity required to achieve target based on Oct-Dec activity in 2018-19.

		18/19 Plan	19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.1%	86.0%
	Numerator	383	585
	Denominator	450	680

Appendix 1[5]

Social Care Institute for Excellence Integration standards - I Statements

1. 'I have access to a digital integrated care record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data).'

2. 'If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital.'

'If it would benefit me, I will be able to access a personal budget, giving me greater control over the money spent on my care.'

3. 'I receive the best possible level of care from the NHS and my local authority.'
4. 'If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care.'
5. 'I receive more care in or near my home and haven't been to hospital for ages.'

'My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it.'

'Areas use multidisciplinary integrated teams and make use of professional networks to ensure high quality joined-up care is delivered in the most appropriate place seven days a week.'

6. 'If I go into hospital, health and social care professionals work together to make sure I'm not here for any longer than I need.'
7. 'If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them'

[5] https://www.scie.org.uk/integrated-care/measuring-evaluating/research/standard