
Hertfordshire: 2017-19 Better Care Fund Plan

High Level Narrative

Cambridgeshire & Peterborough Clinical Commissioning Group

East & North Herts Clinical Commissioning Group

Hertfordshire County Council

Herts Valleys Clinical Commissioning Group

Key References & Related Documentation

Key Document or Information Title	Content
2015-16 Better Care Fund Plan; 2016-17 Better Care Fund Plan	Outlines Better Care Fund plans for the last two years, used as basis for the 2017-19 BCF Plan
CCG Operational Plans	Outlines CCG priorities for the coming year
Health & Wellbeing Board Strategy 2016-19	The Strategy sets out Health & Wellbeing Board priorities for a healthier and happier Hertfordshire
Sustainability & Transformation Plan, 'A Healthier Future'	How local services will evolve over the next 5 years over the STP footprint (Hertfordshire & West Essex)
Ageing Well Strategy 2014-19	Led by the County Council, this has been developed by the multi-agency <i>Older People and Dementia Strategic Commissioning Group</i> that includes providers, carers, service users and Healthwatch Hertfordshire
Carers' Strategy 2015-18	Outlines joint priorities and actions in relation to carers over the next 3 years – due to be reviewed in 2017
Dementia Strategy 2015-19	Outlines joint priorities, approaches and actions in relation to dementia care over the next four years
Joint Market Position Statements	A series of Joint Health and Social Care Market Position Statements summarising commissioning intentions to support current and potential providers develop the right services for residents – these cover mental health, learning disabilities, carers, older people and physical disabilities
Joint Strategic Needs Assessment (JSNA)	Web-based resource with data and intelligence designed to inform commissioning decisions
Mental Health Strategy 2016-21	Outlines joint priorities, approaches and actions in relation to mental health over the next four years
Mental Health Crisis Care Concordat	Deliver of a Hertfordshire-wide action plan to bring together a range of agencies involved in the care and support of those in mental health crisis
East & North Herts Vanguard Programme Value Proposition	Shows development plans for the Vanguard Programme over 4 years from 2015
Your Care, Your Future	HVCCG'S Transformation Programme - http://www.yourcareyourfuture.org.uk/

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Glossary

Acronym	Title
A&E	Accident and Emergency
ACS	Adult Care Services (Hertfordshire County Council)
ACSMB	Adult Care Services Management Board (Hertfordshire County Council)
ASASB	Adult Supported Accommodation Strategic Board
BCF	Better Care Fund
CAMHS	Child & Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CCP	Complex Care Premium
CEPD	Cambridge Executive Partnership Board
CPCCG	Cambridgeshire & Peterborough Clinical Commissioning Group
CQUIN	Commissioning for Quality & Innovation Payment Framework
CWB	Community Wellbeing
DFG	Disabled Facilities Grant
DTOC	Delayed Transfer of Care
ECIP	Emergency Care Improvement Programme
EDD	Estimated Date of Discharge
ENHCCG	East & North Hertfordshire Clinical Commissioning Group
ENHT	East & North Hertfordshire NHS Trust
EMDASS	Early Memory Diagnosis and Support Service
EOLC	End of life care
EPACCs	Electronic Palliative Care Coordination System
ESD	Early Supported Discharge
GPs	General Practitioners
HCC	Hertfordshire County Council
HCPA	Hertfordshire Care Providers Association
HCT	Hertfordshire Community NHS Trust
HEE	Health Education England
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HUC	Herts Urgent Care
HVCCG	Herts Valleys Clinical Commissioning Group
HWB	Health & Wellbeing Board
HWBS	Health & Wellbeing Board Strategy
IDT	Integrated Discharge Team
IG	Information Governance
IUC	Integrated Urgent Care
JSNA	Joint Strategic Needs Assessment
LOS	Length of stay
LTC	Long-term condition
MDM	Multi-disciplinary meeting

Acronym	Title
MST	Multi-speciality team
NEA / NEL	Non-elective admission / Non-elective
OOH	Out of hours
PAH	Princess Alexandra Hospital
QIPP	Quality, Innovation, Productivity & Prevention
SCN	Strategic Clinical Network
SEND	Special educational needs and disabilities
SLG	System Leaders Group
SRG	System Resilience Group
STP	Sustainability & Transformation Plan
S75	Section 75
VCS	Voluntary & Community Services
WECCG	West Essex Clinical Commissioning Group
WHHT	West Hertfordshire Hospitals NHS Trust
YCYF	Your Care, Your Future

1. Hertfordshire's Vision for Health & Social Care Services

1.1 Our Shared Vision

Hertfordshire's **vision** for health and social care integration remains:

"A system that delivers the right care and support at the right time and in the right place for individuals, their families and their carers"

Improved joint working between health and social care has been a long-term strategic priority for Hertfordshire, resulting in the introduction of a range of integrated care solutions that have improved outcomes for people using those services. Over the last year, three such services – HomeFirst, Community Navigators and the Complex Care Premium - have been recognised by winning national awards.¹ In 2016/17, we continued our track record of implementing innovative integrated care models, as summarised in section 2, and retained productive and focused working relationships between partners in the face of challenging financial and demand-led operational pressures.

In this plan, we aim to combine our consistent, long-term vision for integration in health and social care with a number of new areas of focus to take the delivery of our vision into the next phase, and contribute to the achievement of system-wide financial and activity targets set out in the Hertfordshire and West Essex Sustainability and Transformation Plan (STP).

We have also aligned our priorities more closely to citizen focused 'I statements' (SCIE, 2017) to demonstrate the impact of our achievements and objectives for our residents, and remind ourselves that integration is not an end in itself, but is a way of shifting health and care service focus to improving public health and meeting the holistic needs of individuals, of drawing together all services across a place for greatest benefit, and of investing in services which maximise wellbeing throughout life (Stepping up to the Place, LGA 2016).

¹HomeFirst won the Local Government Chronicle magazine's 'Health and Social Care' project of the year (2016), Community Navigators received a highly commended HSJ Value in Healthcare Award (May 2016), Complex Care Premium received the 2017 HSJ Workforce Efficiency Award (May 2017)

Figure 1: Hertfordshire's resident focused planning framework



National Voices definition

"I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me"

















SCIE Integration standard - 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'

1.2 Alignment to other system plans

Hertfordshire's plan for health and social care integration draws from national guidance and brings together a number of local strategies where health and social care integration is necessary for service transformation and outcomes:

Figure 2: Hertfordshire's linked local strategies²

Legislation, strategies, and key drivers									
National	The Care Act 2014  View here	<ul style="list-style-type: none"> Mental Health Act 1983 Human Rights Act 1998 Equality Act 2010 Mental Capacity Act 2005 	Towards Excellence in Adult Social Care (TEASC)  View here	NHS Five Year Forward View – NHS England  View here Next Steps on the NHS Forward View View here	Transforming care: A national response to Winterbourne View Hospital  View here	Health & Social care Integration View here Better Care Fund View here	Health and Social Care Act 2008 View here Think Local Act Personal View here	ADASS 5 year Vision Distinctive, Valued and Personal  View here	
	Hertfordshire County Council's Corporate Plan 2013-2017  View here	Health and Wellbeing Strategy 2016-2020  View here	Police and Crime Plan  View here	NHS STP: A Healthier Future Improving health and care for Herts and West Essex 2016-2021  View here	East & N Herts CCG Strategies  View here	Herts Valley CCG Your care, your future  View here	Healthier Herts – A Public Health Strategy for Hertfordshire  View here	A voluntary sector commissioning strategy for Hertfordshire 2015 – 2019  View here	
	Hertfordshire Compact  View Here	Hertfordshire's Carers Strategy View here	Hertfordshire Skills Strategy to 2017 View here	Children's Services Strategic Plan Shaping the Future  View here	Hertfordshire All Age Autism Strategy 2014 View here	Market Position Statements for <ul style="list-style-type: none"> Carers Mental Health Older People Learning Disability Physical Disability View here		Hertfordshire Dementia Strategy 2015-2019 View here	
	Hertfordshire Domestic Abuse Strategy 2016-2019 View here	Hertfordshire Alcohol Strategic Plan 2014 – 2017 View here	HCC Customer Service Standards View here	Hertfordshire Safeguarding Adults at Risk Policy 2015-2017 View here	HAFLS Needs Analysis  View here HAFLS Partnership Strategy View here	Hertfordshire's Self-management Strategy 2017-2020 View here	Hertfordshire ICT Strategy 2015-2018 View here	Mental Health Strategy (Draft) 2016-2021 View here	
	Health & Community Services 3 Year Plan View here	Ageing Well in Hertfordshire 2014 – 2019 View here	HCS Assistive Technology Strategy (Draft) View here	Joint Commissioning Strategy 2014 – 2019 for Adults with Learning Disabilities View here	HCS Information & Advice - Care Act Strategy View here	Under development: <ul style="list-style-type: none"> 15 Year Plan Supported Accommodation Strategy Physical Disability and Sensory Impairment Strategy Enablement Strategy Health Integration Strategy 			

The following sections outline the recent developments in national and local planning, and how the BCF plan will align in the future.

1.2.1 Health and Wellbeing Board Strategy

The Health and Wellbeing Board (HWB) brings together the NHS, public health, adult social care and children's services including elected representatives and Hertfordshire Healthwatch, to plan how best to meet the needs of Hertfordshire's population and tackle local inequalities in health.

Underpinning this is the HWB's Strategy, **Healthier People, Healthier Communities** which was refreshed in June 2016 and provides the foundation of Hertfordshire's approach to integration. Its vision is "with all partners working together we aim to reduce health inequalities and improve the health and wellbeing of people in Hertfordshire".³

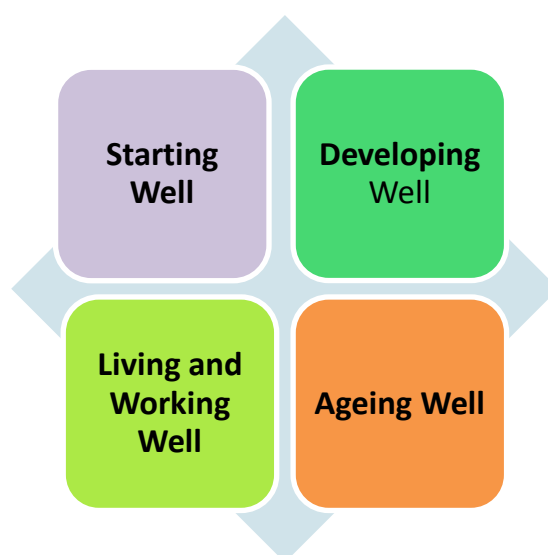
² To view, visit <https://www.hertfordshire.gov.uk/about-the-council/freedom-of-information-and-council-data/open-data-statistics-about-hertfordshire/our-policies-and-procedures/market-position-statements/market-position-statements.aspx> and select 'strategy map'.

³ To view the Strategy, visit <https://www.hertfordshire.gov.uk/about-the-council/how-the-council-works/partnerships/health-and-wellbeing-board.aspx>

The refreshed Strategy is divided into 4 sections, each related to 1 of 4 major life stages:

- Starting Well – babies and very young children including maternity
- Developing Well – children and young people aged 6-25 years
- Living & Working Well – working age adults
- Ageing Well – people aged 65 years and above

Figure 3: Health & Wellbeing Strategy Life Stages



Each life stage has been accorded priorities that meet the following 6 principles:

- **Encourage opportunities to integrate services to improve outcomes**
- Keeping people safe and reducing inequalities in health, attainment and wellbeing outcomes
- Use public health evidence, other comparison information and Hertfordshire citizen's views to focus on the most significant needs
- Centring strategies on people, their families and carers, providing services universally but focusing on the most vulnerable
- Focus on preventative approaches and helping communities to support each other
- Consider what can be done better together by focusing efforts on adding values as partners to maximise benefits to the public

The priorities for 2016- 2020 include:

Starting Well	Developing Well	Living Well, Working Well	Ageing Well
Reducing incidents of smoking during pregnancy	Improved mental health and wellbeing in children (CAMHS)	Improving mental health prevention and resilience	Improving activity and reducing frailty levels in older people
Supporting new mothers	Better support for young carers	Better support for unpaid carers	Reducing preventable winter deaths
Perinatal mental health	Encouraging healthy lifestyles	Tackling homelessness and housing issues	Improving support for those with dementia
Reduce variation in school readiness	Improving life chances of the most vulnerable	Reducing preventable disability and supporting	Reducing social isolation

		those with learning disabilities	
Reduce young child obesity	Improving looked after children outcomes	Improving levels of physical activity	Improving people's ability to live independently

1.2.2 NHS Strategic Priorities

Hertfordshire is making good progress in implementing the 5 Year Forward View where integration is essential to the delivery of the following priorities:

- Delivery of new models of care and moves towards an accountable care system
- Primary care – enhanced access and multidisciplinary teams
- Enhanced support for care homes
- Achieving the priorities of the mental health five year forward view, including expansion of Improving Access to Psychological Therapies.
- Implementing the High Impact changes to reduce delayed transfers of care and free up acute hospital beds
- Improved patient flow
- Implementation of 10 point efficiency plan
- Expansion of NHS 111 services

1.2.3 ENHCCG Strategic Ambitions

“Over the next 5 years we will make a positive difference to the people of East & North Hertfordshire by empowering them to live well and as healthily as possible”

Working together for healthier communities, ENHCCG's Strategic Plan 2014-2019 outlines the following priorities:⁴

- Caring for people at home when it is the best option
- 24 hour medical advice on getting the best health care for people's needs
- Caring as much for a person's mental health as their physical wellbeing
- Helping people to be as healthy as they can throughout their lives
- Putting the right support in place to help people when they need it
- Giving a person and their families the care and compassion they need at the end of their lives
- Modern, high quality facilities at QEII and Lister Hospital to meet changing needs

1.2.4 HVCCG Strategic Ambitions

“Our vision is for people of all ages living in West Hertfordshire to be healthier and have better care that is joined-up and responsive to their individual needs, closer to where they live” (Your Care Your Future Programme)

⁴ For the Strategic Plan, please visit the E&NHCCG website: <http://www.enhertscg.nhs.uk/strategies>

Developed in consultation with local people, including patients, carers and clinicians, the **Your Care Your Future (YCYF)** transformation programme is delivering more personalised, and proactive care developed and delivered in partnership. YCYF is based on the following principles:

- Prevention & Self-Management (addressing growth in activity)
- Joined up care (e.g. extended care)
- Locality based delivery closer to home
- Managing stability and escalation
- Efficient and effective specialist care⁵

It is addressing these by delivering the following:

- Addressing STP priorities for prevention, self-care, patient empowerment and pathway redesign
- Expanding local services – enabling more people to access the care and support they need in their own community which means more care at home and building on existing community and voluntary services
- Health and Wellbeing Hubs – improving connections between health, social care and other parts of the community creating a network of joined up services closer to home
- Improving quality of services in West Hertfordshire
- Healthy living to prevent the development and escalation of conditions in the first place
- Future hospital care – improving quality of acute care while enabling more people to be cared for in the community

1.2.5 Hertfordshire County Council Strategic Ambitions

We want Hertfordshire to remain a county where people have the opportunity to live healthy, fulfilling lives in thriving, prosperous communities. (County of Opportunity, HCCs Corporate Plan 2013-17)

The Hertfordshire Adult Care Services 3 year plan provides the strategic direction for adult social care and health, supporting people with learning disabilities, physical disabilities, those with mental health problems, older people and family carers. This includes implementation of the Care Act 2014, integration with NHS services through Hertfordshire's Better Care Fund, and using new technology and modernising services to meet people's changing expectations.

The next 3 year plan, to be in place next year, will form the first delivery plan that will sit within a new '15 Year Plan with Strategic Ambitions for Adult Social Care in Hertfordshire,

⁵ For detailed plans, visit <http://www.yourcareyourfuture.org.uk/vision-for-the-future/>

2018-2033'. This 15 year plan is to be agreed in October but will contain 4 strategic ambition areas. These are (currently in draft):

1. **Information and advice** – communicating well and providing good information and advice to enable and support people to look after themselves and each other
2. **Community first** – recognising that we depend on each other and need to build supporting relationships and strong communities
3. **Valuing independence** – services that prevent future need, help people get back on track after an illness and support disabled people to be independent and live purposeful lives
4. **Caring Well** – developing personalised, good quality services that addresses people's wellbeing and keeps them safe and resilient

The Care Act Implementation: The Care Act 2014 was implemented in April 2015 and introduced a range of new duties and guidance that impacted on all adult social care policy and practice. At Herts County Council, a programme of implementation included:

- A review and update of all policies and procedures to reflect changes in eligibility criteria and new guidance on how care and support is delivered
- A new assessment process that focusses on giving our service users choice and control, putting more emphasis on local community services and a person's existing support network, interests and wishes
- New support and services for carers which Hertfordshire Councillors agreed would be delivered free to eligible carers
- Improvements and developments to our information and advice service including commissioning an independent service providing financial and care funding advice.
- The development of Market Position Statements with partners and service users for Carers, Learning Disabilities, Physical Disabilities, Mental Health, Asperger's, Older People and Accommodation
- The development and delivery of a comprehensive workforce development programme

Implementation of the Care Act will continue to be embedded in 2017-19, including additional staff training around making safeguarding personal, new quality assurance processes, issuing of Market Position Statements and continuation of the ACS Coproduction Board (see below).⁶

1.2.6 'A Healthier Future' – Hertfordshire & West Essex Sustainability & Transformation Plan⁷

Hertfordshire's 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

⁶ See section 4.2 of the 2016-17 BCF Plan

⁷ For more information, visit the local STP website: <http://www.healthierfuture.org.uk/>

3. Improving urgent and hospital services
4. Providing health and care more efficiently and effectively

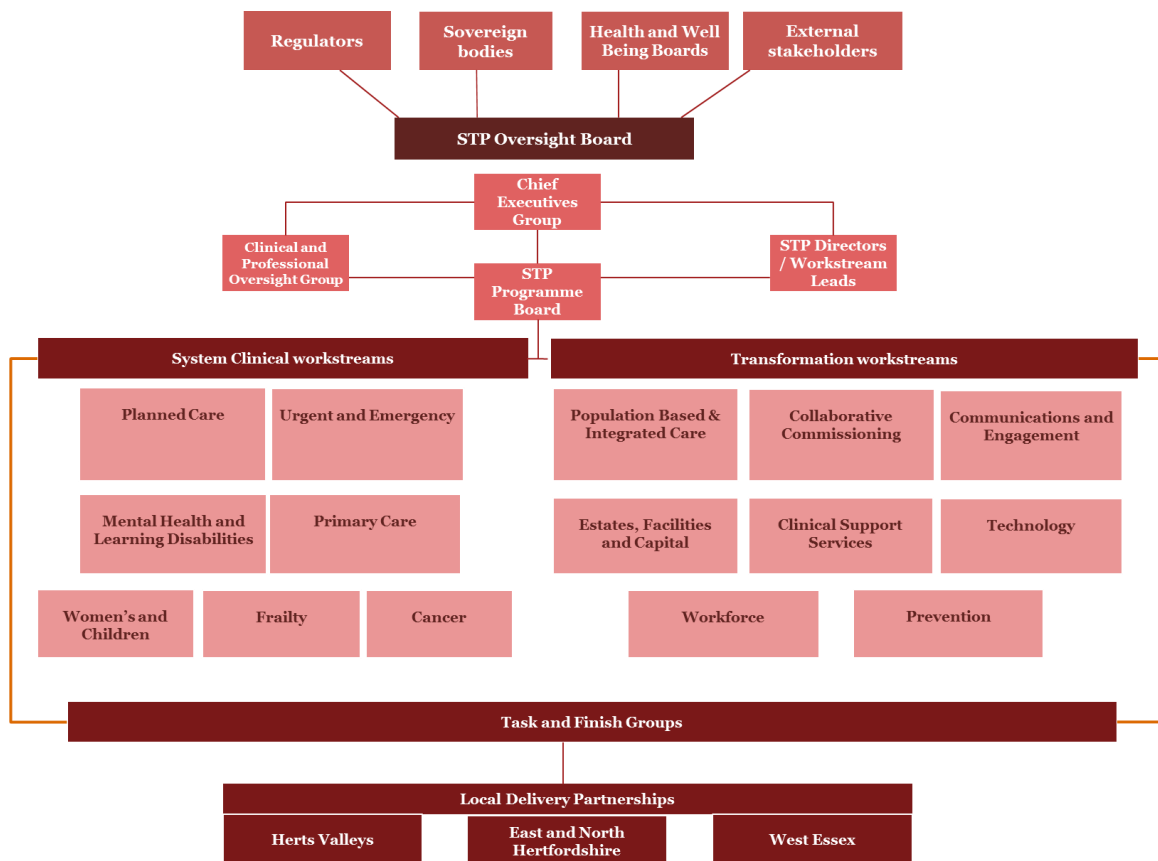
At the centre of *A Healthier Future*, as with the BCF plan, is a collaborative obligation for partners to work together across primary care, social care, community health, acute services and mental health to make our system more citizen-focused and fit for the future.

Integration across health and social care is recognised as a key means of meeting the challenges outlined above, and specific focus has been given in recent months to the alignment of the planning and implementation in the following areas:

- An integrated strategy for, and approach to, self-management
- Wider use of community and voluntary sector assets through social prescribing and Hertfordshire's *Community First* approach
- Risk stratification identifying people at risk of preventable illnesses or ill-health
- Shared care planning and assessment
- Delivery of care closer to people's homes and out of hospitals, including in newly created local health and wellbeing 'hubs' to cater for local people's physical, social and mental health needs
- Alignment of health and social care services within the redesign of end-to-end clinical pathways, including Stroke, Diabetes, End of life and Frailty
- Simplification of the urgent care system
- Extending support to care homes through various in-reach models
- Opportunities for collaborative commissioning
- The development of 'place-based' models of care and integration of community and primary care teams, locally designed and driven by STP-wide locality governance arrangements in accordance with local need. This includes the alignment of services around 'neighbourhoods' of around 30,000-50,000 people.

In 2016-17, major elements of the BCF programme delivery framework were subsumed within STP governance infrastructure to ensure co-ordination of plans and reduce duplication. This includes the evolution of provider-led Integrated Care Programme Boards, which had been providing a systems leadership role in the development of integrated community teams, into the STPs Place-Based and Integrated Care workstream (see STP governance diagram below).

Figure 4: STP Governance Diagram



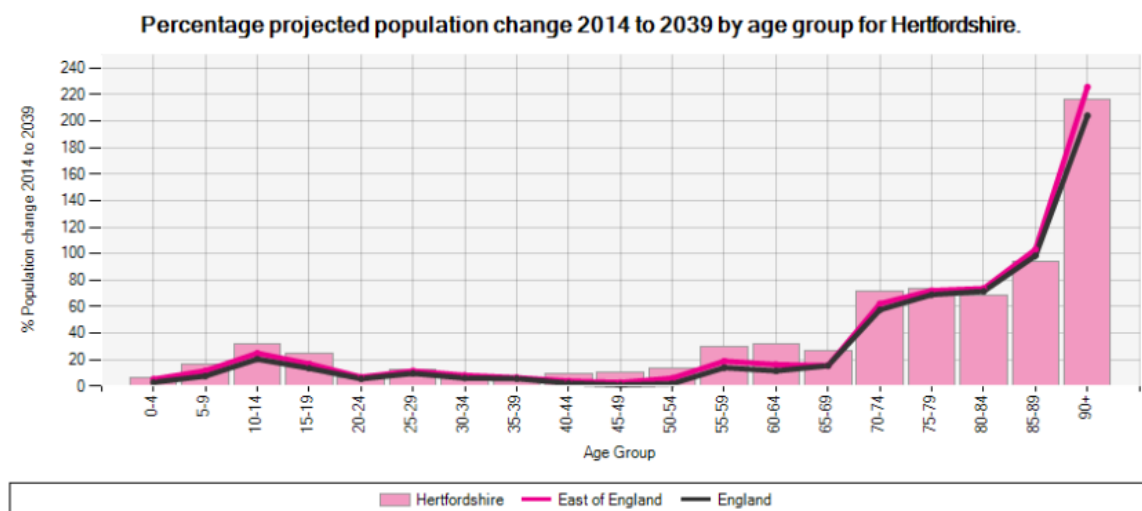
2. The Hertfordshire Context & Progress to Date

2.1 The Hertfordshire Context - Current & Future Challenges

Hertfordshire faces significant current and future challenges within our health and social care system, forming a backdrop to all integration planning and are outlined in the previous two BCF Plans. Hertfordshire and West Essex's STP estimates a combined NHS and social care deficit of £548m (£397m attributed to the NHS and £151m to social care) by the end of 2020-21 if no action is taken. Drawing together information from across health and social care planning and in particular the STP, considerations towards this include:

- **Demographic pressures** as a result of Hertfordshire's ageing population rising above the English average - this includes a projected overall population increase of 24% and an 82% increase in over 85s between 2014-39

Figure 5: Hertfordshire Projected Population Change, 2014-39



Source: Office for National Statistics, 2014-based population projections. Crown copyright.

- **Service pressures** as a result of a rising number of people with long-term conditions, some of the most intensive users of the most expensive services - by 2030, 67,089 residents aged 65 and over will be living with a long-term condition compared to 46,396 currently, an increase of 36%.⁸ There is also predicted to be a 63% increase in those with dementia by 2030.
- An increasing demand in **mental health services**. The wider social costs of mental health are estimated to be about £2.2 billion for Hertfordshire, of which around £636 million is work-related.
- A projected 'tipping point' where the number of older people needing care will outstrip the number of **unpaid carers**
- A need for a larger health and social care **workforce** as a result of rising demand and complexity of required care services as well as recruitment and retention issues

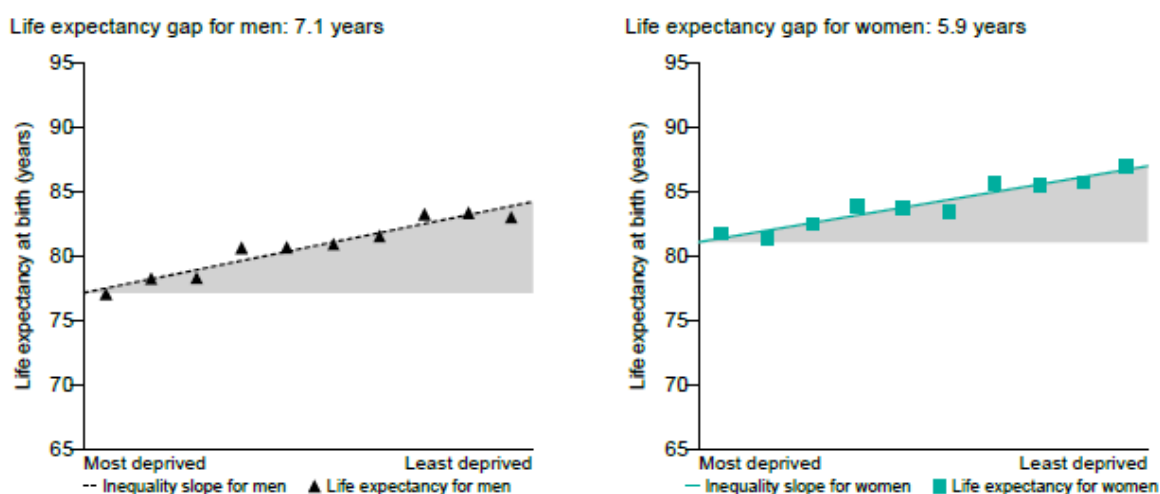
⁸<http://www.poppi.org.uk/index.php?pageNo=331&PHPSESSID=5vls42bae333ufssmphblmo8v6&sc=1&loc=8262&np=1>

- A high use of **urgent care** services putting additional pressure on the local system and making it more difficult to meet national targets including reducing non-elective admissions (NEA) and delayed transfers of care (DToc)
- **Housing** – a decent house, suitable to current need and in a safe neighbourhood is a fundamental right and has a direct impact on health and independence at all ages. This is not always the reality in Hertfordshire and this contributes to increased acute activity, DToc, permanent admissions to care homes, homelessness and social and community issues. Hertfordshire's high housing costs and demand can also make living well more difficult for those on lower income, as well as cause problems recruiting and retaining key workers.

Health Inequalities

Although collectively one of the 20% least deprived counties in England, Hertfordshire has significant pockets of deprivation. As an example, the difference in life expectancy is 7.1 years lower for men and 5.9 years lower for women between the most and least deprived areas of Hertfordshire as shown in the diagram below. Lifestyle factors, as well as other wider determinants of health, are a key contributor towards these differences and should be considered alongside prevention and equal access to services when addressing system pressures. It is known for example that Hertfordshire's smoking rate is higher than the national average among lower-paid occupations who therefore have a higher risk of developing a long-term condition – tackling this issue will involve considering employment, education, healthy places and communities as well as health and care services. Hertfordshire's Public Health is a key partner in advising, developing and reviewing strategies to address these wider causes.

Figure 6: Life Expectancy in Hertfordshire⁹



⁹ For more information, see [Hertfordshire Health Profile 2016](#), Public Health England and [Herts Insight](#) which draws together information and statistics about Hertfordshire and its local communities

Protected Groups

Health outcomes can vary between different groups. For example, Hertfordshire has a consistently lower life expectancy rate for men than women (at its greatest, a difference of 13 years), higher smoking rates among certain ethnic groups and higher levels of obesity among those with disability. The importance of addressing these issues as well as not disadvantaging one particular group when delivering integrated services is acknowledged, with the majority of individual programmes and projects having equality impact assessments and plans in place. An equality impact assessment of the BCF as a whole suggests that joined up care also provides significant openings to advance equality of opportunity and foster good relations among protected groups due to improved care and closer working with existing strategies including the STP.¹⁰ Population statistics – which includes information produced by the JSNA – continues to be developed by the Public Health Data & Intelligence team to act as a useful source of intelligence for future joint strategy review and development.

¹⁰ Available on request.

2.2 Performance to Date - Where are we on our integration journey

Better Care Fund Performance 2014-2017

Last year's BCF focused on progressing the below areas to achieve greater integration:

1. Services working together to maximise the independence of people in Hertfordshire
2. Effective integrated community services built around primary care
3. Jointly commissioned services around individuals and their needs
4. An integrated workforce, appropriately skilled and able to work across organisational boundaries

Summary of Achievements 2016-17

Hertfordshire continues to make progress against its health and social care integration ambitions, with the BCF enhancing already strong relationships between partners. Key successes for last year's BCF include:

- A total BCF of £304m, encompassing an additional £230m of community care budgets than minimally required to enable joint commissioning of a wider range of services
- Gradual sustained roll-out of integrated community teams which includes Rapid Response and Homefirst services and multi-speciality teams
- New models of support for care homes including Vanguard projects
- Development of the Integrated Discharge Teams based in acute settings
- Establishing a collaborative Home Improvement Agency model for innovative use of Disabled Facilities Grant monies
- Business cases agreed or in development for greater digital integrations, in particular for a shared care record and a Live Urgent Care Dashboard, paving the way for system-wide improvements in communications, joint working and patient outcomes
- Embedded and improved partnership governance processes

The following section sets out this progress in greater detail.

Area 1: Electronic Record & Data Sharing

Key Achievements
<p>Hertfordshire health and social care data integration work development:</p> <ul style="list-style-type: none">• Mapping existing physical health, mental health and social care services, resulting in a STP local digital roadmap towards health and social care integration by 2020• Joint approach to ICT opportunities and challenges via the STP Technology Board, now merged into delivery of the STP Technology workstream• Sharing of organisational in-house dashboards to understand current data and access needs in preparation for a joint 'urgent care dashboard' currently at outline Business Case stage• An updated partnership information sharing agreement, reviewed late in 2016, to ensure

compliance with and appropriate controls for information governance and STP-wide data sharing guidance for all staff

- Approval of the NHS IG Toolkit submission, version 13, in April 2016.

Development of **Shared Care Planning**:

- Trialling of 'My Plan' in Herts Valleys with learning used for an E&NH roll-out as part of E&NH's development towards a professional shared care plan.
- An agreed vision and implementation plan for E&NH's 'Personalised Professional Care Plan' to be used alongside 'My Plan'
- Planning by Herts Partnership Foundation Trust to introduce a co-produced, patient owned Crisis Care Plan for high risk patients – this includes sharing arrangements with other agencies, such as the Police and Housing Associations, with patient consent
- Planning for a shared care record accessible by both health and social care professionals is at business case stage – this is being managed by the STP interoperability data integration workstream

Area 2: Early Intervention

Key Achievements

Improving **access and coordination** between services:

- A **countywide review** of HCC, CCGs, HPFT, HCT, HUC and primary care access points around older people with long-term conditions both for patients and onward referrals – this has resulted in the creation of recommendations and options for future development
- Launch of **MiDos** in E&NH, an integrated directory of services capable of smart searches and collecting valuable commissioning intelligence, with plans in place for further roll-out and mainstreaming of the service

Improving the use of **risk stratification** for prevention and to target key groups:

- Using Medeanalytics to risk stratify and case manage Homefirst patients for hospital avoidance – this followed a period of training and procedures with GP practices to identify their 'at risk' patients (those in danger of acute admittance within 6 months) and post-clinical review to refer suitable patients to the multi specialist team. Utilising collaboration networks to analyse cross-system intelligence.
- Using the local linked data sets held within Medeanalytics for business intelligence purposes having established Information Governance compliant monthly data flows from hospital trusts, social care, the community, mental health and continuing healthcare data. Examples include in-depth study of the services touched by those experiencing a Broken Neck of Femur, evaluations of the Rapid Response and care home services effectiveness, and measuring and monitoring the effectiveness of the Care Home Vanguard initiative.
- Agreement from E&NHCCG and West Essex CCG to promote GP practice data flow into Medeanalytics to link with the other data sets in order to improve the effectiveness of the Risk Stratification algorithm and the targeting of prevention services, and allowing details of the patient's needs, journey and outcomes and care gaps to be more fully understood.
- Utilising collaboration networks to perform analysis and gain cross-system in-sights. Business Analysts from across the local Health and Social Care system have been working together to build their own competencies and understanding of the Medeanalytics tool and the use and interpretation of the information available to them from the multiple datasets for service

improvement purposes.

Development of the HV **Community Navigator** scheme:

- With over 2000 referrals last year and 50% of 2015-16 referrals coming from GPs, the seven Navigators based around 5 localities with a 100k population each will be an important part of the STP's preventative and social prescribing agenda going forwards. The navigators also sit on local MSTs and have helped join up the voluntary and statutory inputs
- Scheme was highly commended in the HSJ Value in Healthcare Awards, May 2016
- The introduction of a part-time navigator at Parkfield Medical Centre to test the Navigator approach within a GP surgery
- Trialling the navigator approach in a hospital setting by reviewing attendees with more than 10 A&E admissions a year with a non-clinical HRG code

Area 3: Value for Money

Key Achievements

Integrated Commissioning:

- Using agreed priorities developed jointly in 2015-16 to continue discussions around areas of joint commissioning
- STP partners have agreed to work together to review their Data Services for Commissioners Regional Officers (DSCROs) contracts and Business Intelligence needs.
- **Continuing Healthcare:** Developing a collaborative approach to Continuing Healthcare across Hertfordshire. An approach is being put in place whereby HCC will contract for care on behalf of the CCGs, leading to more effective contracts and improved management of the care market. Arrangements for closer working have been put in place, including shared desk space and staff workshops. Reviews of assessment processes have also taken place.

Developing a **joint commissioning strategy** between HCC and CCGs for improvements in **care home** services:

- Care Home improvements were given prioritisation in 2016-17 BCF plan resulting in the implementation of a wide number of new services.
- Additional training opportunities for staff – as well as enhanced training via the Complex Care Premium, care homes in E&NH were also offered End of Life ABC training delivered by a local hospice. These have helped both upskill and empower staff to enable residents to die in their preferred place of care.
- Care home had access to the integrated rapid response services across all localities
- Co-ordination of commissioning for short-term rehabilitative services
- Residential community flexi bed model of care with wraparound nursing and therapy
- Planned integration of nursing care commissioning linked to new CHC approach
- Planning for pilot MDT 'wrap around' service from core community teams around care homes in Herts Valleys for a 2017-18 start.

Disabled Facilities Grant (DFG) review project, now known as the Hertfordshire Home Improvement Agency:

- Joint working with a range of partners – including district and borough councils – to develop a more strategic and collaborative approach to the use of Disabled Facilities Grant monies that

will improve outcomes across health, social care and housing, particularly against a context of rising need.

- As a joint project, HCC (responsible for ensuring people's homes are suitable for meeting their needs), District and Borough councils (statutorily responsible for delivering adaptation grants in their areas) and other stakeholders, 2016-17 has seen development of plans to create a Shared Home Improvement Agency function inclusive of the DFG service and integrated Occupational Therapy. With the Home Improvement Agency due to launch in Autumn 2017, progress to date includes:
 - Development of a shared service model between four housing authorities and HCC, with a further authority expected to join in year 2
 - Creation of a legal partnership agreement to set up the service and delegate functions to HCC in order to authorise DFG spend on behalf of district and borough partners
 - Recruitment of a new Head of Service has been recruited, to take up their post in the summer
 - The new HIA Board to oversee HIA's operation and strategic direction, came into shadow form in April 2017
 - Procurement of the contractor framework to undertake standard adaptations underway
 - Service pathways mapped and refined
 - Modelling on demand and capacity
 - A team area co-located with the Occupational Therapy service identified and secured

Area 4: Assessment and Care Planning

Key Achievements

- A successful bid in late 2016 by HCC, ENHCCG and HVCCG to join the **Integrated Personal Commissioning early adaptors programme** on the strength of existing partnership working.
- Introduction of the E&NH Vanguard's **Impartial Assessors (IA)** – these are assessors independent of the NHS working at Lister Hospital to assess care home places on behalf of care providers. As of the summer, over 245 assessments resulting in 393 fewer beds days in hospital have been made. The Impartial Assessor model will now be introduced into Watford General Hospital and Princess Alexandra Hospital.
- Capturing and sharing learning for the Impartial Assessor – the model is based on an existing model from North Lincolnshire which, using their lessons learnt, was adapted by Hertfordshire. Hertfordshire has since actively promoted the IA through conferences and events including June's High Impact Change Event and a publically-accessible YouTube animation created to demonstrate how the model works. Work with NHSE has also taken place to develop generic FAQ's on the scheme and the service is being promoted in the national guidance around trusted assessor models. In addition, project leads spoke to multiple CCGs, local authorities and trusts about the model and will continue to do so over the next 2 years.

Area 5: Integrated and Community Care

Key Achievements

Development of **community integrated care models** including case management:

- Roll out of health and social care teams in HVCCG to rapidly respond to crisis within 60 minutes
- Shortlisting of the St Albans & Harpenden rapid response team for the Community Health

Service Redesign HSJ award.

- Roll out of **Homefirst** – effective discharge support and/or case management integrated with rapid response services - from two ENHCCG localities to area-wide coverage
- External evaluation of the Homefirst and rapid response models across both CCGs with learning fed into the next stage of development. ENHCCG have also reviewed the three elements of Homefirst model (case management, rapid response and supported discharge from hospital) to look at cost effectiveness and outcomes.
- The **multi-speciality team** approach has been rolled-out to all localities in Herts Valleys. This means professionals from different organisations across West Hertfordshire working together for assessment, coordination and development of shared care plans, using weekly MST meetings to share information, plan and keep the person at the centre of their care. An MST locality-coordinator post has been recruited in each locality to work across organisations and proactively reach into GP practices. Over 200 referrals for complex patients have been holistically assessed through the MST approach which is now influencing mainstream activity including through improved working relationships. A MST Members workshop in November 2016 reported improved relationships, better understanding between agencies, and staff reporting greater empowerment and motivation.

Continuation of **the E&NH Enhanced Care in Care Home Vanguard**:

Hertfordshire's 'Enhanced Care in Care Homes' Vanguard started in 2015, selected by NHSE from 269 bids as being particularly innovative.¹¹ As a partnership between ENHCCG, HCC and Herts Care Providers Association, the Vanguard has been working to four themes: 1) training staff to upskill them to do low-level observations of residents; 2) Multi-disciplinary teams; 3) Rapid response; and 4) data and technology including increase use of videoconferencing. All 92 care homes in E&NH are involved in the Programme and intended outcomes are fewer 999 calls, acute activity and delayed transfers of care, as well as people living healthier lives in care homes, more calls to NHS 111 and staff choosing to stay working in care homes. This is now being translated into long-term transformation of care home care and services.

Impact of the Programme to date – because of IG reasons ENHCCG has not tracked individual patient journeys but has used an aggregated data dashboard to measure the impact on overall patient outcomes. This has shown:

- Roll-out of the **Complex Care Framework**,¹² which offers tailored training via Complex Care Access (14 care homes), Complex Care Foundation (6 care homes) and continuation of the **Complex Care Premium** (CCP - 18 care homes in E&NH plus 9 care homes in Herts Valleys). Rolled out in stages, to date 44% of care homes (214 staff) have been trained
- The CCP has resulted in staff trained in complex care ('Champions') with homes incentivised via a paid 'premium' to take on those with more complex needs. Analysis of the first wave of 8 E&NH CCP homes, or 48 staff, showed a 45% reduction in hospital admissions, with lower admissions continuing to maintain themselves over the past year. The CCP was also winner of the **2017 HSJ Award for Workforce Efficiency**.
- Roll out of two **Early Intervention Vehicles** – see area 7.
- **Targeted support for care homes** for those with particularly high hospital activity rates.
- **Medicines Optimisation** involving a 'deep-dive' and changes to resident medication (on

¹¹ For more information, visit www.enhertsvanguard.uk

¹² See figure 7 of the 2016-17 BCF Plan

average each resident was using 7 medicines per day) has resulted in a 12% reduction in medicines, including those linked to falls, 35 care homes visited and more than 4000 recommendations for changes to medicine.

- Piloting of the '**Red Bag**' initiative ready for roll-out in 2017. This was trialled between Jan-March 2017 in 10 care homes to ensure that relevant information, medication and personal effects are transferred with the resident between locations reducing delays. Learning has been used to inform scaling up of the scheme which has been rolled out to 60 homes in E&NH and to all care homes in HV.
- **Aligned GPs** offering support to all older people care homes in E&NH, for example, by undertaking weekly ward rounds and proactive care.
- **Impartial Assessor** – see area 4.
- Development of the **Vanguard Dashboard** to capture Programme impact. This includes a front-page of latest activity and individual project dashboards – see <https://www.hertfordshire.gov.uk/statweb/infostore/VP/VE.html>

Area 6: Timely and Safe Discharges

Key Achievements

Acute Frailty Service to support frail and older patients in the community:

- Enhancement of the existing frailty service in E&NH for better outreach to care homes – this includes agreement of a service expansion model with possible future expansion to the other STP-footprint areas.

Development of discharge services:

- Using a whole-pathway approach to provide an end-to-end Stroke Early Supported Discharge service with integrated community resources.
- Mobilisation of the **Specialist Care at Home** lead provider model which aligned a number of disparate transitional pathways, including rapid response and enablement, into a single service to deliver an up to four week package of enabling care. Taking referrals from the community and acute, it has supported individuals to return or remain at home, regain independent, and improve their long-term outcomes, prevent future hospital admissions and support discharge. Over 2016-17, Specialist Care at Home:
 - Introduced a new and joined up way of working from April 2016 with a more comprehensive enablement offer and even provision
 - Enabled care extended to higher acuity service users, with focus on enhanced training for care workers with a particular emphasis on dementia specialism
 - Delivered 178,000 hours of enabling homecare, with 86% of those discharged from hospital still in their own home 91 days later
 - Over 50% of service users required no ongoing care following receipt of the service
- **Delirium Recovery Programme** (previously known as the Delirium Pathway), or a specialist homecare service in Herts Valleys that supports individuals with delirium enabling them to stay at home – over the last year, the Programme has helped 26 patients, 92% of who were able to stay at home. The next year will see a review of the patient identification process and specialist delirium and enablement training for live-in carers.
- Process mapping between partners in preparation for roll-out of Discharge to Assess where medically fit patients will be discharged to a home setting for assessment of ongoing care

needs.

- Expansion and embedding of the **Integrated Discharge Teams**, or fully integrated health and social care teams, at Lister, Watford and Princess Alexandra Hospitals. This introduced joint processes from admission to discharge helping to reduce lengths of stay and increase patient flow. At Watford for example, in addition to the existing Discharge Coordinator, Planning Nurses, Adult Social Care and Voluntary Sector workers, there are now Hertfordshire Community Trust (HCT) in-reach workers supporting transition into HCT community rehabilitation beds to significantly improve flow into this resource. Earlier utilisation of the Choice Policy has also had an impact.

Area 7: Integrated Urgent Care

Key Achievements

- Development of **out-of-hours services** - Procurement and contract mobilisation for Integrated Urgent Care (formally 111 and Out-of Hours) for out-of-hours service provision.
- Roll out of two **Early Intervention Vehicles**. Hosted by the East of England Ambulance Service, this provides 7-day immediate response to any care home in E&NH via screened 999 calls. It has seen a fall in the proportion of people taken to hospital from an average of 50% to 28%. The vehicle has made over 1097 visits since service began of which 72% visited were kept out of hospital.

Partnership Working:

In addition, **partnership working** has been able to develop under Better Care Fund governance including:

- **Continuation of one of the largest BCF pooled budget in the country** incorporating out of hospital service budgets totalling £328m in 2015-16 and £304m in 2016-17.
- **Strengthening of existing governance arrangements for partnership working** with a system-wide approach sustained and refined over 2016-17 – this included joint CCG-HCC Executive Boards continuing to work together to evaluate opportunities, assess risk and align strategic priorities, shared risk management approaches, and an increasing number of operational teams co-locating and working closer together to provider responsive, coordinated care in the community.
- In 2016-17, the CCGs and HCC conducted BCF audits, which validated the overall approach to partnership governance and made recommendations – since implemented in full - for further improving joint processes for monitoring, reporting and informing future strategy.
- Development of a collaborative approach between providers and commissioners towards the design and implementation of integrated care models, led by Integrated Care Programme Boards (ICPBs) covering East and North Herts and West Herts.
- The ICPBs focused particularly on delivering services together that improved the care, independence and health of older people with complex needs and patients with long-term chronic physical and mental health conditions. They were responsible for overseeing delivery of a number of the projects and services listed above.
- **Launch of new strategies / governance arrangements** - various joint strategies to facilitate and direct integrated working have been launched or worked on including

CAMHS (Children & Young People's Mental Health Service) Strategy, the Hertfordshire Dementia Strategy, Hertfordshire Carer's Strategy and the Mental Health Strategy and Public Health Prevention Strategy.

- **Transition to STP governance structures** - From September 2016, established collaborative governance arrangements including Integrated Care Programme Board portfolios were transitioned into new governance STP structures.

Case Studies

Case Study 1: Multi-Speciality Team Approach

A Community Psychiatric Nurse (CPN) working in mental health services for many years remarked on the difference the MST approach has made to her way of working. Having never worked with the Community Matrons, since introducing MST in her locality 9 months ago she has since participated in at least 6 joint visits with them co-ordinated through the MST meeting or as a result of understanding who else is involved in someone's care and understanding the benefits of joint assessment and co-ordinating their care planning approach.

Another CPN reflected on the difference improved relations in a locality have made - on visiting an elderly couple who were expecting the visit, the CPN found no-one answering the door. Previous to MST in the locality, the CPN would have called the police to break down the door for fear of something having happened to the couple. However, knowing the Social Worker also involved in their care, the CPN called her, where it transpired the couple had been taken into Respite Care at the weekend. The CPN was able to feel assured about her patients, update her records to reflect their whereabouts, saved her time and effort that afternoon and no police time was called upon

Case Study 2: Early Intervention Vehicle, E&NH Vanguard

An ambulance was called by the family of a 96-year-old lady who were concerned she was not eating or drinking properly and about her deteriorating state of health. 999 call centre operators despatched the EiV team which, after medical and functional assessments, ascertained that the lady was dehydrated but not in need of hospitalisation. Their main concern was that the family was not coping well with their mother/grandmother's deteriorating health.

The lady herself was accepting of the fact that she was coming towards the end of her life, and wanted to stay in her own home, but the family needed support to help her achieve this. The team contacted the lady's GP and rapid response services who were able to assess her needs and put in place a care package and practical aids to help maintain her hydration and wellbeing. Altogether the team was with the patient for two hours but was able to help her achieve her wishes and ease the burden on her family – a rewarding outcome for everyone.

Case Study 3: Impartial Assessor, E&NH Vanguard

The Impartial Assessor (IA) was contacted by the Lister hospital's discharge team about a lady who had been identified as medically fit for discharge several days previously but the care home had not been able to assess her. The IA assessment took just over an hour, involving reading through the patient's notes, talking to her and carrying out a visual assessment. She relayed her findings to the home which was amazed at the level of detail provided and agreed to accept the patient. The ward fast-tracked her transport and medications and the whole process took four hours.

Julie Hutchins, Registered Manager at Honister care home, Hatfield, said first impressions of the new Impartial Assessor service were good: *"The IA contacted me a few weeks ago and came for a visit. We ran through some of the questions that I thought were important when assessing a patient for discharge. I thought the process and communication were very good and our resident's discharge went well...Most of my staff live locally and do not drive so cannot pick up this task if I am not around. Lister Hospital is a 30 mile round trip from here, so there is often a time issue on busy days. We look forward to working with the IA again in future."*

Case Study 4: Community Navigators, referred by a GP Surgery

Mr Smith was being treated clinically by the GP for diabetes and dementia but the GP felt there was more that could be done to support Mr Smith's needs and that of his wife, Mrs Smith, his main carer who was finding it increasingly hard to cope.

The Community Navigator spoke to Mr and Mrs Smith on what they felt they needed – Mrs Smith wanted a break from her caring role as well as more support and a local social activity for Mr Smith. Referrals were made to Carers in Hertfordshire (for ongoing carer support for Mrs Smith), Age UK day-centre (allowing Mr Smith to be more socially active), Alzheimer's Society (to help Mr & Mrs Smith better understand their situation), local lunch club (allowing Mrs Smith a break) and IAPT service (Mrs Smith received CBT to develop coping strategies).

"I now feel that I can cope and I now feel like I have a reason to live. Before I met the Community Navigator I was in an awful place. I feel so much better now I am getting a break, knowing that he [husband] is getting the support and stimulation that he needs as well." – Mrs Smith

3. Delivering Joined Up Care

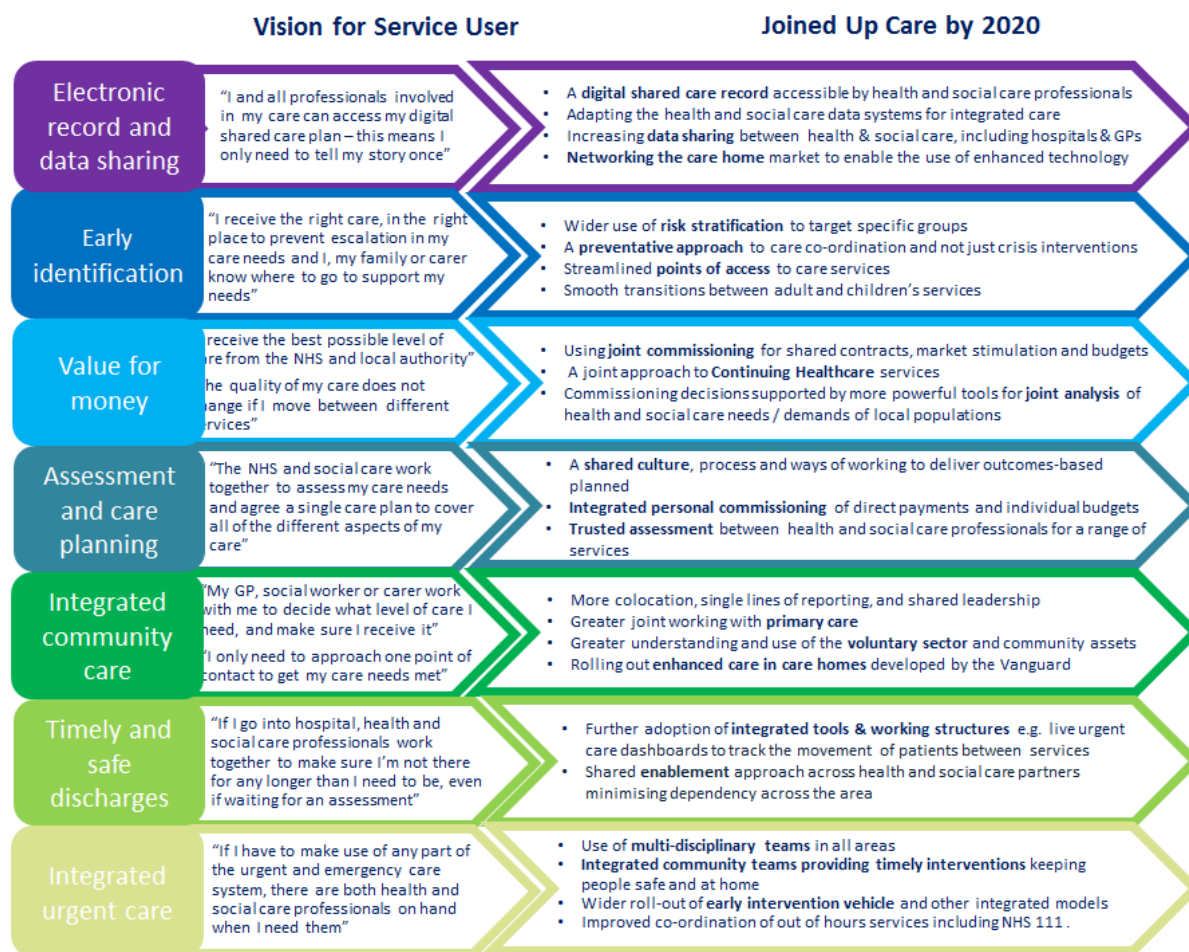
Hertfordshire's plans for integration over 2017-19 are outlined in the section below. By signing off this plan, partners have signalled a continued joint commitment to the shared purpose, leadership and accountability of delivering joined up care by 2020. They have also agreed to work together to address the following priority areas, many of which have been identified from joint working in previous years:

- Evidencing the combined impact of health and social care integration schemes against increasing demand and activity as a result of demographics
- Mainstreaming health and social care integration pilots into core services
- Developing the workforce, including introducing a greater number of integrated roles, to deliver integrated models of care that meet rising levels of care
- Incorporating preventative approaches throughout joint working
- Driving transformation in the context of continued operational and financial constraints
- Showing strong system leadership
- Capturing and sharing learning regionally and nationally – Hertfordshire has already led on transforming services and introducing new models of care, for example, the Impartial Assessor role (see area 4 above). Hertfordshire will continue to do so while also using learning acquired elsewhere, for example through HCC membership of the Association of Directors of Adult Social Services (ADASS), to shape model development.

In line with our vision, Hertfordshire's priorities for 2017-19 have been designed around the 'I' Statements for person-centred, coordinated care which demonstrates our local commitment to person centred planning.¹³

¹³ 'I' Statements have developed and recommended by Social Care Institute of Excellence

Figure 7: Delivery of Joined Up Care by 2020 (*abbreviated version – for full version, see appendix 1*)



3.1 Projects and Programmes of Work

Statement 1: Electronic Record and Data Sharing

Our vision:

"I and all professionals involved in my care can access my digital shared care plan – this means I only need to tell my story once"

Hertfordshire is making good strides towards better sharing of information between health and social care teams and other partners. This will culminate in development of shared care plans accessible to all that need them and which empower the patient. Key milestones by 2020 are:

- A **digital shared care record** accessible by health and social care professionals
- Adapting the health and social care data systems for integrated care
- Increasing **data sharing** between health & social care, including hospitals & GPs
- **Networking the care home** market to enable the use of enhanced technology

How we will achieve this:

Through joint planning, Hertfordshire's health and social care partners have identified four key strategic priorities across organisations to maximise patient care and empowerment. These are:

1. **Designing and implementing interoperability**, to share live patient information between health and social care partners across the STP footprint – a central part of this is development of a **digital shared care plan** which will allow relevant health and social care professionals and potentially patients read-only access to the same care plan. Joint agreement of an outline business case has already been achieved, with a full business case and preparatory technological improvements to be carried out by the end of 2017 and implementation over the following 2 years. Other plans include implementing an automated route of information exchange between social care and Lister Hospital following a feasibility study last year with NHS Digital.
2. **Live Urgent Care Dashboard**, to give a live view of system flow across the STP footprint to all who need it, including hospitals, NHS 111, the Ambulance Service, and social care. This will enable identification as well as anticipation of system pressures, and the quick establishment of joint mitigation measures. For example, this can be pre-programmed to send early warning to named leads should activity indicate impending pressures in certain areas. Following a strategic development session between partners, a business case is currently in development with roll-out planned for winter 2017-18.
3. **Shared Intelligence**, to inform system-wide decision making across all organisations, whether a commissioning, performance monitoring or patient risk stratification decision. To date, aggregated data analysis has been used to better understand individual themes, for example falls, but over 2017-19 will be expanded to cover a range of system-wide, population health issues. This includes defining what is required from a system-wide risk stratification tool and workforce then making sure this is implemented.
4. **Technology & Infrastructure**, to enable sufficient resourcing and expertise to allow the above. Plans include establishing a collaborative platform for document and other information sharing, reducing fax use, reviewing cyber security, and 'federating' wifi, for example, allowing internet access across Hertfordshire and West Essex GP surgeries.

Hertfordshire's **Digital Integrated Care Programme** is responsible for delivering the ICT elements of the BCF Plan and Hertfordshire and West Essex's STP (or local digital roadmap). As part of the transition into STP governance, the Digital Integrated Care Programme has taken on the leadership role of the **Health & Social Care Data Integration Board**, including a new clinical reference group. This group provides a critical eye to review, sense-check and approve proposals, as well as identify potential future opportunities. .

The Integrated Digital workstream is also supporting the emerging priorities of integration projects that are targeting and achieving more efficient working through better use of technology and data sharing. For example, a current project is reviewing opportunities to improve networking with care homes through the ‘**Technology in Care Homes**’ project. Currently residential and nursing homes are unable to access or receive patient identifiable information for clinical professionals. Potential solutions to be reviewed and tested include the use of Systm1 or other care planning systems and using telehealth in urgent care cases. Plans are also in place to deploy the nhs.net email to all care homes by the end of 2017-18 which requires completion of the IG Toolkit. The workstream will also be looking at Assistive Technology across the STP area, reviewing learning and rationalising existing strategies to develop clinically-led solutions across the system.

Information Governance: The Integrated Digital programme also includes a cross cutting commitment to information governance, with a Programme Information Governance Group overseeing the development of our joint approach. Hertfordshire continues to have in place the cross-organisational Data Sharing Agreement, reviewed annually (next review due late 2017), to ensure the Caldicott guidance and duty to share data appropriately are fully met. This includes the over-arching [Fair Processing Notice](#) published on the Council’s website. This means respecting patient information confidentiality and that their right to object to their data being shared is respected. Hertfordshire’s last successful submission of the NHS IG Toolkit (Version 14) was in April 2016, assessed at Level 2. ¹⁴

The Digital Integrated Care Programme has recently developed the ‘Information Sharing Every Day in Health and Social Care’ booklet, a set of STP-wide data sharing principles and guidance that draws on a number of central guides to assist health and social care staff in understanding and practicing safe information sharing. ¹⁵ A sub-group, in partnership with Hertfordshire Healthwatch and service users, will be used to test as well as potentially co-produce data sharing solutions.

Hertfordshire has also responded to the National Data Guardian’s consultation on the proposed 10 data security standards and new consent and opt-outs model for data sharing in the NHS and social care and is awaiting publication later this year.

Medeanalytics, the single integrated data platform for health and social care data, ensures the information used for service planning across West Essex and Hertfordshire is flowed in pseudonymised form and joined and stored securely with appropriate access controls in place to ensure it can be accessed and used in line with the agreed purpose, and benefits whilst minimising any risk of inappropriate re-identification.

¹⁴ For more information, see the information governance section of the 2016-17 BCF Plan

¹⁵ Available on request

Statement 2: Early Intervention

Our vision:

“I receive the right care, in the right place to prevent escalation in my care needs and I, my family or carers know where to go to support my needs”

Early intervention seeks to both prevent escalation of need and ensure that patients, their families and carers have access to the care, information and advice needed to improve or maintain their health and wellbeing. Accelerating progress in this area will be a crucial response to the demographic pressures outlined in section 2 and improving care outcomes. Key milestones by 2020 are:

- Wider use of **risk stratification** to target specific groups
- A **preventative approach** to care coordination and not just crisis interventions
- Streamlined **points of access** to care services
- Smooth transitions between adult and children’s services

How we will achieve this:

Developing **risk stratification** or population health management in a move from reactive to proactive care. This means implementing appropriate interventions and aligning resources according to the level of risk for that individual as below:

- Intensive case management for very high-risk patients
- Early intervention/care management for patients at rising/moderate risk
- Supported self-care interventions for moderate risk patients
- Prevention and wellness promotion for low-risk patients

It has been agreed to pilot a number of different approaches across the STP so that learning can be shared between partners. West Essex CCG will be trialling two different approaches:

- Part 1 Risk stratification of the over 18 patient population using eFI (SystmOne) or QAdmissions (EMIS).
- Part 2 GOLD classification of a practice’s COPD population with specific interventions according to tier and support review for patients with COPD.

ENHCCG will focus on the Population Health data accumulated in their Lower Lea Valley locality and held within MedeAnalytics to:

- Refine the Risk of Unplanned Admission algorithm to utilise elements of the newly linked GP data to improve its accuracy and action ability
- To introduce the eFI (frailty) classification into the Medeanalytics tool
- To allow the extent and patterns of Long Term Conditions and multi-morbidity to be identified and their impact on the individuals patient’s risk to be quantified. This will

have a particular focus on Diabetes and reducing Variability in Care/identifying Gaps in Care.

- To segment the practice population using the Primary Care Home population health model to identify homogenous/actionable segments. This will inform commissioning decisions as well as traditional risk stratification with a clinical and prevention-of-admission focus using demographic data, Long Term Conditions and cost.

Making the most of Hertfordshire's **voluntary and community assets**, which includes embedding preventative infrastructure in local communities as well as the health and social care system within STP governance structures. Priorities include:

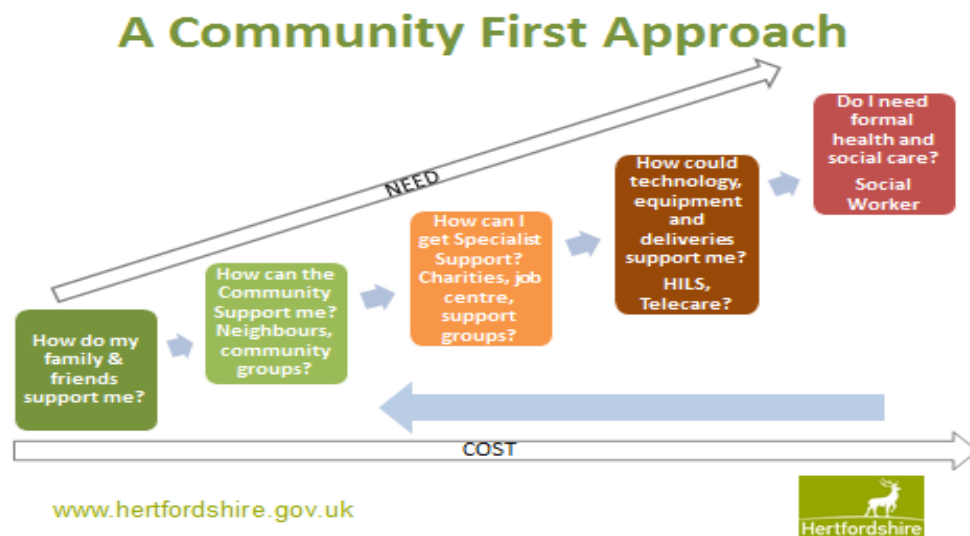
- To maximise the use of '**social prescribing**', a model of support using a social intervention usually via a third sector organisation, to reduce, delay or prevent the need for further health and social care intervention. This is in recognition of the growing body of national evidence, as well as findings from the Community Navigator project in West Herts, that non-clinical interventions that reduce isolation, provide information, practical help and emotional support can reduce, delay and prevent ill health as well as better coordinate care. To this end, Hertfordshire is assisting the **National Social Prescribing Network** to develop the national social prescribing strategy as well as developing a local approach. This will include development of a Prevention Strategy as part of STP delivery.
- A refreshed **Self-Management Programme 2017-20** for Hertfordshire¹⁶ aims to embed the principles of self-management across the health and social care system helping people take ownership for their own health and wellbeing in collaboration with health and social care professionals, the community, carers and families. It will do so using principles of sustainable support to build resilience, make better use of technology, train groups to be self-sustaining, and encourage preventative messages
- Developing community networks through the **Community First** strategy. The strategy, illustrated below, recognises the vital role of existing networks between third sector organisations and the wider health and social care system. It aims to embed the following principles:
 - Communities are able to take responsibility for their health and wellbeing
 - People can receive and provide support outside formal frameworks
 - Communities are seen through their assets, not their problems
 - Professionals use care resources more intelligently
 - Networks are simple to navigate and well managed, via Herts Help¹⁷

The principles acknowledge that community-based assets, resources and services are often able to bring more appropriate and innovative solutions to complex support needs and can lead to better individual outcomes as well as better use of system resources. A series of 'Community Conversation' events held in each district area earlier this year have already begun the implementation process.

¹⁶ Available on request

¹⁷ HertHelp is a free, independent and confidential service to anyone who lives in Hertfordshire offering a single point of contact for local information, advice and support. Funded by Hertfordshire County Council and NHS partners, it is delivered by local community organisations. <https://www.hertshelp.net/hertshelp.aspx>

Figure 8: The Community First Approach



- **Building on existing services:** Plans are in development for the countywide roll-out of community navigator scheme (see below) and hospital discharge services. This will result in every locality having a dedicated resource to proactively use social prescribing to reduce, prevent or delay the need for formal health and social care services.
- **Community Navigators** – With a total of 7 navigators based across 5 local authority areas, this Herts Valleys’ service will continue to support local people who would benefit from additional community support to access statutory or voluntary services. With over 2000 referrals last year and 50% of 2015-16 referrals coming from GPs, the Navigators will be an important part of the STP’s preventative and social prescribing agenda. The navigators also sit on local MSTs, helping join up the voluntary and statutory inputs. Plans for 2017-19 include:
 - Working with GP surgery Patient Participation Groups (PPG) and the community and voluntary sector (CVS) to see if a volunteer led programme, under the supervision of the PPG, could assist with low level navigation to the voluntary sector. This is starting with the Maltings GP Surgery in St Albans which has had 12 volunteers since Feb 2017 and has been running a ‘social prescribing / navigator’ clinic in the surgery.
 - Scaling up the use of volunteers – this includes GP surgeries based in areas of deprivation where the Navigator approach can be used in support of the wider determinants of health and the reduction of health inequalities.
 - Refining the cost model to determine scheme savings to the health and social care system and impact on the voluntary sector (e.g. through reduced GP appointments, prevention of admissions, or saving social worker time) now that greater evidence is available – the provisional net figure using the current conservative methodology suggests £646k savings to the NHS.
 - Developing a model to measure service impact on wellbeing and self-management of long-term conditions

- Introducing a more targeted approach to service user feedback, including investigating the use of the Impact Assessment App.

Streamlining **points of access** for patients and professionals making onwards referrals:

- Following a review of all major health and social care access points, a joint Access Review Group will be developing a new model of access. This will seek to reduce the number of contact points for both professionals and patients leading to simplified pathways, improved customer experience and appropriate handovers between services. The proposed models will take account of the split between access at a countywide scale and access at a locality level.

Smoother transitions between adult and children's service: The 0-25 Integration Programme is looking at how children's social care, adults' social care, education and health services can work more effectively together to better support families with children and young people that have additional needs, as well as prepare them for adulthood and greater independence. This means joining up service delivery and commissioning for improved outcomes for children and young people as they enter adulthood. Actions include developing workforce and Hertfordshire's SEND offer and reviewing customer experience and existing services to ensure smooth transition from children's to adults' services, as well as developing a commissioning strategy and commissioning delivery unit.

Programme outcomes include a Hertfordshire where:

- Resources are used fairly and effectively with preventative investment so people get the right support at the right time
- Parents have a real choice over their child's education and the opportunity for direct control over support for their family
- Systems are clear so that professionals from different services and the voluntary and community sector can work together
- Children, young people, their families and communities have much more influence over local services

Statement 3: Value for Money

Our Vision

"I receive the best possible level of care from the NHS and local authority...The quality of my care does not change if I move between different services"

Integrated working presents considerable opportunities for more streamlined and efficient ways of working that at the same time directly benefit patients through better quality services. Hertfordshire already has examples of shared resourcing and analysis but intends to pursue these to a much greater level. Key milestones by 2020 are:

- Using **joint commissioning** for shared contracts, market stimulation and budgets
- A joint approach to continuing healthcare
- Commissioning decisions that are supported by more powerful tools for joint analysis
- An operational **Home Improvement Agency**

How we will achieve this:

Further development of joint or integrated commissioning arrangements means better patient care and no change in quality if using different services as well as enhancing the value for money of what is spent.

- Using joint approaches for shared contracts, market stimulation and budgets
- Introducing a joint approach to **continuing healthcare**:
 - Operating teams using shared office space
 - Working up detail and implementing the E&NH commissioning model for integrated contracting processes, to be in place by April 2018
 - To facilitate a CHC conference to raise awareness of CHC, assessment processes and user experiences. Anticipated outcome is improved engagement with CHC processes by professionals.
 - In HV, there will be shared learning with the E&NH project and progressing identified areas which is likely to include joint contracting, transition from children's CHC, mental health CHC.

Home Improvement Agency: Hertfordshire has been working together with stakeholders since 2016 to think more strategically about the use of Disabled Facilities Grant monies in the county, as well as the role of home adaptations and housing in general. This collaborative approach involved consulting directly with District and Borough councils, statutorily responsible for delivering adaptation grants in their areas, and HCC, responsible for ensuring people's homes are suitable for meeting their needs. Following a period of development, it was agreed to create a Shared Home Improvement Agency function inclusive of the DFG service and integrated Occupational Therapy. This uses economies of scale to maximise income generation, efficiency and value as well as sharing of skills and knowledge between authorities and increased user satisfaction.

The Home Improvement Agency will be launched in Autumn 2017. The model includes:

- Four local district authorities with further potential additions in 2018-19
- Introduction of a shared service model delivering end-to-end service
- A Head of Service, HIA team and HIA Board to ensure strategic direction
- Procurement of a contractor framework to undertake standard adaptations
- Potential future developments to cover a range of housing issues

Introducing the HIA will mean:

- Individuals who need housing adaptations to support independent living have access to an appropriate, timely, accessible, equitable and fit for purpose service to address rising demographic pressures

- Delivering a fully standardised service that enhances operational efficiency, customer satisfaction, and value for money
- Implementation of robust monitoring arrangements to measure impact
- Improved service resilience through joined up working, adopting a common methodology and service standards, sharing staff knowledge, skills and expertise
- Opening up future opportunities to expand into private sector adaptations and align to wider Clinical Commissioning Group activity that will help maximise income generation, efficiency and value and impact of the DFG

Linked datasets: Significant work has been undertaken in the past year, which will continue during 2017-19, to link datasets with the NHS number so it is used as the prime identifier for health and social care services. The direct link established early last year between the adult social care system ACSIS and the NHS spine means around 94% of records now have an NHS number. This includes implementing the Personal Demographic Messaging Service enabling approved social care staff access to NHS numbers in accordance to jointly established governance and collaboration protocols. This has already improved the ability to share more meaningful information across multiple datasets. Planned developments for 2017-19 include:

- Establishing an appropriate digital approach with NHS Digital that will widen current access to NHS numbers beyond the existing card reader method to a larger number of approved social care users
- Reducing the number of remaining social care records without an NHS number with a target of 99% having a NHS number by 2018

Tools for joint analysis of health and social care needs / demands of local populations:

The STP partners have agreed to scope and jointly procure the required business intelligence tools for joint analysis of health and social care needs / demands of local populations in order to identify efficiencies. Within West Essex and Hertfordshire the three CCG's have been collecting and linking patient level data in an IG compliant way over the previous two years, with data flowed on a monthly basis. By holding hospital, community, mental health, primary care and social care data sets relating to local populations, it is starting to become possible to track patient journeys across the whole of the local health and social care system.

Starting in April 2016 a small group of 'Super-Users' including analysts from each of the three CCGs but also from the other health and social care providers and Public Health agreed to come together to understand the data available, and use this to provide an evidence base for improved efficiency and to build their skills and tools for linked data use. However, as the importance of population health management and linked data's role in providing an evidence base for system development to the STP partners is recognised, agreement has now been reached that the scale and pace of this work needs to be increased. An audit of analysts working in the STP have identified almost 100 individuals in Hertfordshire alone who could assist with this work if they were engaged appropriately. Therefore the creation of a virtual team across health and social care organizations with the ability to deliver integrated insights across multiple services and ensuring effective IG has been agreed as a priority. The development of an integrated in-house training programme,

which provides opportunities to build skills and capacity across the STP footprint is proposed.

Statement 4: Assessment and Care Planning

Our vision:

“The NHS and social care work together to assess my care needs and agree a single care plan to cover all of the different aspects of my care”

Integration means developing a shared system culture that encourages an outcomes-based viewpoint and approach across partners. It also means viewing the patient as a key partner in their care. Key milestones by 2020 are:

- A **shared culture**, process and ways of working to deliver outcomes-based planning
- **Integrated personal commissioning** of direct payments and individual budgets
- **Trusted assessment** between health and social care professionals for a range of services

How we will achieve this:

Integrated Personal Commissioning (IPC): Late in 2016, HCC, ENHCCG and HVCCG were successful in their bid to join the IPC early adaptors programme on their strength of existing partnership working. This ambitious programme seeks to systematically harness the potential of people needing support and their families, to be active co-producers of that support, and members of their community to help keep them independent and well. Working across health, local government and the voluntary sector, it pulls together resources and works with users to understand and plan how best to use these. IPC requires a different approach to planning and commissioning community, social care and other services to deliver person-centred, coordinated care at scale for target population.

Hertfordshire proposes to deliver these ambitions through a programme which will develop the local personal assistant market, develop an integrated personal budget support service and maximise community potential. It will start by focusing on people with multiple long-term conditions, using this cohort as a learning platform to roll out IPC to the remaining three cohorts: people with complex mental health needs, people with learning disabilities with complex needs, and children with complex needs. Hertfordshire’s IPC will also support the major expansion of personal health budgets as detailed in CCG local offers, also leading to adoption of a countywide approach.

Hertfordshire will perform against ambitious national and local targets, including:

- Having appropriate programme and governance arrangements in place with alignment to partnership programmes by quarter one of 2017-18
- Supporting 50 people through the IPC personalised care and support planning process by quarter one of 2017-18

- 1% of the national population to have person-centred support by March 2018, and that IPC will be the main model of care for around 5% of Hertfordshire's population
- Work with the local voluntary and community sector to coproduce the programme and make IPC sustainable
- Expanding use of a shared care plan between services

To date, an all-age Personalisation Steering Group with representation from across commissioning organisations has been established to lead on IPC development and oversee system-wide outcome delivery. The programme will look to expand to the remaining area of the STP-footprint in 2018-19.

Trusted Assessment between health and social care professionals for a range of services where quick access is required for system flow.

- The **Impartial Assessor**, introduced in 2016 as part of the E&NH Vanguard and independent from the NHS, will continue operating at Lister Hospital – to date it has achieved faster, trusted discharges between hospital and care homes by assessing on behalf of care homes. This has increased bed flow, reduced miscommunications and freed up valuable resources for care staff. HCPA have also been able to support care home engagement. With 245 assessments already conducted and an estimated 393 bed days saved, a recently recruited second Assessor means the service will be extended to cover 6 days a week, Monday-Saturday. Other plans include:
 - Introducing the Trusted Assessor model at Watford General Hospital and Princess Alexandra Hospital
 - Identifying, monitoring and helping to resolve potential issues between hospital and care homes transfers, and encouraging a joint understanding of equipment, weekend transfers and communication links between care homes and IDTs.
 - Ensuring the Impartial Assessor role is in line with plans for Discharge to Assess
 - Introducing a pilot role at Lister Hospital to support self-funders and their families who are moving into a care home to make an informed decision.

Statement 5: Integrated & Community Care

Our vision:

“My GP, social worker or carer work with me to decide what level of care I need and make sure I receive it...I only need to approach one point of contact to get my care needs met”

Hertfordshire's moves towards more locality-based planning and service delivery is an important next step in ensuring the patient, their family and carers, get the most appropriate support tailored to their care needs. Key milestones by 2020 are:

- More colocation of community teams with single lines of reporting and shared leadership
- Greater joint working with **primary care**
- Greater understanding and use of the **voluntary sector** and community assets

- Rolling out **enhanced care in care homes**

How we will achieve this:

Integrated Community Teams: As part of Hertfordshire's developing locality-based approach to planning and service delivery (see STP section), we are piloting approaches to the integration of community services to further ensure services are delivered in accordance to individual, and local population, need. A number of localities are already implementing plans which include greater colocation and shared team leadership. Much of this activity represents the natural next step from highly regarded integrated case management and care coordination services, including rapid response, Homefirst (E&N Herts CCG area) and Multi-Speciality Team (MST) approach.

To support greater autonomy in localities, changes to the commissioning approach (E&N HCCG area) will distribute an equalised resource in each locality to support Frail patients. An overarching Outcomes Framework, referenced by partners' existing contracts, will support and motivate partnership approaches to delivering outcomes with best use of resource. This approach will be overseen locally by Locality Delivery Groups, featuring membership from all STP partners. Whilst providing assurance to the CCG and maintaining quality, the Outcomes Framework will support localities to work together, developing and reviewing locally agreed models of care which best suit the needs of the local population. Over the next two years integrated services will be mainstreamed and organised around neighbourhood service 'hubs'. There will be a greater focus on integrated care planning and proactive support of self-management through personalised care planning, empowering patients and their carers to contribute to their plan for care.

HVCCG are currently in the process of redistributing and redesigning core community nursing and therapy services as well as undertaking a number of pathway specific reviews and recommissioning exercises such as in diabetes and stroke services. An overarching principle of this commissioning approach has been the for partner organisations to jointly plan and implement integrated service models to better meet the needs of target populations. As in E&N Herts, locality delivery groups established by STP partners are leading the development of place based models of primary and community care around local clusters or neighbourhoods of 30-70k.

Enhancing Care in Care Homes to deliver an enhanced model of health and social care to support frail elderly patients, and those with multiple complex long-term conditions in the community in a planned, proactive and preventative way. See appendix 4 for milestone breakdown, but plans include:

- **Complex Care Framework**, including **Complex Care Premium**
 - Continuation of scheme, with support and learning network continuing for participating care homes
 - Analysis of activity data, including evaluation of the service by the London School of Economics who will use this to draw lessons for other preventative-aimed services
 - Potential development of model into other areas, for example, homecare provision

- **End of Life ABC Training**

- Training has been delivered to 44 care homes – to be rolled out to remaining homes.
- Developing impact assessment measures with hospices.
- To be built into E&NH's End of Life Strategy being developed this year

- **Enhanced Primary Care Support**

- Developing the robust service-level agreement and delivery model that meets both care home and GP needs
- Working with CCG commissioning to adapt a place-based approach to delivering the service – this includes Governing Body GPs working within their localities to develop ideas for a new model of care in which to deliver the specification

- **Medicines Optimisation**

- Continuing to deliver this person-centred approach to safe and effective medicines use so that residents obtain the best possible outcomes from their medicines – this includes a deep-dive into resident medication and recommendations made to a care home's aligned GP
- Pharmacy technician to start in June 2017
- To work with in-patient pharmacists
- Review options of scalability

- **Red Bag**

- Reviewing lessons from the project pilot across 10 care homes between January and March earlier this year
- Roll-out to all older-people care homes in the Lister Hospital and Watford Hospital footprint over this year
- To consider options for roll-out to Princess Alexandra Hospital footprint

- **Targeted Support**

- To work with 10 care homes – identified to have particularly high acute activity – to offer targeted support in the form of small interventions to pilot their effectiveness as well as gather intelligence on key themes around care homes and admissions. This is with the aim of reducing admissions by 10%.
- To particularly focus on care home retention, recruitment and leadership issues, with delivery of a workforce analysis
- Case review with 5 care homes to better understand why patients are being admitted to hospital – this will inform a wrap-around support approach for these care homes. If successful, to be rolled out wider.

Last year's Vanguard programme was designed to be an early adopter for trialling new models of care within care homes and beyond. Learning has been fed into care home development plans. Currently an exemplar site for Impartial Assessor, enhancement in care home services will continue working towards achievement of all 8 aspects of NHSE's 'Enhanced Care in Care Home Framework'. This means working with care homes to provide

joined up primary, community and secondary, social care to residents of care and nursing homes, via a range of in reach services.¹⁸

- See statement 1 for information on the **Technology in Care Homes**
- See statement 2 for **Community Navigators**
- See statement 4 for information on the **Impartial Assessor**
- See statement 7 for **Early Intervention Vehicle**

Statement 6: Timely and Safe Discharges

Our Vision:

“If I go into hospital, health and social care professionals work together to make sure I’m not there for any longer than I need to be, even if waiting for an assessment”

An integrated health and social care system is important to managing patient flow and providing the best possible care. Working together to improve discharges is a key goal of High Impact Change Model with partnership working helping to expand or implement various schemes and ways of working. Key milestones by 2020 are:

- Further adoption of **integrated tools and working structures**
- **Shared enablement approach** across health and social care partners minimising dependency across the area

How we will achieve this:

Hertfordshire is committed to ensuring the timely and safe discharge of patients from acute and non-acute facilities into their long term place of residence as quickly as possible. This is both to alleviate pressure on the urgent care system, but also to help assess for and put in place the most appropriate long term care and support for the individual which helps to best enable and maximise their independence for as long as possible.

As shown in the previous section and appendix 6 (Hertfordshire’s progress against the 8 High Impact Changes framework), partners in Hertfordshire have worked together to deliver the main building blocks of an effective discharge system. This includes jointly managed integrated teams, jointly commissioned enablement and intermediate care service models, voluntary sector discharge schemes, trusted assessment processes, seven day working and other specialist pathways and services such as Dementia and Stroke. However, Hertfordshire remains challenged by a high rate of delayed transfers of care in both acute and non-acute beds, with a particularly high number of delays at Watford Hospital and in physical and mental health units for adults and older people. There are a number of

¹⁸ For more information see <https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/care-homes-sites/>

schemes and initiatives that Hertfordshire will implement or expand over the next 2 years, which include:

Developing Discharge to Assess Capacity:

Building upon our successful and jointly commissioned bed based discharge to assess model, we will be looking to develop further discharge to assess capacity across our system, including:

- Further development of our enabling domiciliary care discharge model 'Specialist Care at Home' (SC@H). Procured collaboratively under the BCF, last year saw the successful mobilisation of this service which drew together multiple transitional pathways into a more efficient and joined up single service delivering 178,000 hours of care over 2016-17. Over the next 2 years the service aims to deliver more capacity supported by iBCF monies (£213,000 in 2017-18). This will be aided by changes to HCC social care ICT system in 2016-17, which will allow social care providers direct access to a person's assessment information and care planning outcomes
- Implementing **First** (Facilitating Integrated Reablement to Support Transition)¹⁹, a discharge to assess scheme in Herts Valleys to provide support for up to 50 people in their own homes after hospital that are medically fit for discharge. Social care and homecare support will be provided for up to 6 weeks. This is working in arrangement with WHHT to increase its capacity to support people in their own homes in response to the need to reduce community hospital bed numbers, reduce delays and keep the flow going (e.g. stop waiting in emergency).
- Delivery of 'discharge flats', a model developed in collaboration with housing associations to enable patients to be assessed and rehabilitated in a familiar domiciliary setting.
- Expansion and improvement of existing voluntary sector discharge schemes, including the commissioning of a countywide service model which integrates discharge pathways with the nationally recognised community navigator service.
- Building on the success of SC@H working alongside community services to develop improved home to assess models of discharge allowing enablement, rehabilitation, assessment and care to help improve patient flow and maximise patient independence.
- Working to develop further our jointly commissioned bed based discharge and intermediate care models to enable maximum efficiency and effective identification of patients with potential for rehabilitation and enablement.

Improving Multi-disciplinary discharge arrangements at acute sites

Having successfully put in place joint Heads of Integrated Discharge teams at Watford and Lister Hospitals, work will continue to develop multi-disciplinary working between all professionals involved in discharge planning for complex patients. The social care capacity in integrated discharge teams will also be enhanced, including supporting a recently introduced seven day working rota in which all staff are expected to work for one in every eight weekends.

¹⁹ <https://www.hct.nhs.uk/news-and-events/hertfordshire-community-nhs-trust-first-for-innovation/>

Developing Trusted Assessment

Building on a successful pilot of the 'Impartial Assessor service' at the Lister Hospital, rolling out this model across all main acute sites used by Hertfordshire residents to improve patient experience, discharge process and trust between hospitals and care homes.

Strengthening reporting and monitoring of discharge

Building upon effective existing daily and weekly monitors of patient flow, our system will look to move further towards real time reporting and oversight of patient flow through both acute and non-acute facilities, improving our ability to better match capacity with demand.

This will include:

- Extending the use of our nationally recognised 'Bed Finder' system which allows for daily monitoring of care home capacity.
- Working with NHSD to implement the 'adaptor' product which will stream line information flows between acute trusts and social care, improving accuracy and timeliness of information to practitioners.
- Developing our focus on supporting non-acute patient flow, working with both our community and mental health trusts through the local delivery boards

This will:

- Identify stranded patients sooner in their acute stay and work closely with ward discharges planners to plan and prepare for discharge as soon as possible, improving patient flow
- Enable better 7 day coverage of discharge planning and patient flow.
- Maximise any enablement and rehabilitation potential of patients to improve independence and ensure that long term care needs are assessed and met most appropriately

Medicines in Transition: This STP-wide projects aims to reduce discharge delays from hospital as a result of changing medicine prescriptions. It will bring together chief pharmacists from the community, acute and CCGs to improve the current medicines pathway. This will not only mean a better use of resources but will result in better patient outcomes. Evidence suggests this will result in both a reduction in costs and a rise in patient experience satisfaction levels.

Flexicare accommodation models for older people will be developed further. Additional investment into this accommodation is planned following a review of services, demand and locality provision undertaken earlier this year. An outcome of this will be future models of flexible older people's accommodation will be aligned to changes in the residential and nursing markets as outlined in sections above. Flexible accommodation schemes will be taken forward in close partnership with district and borough councils taking in account local strategic housing plans.

- | |
|--|
| <ul style="list-style-type: none">• See statement 1 for information on the Live Urgent Care Dashboard• See also National Condition 4, 'Managing Transfer of Care'• See appendix 6 for the High Impact Change DTOC plan |
|--|

Statement 7: Integrated Urgent Care

Our Vision:

“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”

Recognising its value in improving a joined up health and social care system, Hertfordshire has developed joint working between emergency and community teams and will continue to do so over the next few years. Key milestones by 2020 are:

- Use of **multi-disciplinary teams** in all areas
- **Integrated community teams** able to provide **timely interventions** keeping people safe and at home
- Wider roll-out of **early intervention vehicle** and other integrated models
- Improved coordination of out-of-hours services including NHS 111

How we will achieve this:

Use of multi-disciplinary teams in hospitals and in the community, including having rapid response functions fully joined up with integrated community teams.

Mobilisation of the **enhanced NHS 111 service** providing out-of-hours service provision from the end of June this year. Also known as Integrated Urgent Care, the new service commissioned by ENHCCG and HVCCG will be provided by Herts Urgent Care, who provides the current 111 service. Available 24 hours a day, 365 days a year, the enhanced 111 service gives individuals direct access to a wider variety of healthcare professionals including GPs, nurses, dentists, prescribing pharmacists and mental health professionals. Depending on circumstances, an individual can also be given self-care advice by a health advisor supported by a clinical advisor or be put through to a GP or nurse and an over-the-phone consultation.

Early Intervention Vehicle (EIV)

- Continuation of the EIV, dedicated ambulances staffed by a paramedic or emergency care practitioners and a health and social care professional. These respond to triaged 999 calls around, for example, falls, dehydration, UTIs, acute decline in function and mobility – with health and social care working together, this service is not limited to care homes and is helping to reduce pressures on the East of England Ambulance Service, reduce residential placements and helping people stay independent at home
- Subject to a service review, operational hours of the 7-day service will be increased from 80 to 147 a week
- Reviewing project scalability to expand the number of vehicles in operation

Frailty service: The E&N Hertfordshire Trust Interface Geriatrician service supports the Lister frailty unit, primary care advice line, frailty clinic and outreach to nursing homes. A service

model for this frailty service has been agreed and will be implemented over the coming year. This will include increasing resource to consolidate and enhance the work in care homes alongside HCT locality teams. By 2018-19, an assessment for frailty should be established as a routine part of all relevant medical interventions at GP level, ambulance, on arrival at hospital or in a care home.

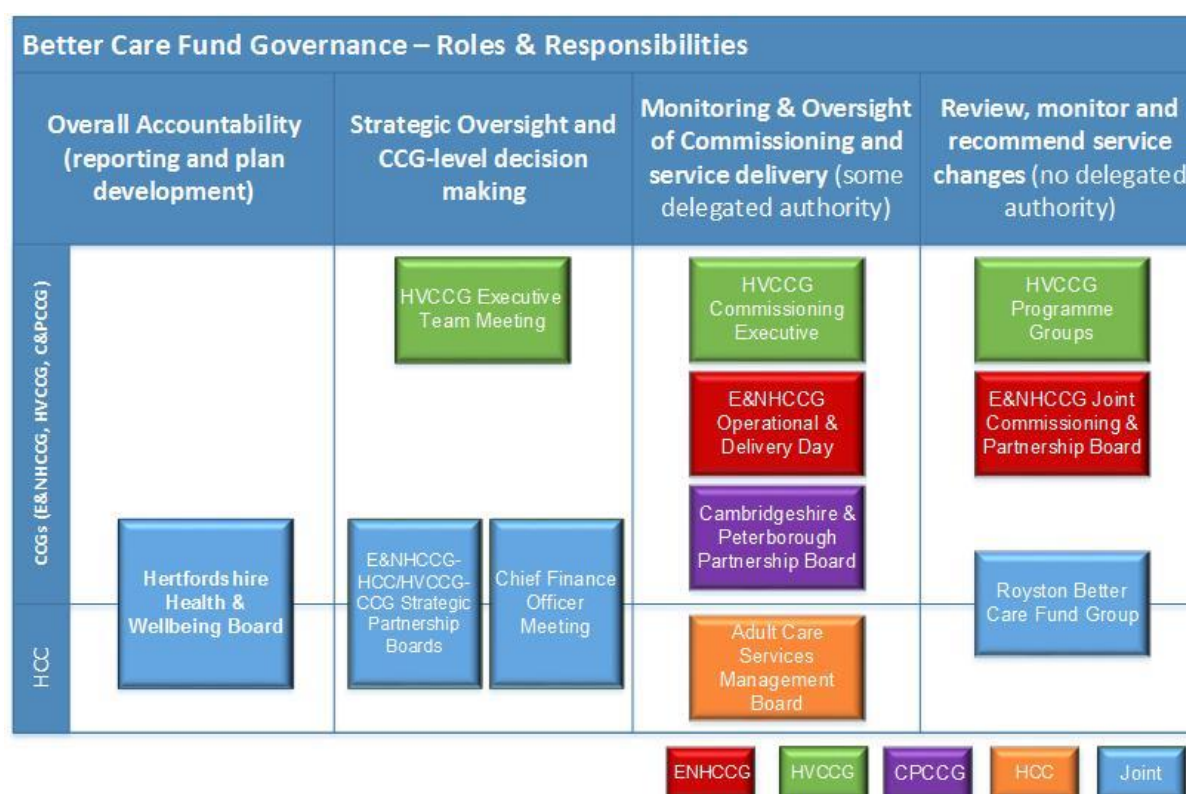
For Key Project Milestones of all projects listed above, see appendix 2.

3.3 Governance & Management Structures

Governance of the BCF

Governance of the BCF for 2017-19 will use the same mechanisms developed for the previous Plan (see below diagram) with some minor updates. As previously, performance of individual projects is 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 the 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).

Figure 9: Better Care Fund Governance



Reporting Arrangements: Better Care Fund reporting operates within existing organisational partnership structures.

- **E&NHCCG:** As the first stage of governance, the Joint Commissioning Partnership Board is responsible for monitoring and overseeing the commissioning and delivery of services for the population of East & North Hertfordshire. The JCPB reports both internally (Operational & Performance Day and Governing Body), and to the ENHCCG-HCC Strategic Partnership Board when related to joint areas of activity.
- **HVCCG:** As the first stage of governance, the HVCCG Programme Boards are responsible for monitoring and overseeing the commissioning and delivery of services for the population of West Hertfordshire. The Programme Boards report both internally (HVCCG Executive Meeting and Governing Body), and to the HVCCG-HCC Strategic Partnership Board when related to joint areas of activity.
- **C&PCCG:** This bi-annual group reviews and monitors service changes to the commissioning and delivery of health and social care services in the Royston area and makes recommendations to HCC's Adult Care Services Management Board and Cambridgeshire & Peterborough's Older People & Adults Wellbeing & Transformation Board.

The bi-monthly CCG-HCC **Strategic Partnership Boards** lead the integrated health and social care agenda and are accountable to the Health and Wellbeing Board as well as internal governance. The **Health and Wellbeing Board** has overall accountability and decision-making for all matters relating to the Better Care Fund Plan development (and Section 75 Agreement) and monitoring as part of their statutory duty to encourage integrated working between commissioners. The HWB will agree the BCF Plan and receive subsequent reports on its overall delivery and performance.

4. National Conditions

4.1 National Condition 1: Plans to be Jointly Agreed

Hertfordshire is required to commit a minimum pooled Fund of £70m (£71m in 2018-19). As in previous years however we have collectively agreed to pool a much larger amount in line with last year's £304m with plans to do the same in 2018-19. This will encompass the majority of out-of-hospital monies relating to older people's care. The size of Hertfordshire's fund reiterates HCC and CCG continued commitment to joint working for better patient outcomes. This, along with the BCF Plan priorities, has been developed:

- With a shared vision and understanding of progress to date to aid joint delivery of joined up care by 2020, as outlined in the above sections
- Alongside the STP's 'A Healthier Future' and other related plans, which will continue to work together through shared governance and delivery networks throughout the BCF delivery period
- With a view to demonstrating an agreed impact of the BCF in relation to BCF metric and other performance, particularly in the face of rising demographics
- With arrangements in place for continued financial and risk monitoring and review of joint spending plans between partners

As outlined in the Planning Template, there is also a shared understanding in place for the use of DFG monies, some of which will be go directly to the Hertfordshire Home Improvement Agency during 2017-19. This has been agreed with participating districts (for more information, see the Planning Template and HHIA section above).

Partnership Working & Engagement

- **Commissioners and Providers:** The BCF Plan has been jointly developed by HCC, ENHCCG, HVCCG and CPCCG in conjunction with providers. Although it has been reviewed by Health and Wellbeing Board members, due to scheduling, it will not go to a formal Board for sign-off until its next meeting in October. Alongside more informal engagement which included 1 to 1 sessions with HWB members and Chief Executives, the BCF Plan was also formally presented at the following:

Table 10: Key meeting dates for Plan Engagement

Group	Organisation	Date
Adult Supported Accommodation Strategic Board	Joint (ACS, district housing, Public Health, NHS)	11 April
Operational & Performance Delivery Day	E&NHCCG	1 May
HV Board	HVCCG	29 June
Finance & Performance Committee	HVCCG	6 July
HV-HCC Strategic Partnership Board	Joint (HVCCG, HCC)	10 Aug

Adult Care Services Management Board	HCC	16 Aug
Chief Finance Officer Meeting	Joint (ENHCCG, HVCCG, HCC)	31 August
Executive Team Meeting	E&NHCCG	5 Sept
Public Health Board	Joint (HCC, NHS, districts, voluntary sector)	5 Sept
Finance & Performance Committee (followed by HV Board on 14 Sept)	HVCCG	7 Sept

- The Plan has been reviewed by STP governance via the **STP Delivery Boards**, with links between the STP and BCF further strengthened by the STP programme leader also being a member of the HWB and Chief Executive of Herts Partnership Foundation Trust (HPFT). Input has also been sought from Hertfordshire's main acute Trusts, East & North Hertfordshire NHS Trust, West Hertfordshire Hospitals NHS Trust and Princess Alexandra Hospital NHS Trust, as well as by key community providers Herts Community Trust and HPFT. Hertfordshire continues its commitment to a collaborative approach with both providers and commissioners having membership of the HWB.
- **Housing and District Councils:** The Home Improvement Agency project and use of the DFG is one example of engagement with **district councils**, responsible for statutory housing duties in their areas. In recognition of housing being a key partner in 2020 integration plans, the BCF Plan has also been taken to the Adult Supported Accommodation Strategic Board (ASASB). Created in 2016, the ASASB jointly considers plans for health and social care accommodation needs and feeds into newly established District Accommodation Boards responsible for local implementation. The district councillor members of the HWB also report to district councils at the Herts Leaders Group.
- **Community and Voluntary sector:** The CVS are present at various Boards where the Plan has been reviewed, such as the Public Health Board, and will be an increasingly important stakeholder as BCF plans are delivered. CVS engagement has formed an integral part of Hertfordshire's move towards building stronger communities – for more information, please see Community First.
- **Patients and carers:** 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 plan based on their own patient and carer engagement such as the STP, HV's Your Care Your Future, and the Health and Wellbeing Board Strategy. Hertfordshire Heathwatch is also a key member of the HWB.
- Integrated projects have and will continue to proactively engage with patients, their family and carers. Building on lessons informed by the 2015-16 Neurological Coproduction project,²⁰ coproduction is increasingly recognised and used as a way of reviewing and improving care services. For example, the adult social care **Strategic Coproduction Board** – created last year - brings together equal representation and a

²⁰ For more information, see the 2016-17 BCF Plan, p. 16

variety of experience and expertise from services users, carers, community organisations and council management board members. The Board has already reviewed proposed spend and savings in adult social care services, areas of transport, and have recently started a disability friendly county group. The first of its kind in the country, the Board will focus on various other areas over 2017-19, using learning to improve engagement in other groups and services and producing a guide intended for use by other coproduction groups.²¹

Improved Better Care Fund

Hertfordshire's share of the improved Better Care Fund (iBCF), a new adult social care grant allocation to support local care capacity, amounts to around £13m in 2017-18 and £12m in 2018-19. This non-recurrent funding will be pooled into the BCF providing additional stability for Hertfordshire's care system and supporting delivery of the High-Impact Change Model and to address the key requirements of the fund:

- Stabilising the social care market
- Meeting adult social care needs
- Reducing pressures on the NHS

The areas of spend of the iBCF monies were agreed between the local authority and CCGs in April 2017, and endorsed through A&E Local Delivery Boards shortly afterwards. It has not been offset against the contribution from the CCG minimum. The breakdown of funding is as follows:

Figure 11: Breakdown of iBCF spend

Table One: Agreed spend on HCC £2bn share	Herts Valleys CCG			E&N Herts CCG			Total
	17/18	18/19	19/20	17/18	18/19	19/20	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1 Smooth impact of reducing CCG funding	4,000	4,500	2,490	3,700	3,700	2,303	
2 Inflationary uplift for homecare (71p pay rise)	350	450	450	466	589	589	
3 Discharge to Assess Programme	1,000	650	0	1000	1000	0	
4 Social work team capacity and OTs	290	290	0	290	290	0	
5 Admission prevention schemes (one-off training)	450	0	0	450	200	0	
6 Voluntary sector discharge schemes & project resource	500	0	0	550	0	0	

²¹ For more information, see <http://www.hertfordshire.gov/coproduction> and [TLAP & Co-production: all about the Ladder of Participation - YouTube](#).

Total cost of schemes	6,590	5,890	2,940	6,456	5,779	2,892	30,547
Total annual allocations	6,598	5,884	2,938	6,473	5,772	2,882	30,547

Figure 12: Description of iBCF spend

Funding will have the following anticipated impacts to the health and social care system: Investment Area	Description	Impact and benefit	Funding Requirements Covered
1 Smooth impact of reducing CCG funding	Managing transition of CCG funding previously allocated to older people community budgets (homecare, direct payments and carer support)	Maintaining existing levels of care provision across the county in the face of reduced funding	Meeting adult social care needs
2 Inflationary uplift for homecare (71p pay rise)	Supporting the homecare workforce through an enhancement to hourly wage rates with the intention of bolstering recruitment and retention	Improve the level of homecare capacity through better workforce recruitment and retention and improve market resilience, allowing flow of service users out of hospital	Stabilising the social care market
3 Discharge to Assess Programme	Providing funds for short-term care and reablement in people's homes or for 'step-down' facilities to bridge the gap between hospital and home.	Reductions in delayed transfer of care and stranded patients in acute and non-acute beds	Support the NHS
4 Social work team capacity and OTs	Investment in enhanced professional staffing levels to enable full staff cover to be sustained during the week following the recent adoption of 7-day services, allow teams can support a higher number of discharges and undertake more comprehensive embedding of enabling and independence-sustaining assessment approaches.	Improved 7 day working Managing demand for ongoing care needs	Support the NHS Meet Adult Social Care Needs
5 Admission prevention schemes (one-off training)	An array of schemes to support more proactive and targeted assistance to vulnerable adults and carers, to prevent crises, including managing falls and enhanced training for domiciliary care workers	Preventing unnecessary or avoidable crises	Support the NHS

6 Voluntary sector discharge schemes & project resource	Using voluntary sector organisations to assist in hospital discharge and to help residents better navigate and access preventative services	Reductions in delayed transfer of care and stranded patients in acute and non-acute beds Preventing unnecessary or avoidable crises	Support the NHS Meet Adult Social Care Needs
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Hertfordshire County Council and the three CCGs will be working together to assess the impact of iBCF funding against the three key requirements of the fund. The County Council is developing measures that will allow the Hertfordshire health and social care system to assess how effective the fund has been in responding to immediate pressures as well as supporting sustainable medium and long term initiatives to support the sustainability of the system. It will also allow the Hertfordshire system to evaluate the effectiveness of the funding where it is being used to support more innovative approaches. This will support Hertfordshire's health and social care system to make sustainable investment decisions in future years.

4.2 National Condition 2: Maintain provision of adult social care services

Hertfordshire health and social care partners recognise the importance of protecting social care services to ensure that those who require it continue to receive the support they need in a time of growing demand and budgetary pressures. This allows for Hertfordshire, among other things, to maintain its current eligibility criteria for social care while developing more personalised care commissioned and delivered in an integrated way.

As outlined in the Planning Template, the CCG contribution to adult social care has been agreed jointly as the CCG minimum in line with the annual inflationary increase. Spending profiles, all of which have a health benefit, have been approved by HCC and the CCGs in line with governance structures outlined in a previous section. Each aligns with at least one 'I' statement in the joined up care framework (see appendix 1) towards greater integration and a stronger and stable care system. This spend was considered as part of the review of associated BCF risks and issues with mitigations built into the BCF risk log (see appendix 5). Each scheme also has a Partnership Agreement outlining agreed objectives, benefits, roles and responsibilities and risk to enable ongoing monitoring of impact and outcomes. Other developments, for example, joint action on data integration (see statement 1) will allow for a greater joint oversight of system performance.

In line with last year, Hertfordshire's BCF also includes significant additional contributions from the CCGs and HCC although maintenance of adult social care services will continue to be a key part of the BCF strategy.

4.3 National Condition 3: NHS Commissioned Out of Hospital Services

The BCF funding from CCGs to be used for out of hospital commissioned services includes CCG minimum contributions of £69,990,526 in 2017-18 and £71,320,346 in 2018-19. In addition to this, additional contributions from both the CCGs and HCC means Hertfordshire's BCF encompasses the majority of out-of-hospital monies relating to older people's care. Spend has been jointly agreed as outlined in the BCF Planning Template.

In line with last year, it has been jointly agreed that none of the above amount will be ring-fenced or placed into a risk-sharing agreement dependent on meeting additional non-elective admission (NEA) targets, but will be used to invest in out of hospital services. This is because CCG plans on which original NEA targets have been based already take into account integration plans. This position also continues to reflect Hertfordshire's decision to be jointly accountable for a much larger pooled budget of local authority and CCG monies.

4.4 National Condition 4: Managing Transfers of Care / High Impact Change Model

Building on last year's DToC Action Plan, Hertfordshire's summary of actions to managing transfers of care is set out in the 'High Impact Change Model implementation plan' - see appendix 6 for Hertfordshire's progress against the 8 High Impact Changes framework as well as the Statements, particularly Statement 6, for further detail on individual projects. The HICM encompasses organisational and system-wide priorities that seek to increase quality of care, improve patient experience and increase service efficiency. The HICM has been agreed for this submission between partners but, intended to demonstrate headline actions, will remain a fluid document to be regularly updated and reviewed in conjunction with partners and other DToC plans. These include the Winter Plan and Urgent Emergency Care highlight report, submitted earlier this year, which contain information on DToC actions in much greater detail.²² Progress against the HICM will be monitored via an ongoing action tracker currently in development.

4.5 Enablers

4.5.1 Better Data Sharing between health and social care, based on the NHS number

Data sharing is being driven by the Digital Integrated Care Programme responsible for delivering the ICT elements of Hertfordshire and West Essex's STP including health and social care integration – for information on action plans, see Statement 1: Electronic Record and Data Sharing and Statement 3: Value for Money.

4.5.2 Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Proactive planning and managing care between other health and social care professionals is a key driver for health and social care integration.²³ Plans are outlined in the Statement sections above, but include:

- Pursuing interoperability, including a digital shared care plan, so that relevant professionals from both health and social care are able to efficiently and safely access information

²² Available on request

²³ For more information, see the 2016-17 BCF Plan, National Condition 5

- Continuing the Multi-Speciality Team approach in Herts Valleys, with a range of relevant professionals across health and social care working together to organise the most appropriate and person-centred care for complex individuals
- The use of multi-disciplinary teams with accountable lead professionals and joint assessment processes to deliver proactive and reactive care, including the integrated community teams and the acute-based Integrated Discharge Teams
- Joining up services in-reaching into care homes
- Greater use of the community and voluntary sector when planning and delivering care

4.5.3 Seven Day Working

Over 2016-17, CCGs, social care and Acute Trusts continued working towards the seven day working national condition areas to reduce variation in and improve mortality rates, reduce non-elective admissions and reduce delayed transfer of care. This includes the four priority Clinical Standards, but also 5 priority areas chosen by each CCG area:

E&N Herts Trust / CCG	West Herts Trust / Herts Valleys CCG
2. Time to First Consultant Review	2. Time to First Consultant Review
4. Shift Handovers	4. Shift Handovers
6. Intervention / Key Services	5. Diagnostics
7. Mental Health	7. Mental Health
9. Transfer to community, primary and social care	9. Transfer to community, primary and social care

Progress has been demonstrated in acute seven day service returns and benchmarking exercises, including WHHT compliance against the four priority Clinical Standards and ENHT to be compliant by March 2018. All milestones for the expansion of seven day services outlined in BCF 2016-17 plan have also been achieved, including:

- Establishment of more robust seven day staffing for hospital based integrated discharge teams – this includes 7 day working implemented and having a positive impact at Watford Hospital and Lister Hospital
- Implementation of seven day service specification for specialist homecare services that support hospital discharges
- Expansion of short term care home beds available at weekends
- Aligning job plans with organisations priorities – for example, at Watford Hospital which now has 7 day in-house consultant-led service provision for key specialities such as stroke, cardiology and intensive care. Along with introduction of a senior decision maker 24/7, this has resulted in significantly reduced turnaround times for investigations and imaging with all patients screened within 15 minutes of arrival.

Over the next two years, Hertfordshire's health and social care system will continue to give high priority to the four priority Clinical Standards in line with ambitions to roll out to 100% of the population by 2020. Hertfordshire hospital trusts have recently undertaken the latest biannual NHS Improvement survey on 7 day working, the results of which will be used to establish a baseline of remaining requirements and refreshed action plan (see also Area 5 of

the High Impact Change Model, appendix 6). This includes ENHT working with NHS Improvement on a diagnostic of remaining requirements for 7-day working. Plans also include strengthening existing 7 day working arrangements, for example, expanding consultant presence to cover a full range of specialities at Watford Hospital.

4.5.4 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The BCF Plan has been reviewed by Hertfordshire's main acute Trusts, East & North Herts Hospital Trust, West Herts Hospital Trust and Princess Alexandra Hospital Trust, as well as our key community providers Herts Community Trust (HCT) and Herts Partnership Foundation Trust (HPFT).

Achieving health and social care integration, or the 'right care and support at the right time and in the right place', means organisations working together to ensure people are treated where it is most appropriate, including shifting activity from the acute to the community and increasing prevention and access to advice and support. It also means that, if a patient does have to make use of the urgent or emergency care system, there are 'both health and social care professionals on hand when needed'. Please see the 2016-17 BCF Plan for more information on planned impact on the acute sector, which includes:²⁴

- Improving integrated discharge services to improve patient flow from hospitals (see Statement 6 and High Impact Change Model)
- Continuation of integrated community schemes aimed at prevention of admissions, including Community Navigators, Vanguard schemes (e.g. Early Intervention Vehicle) and integrated community teams
- Establishing or extending use of multi-disciplinary teams in hospitals and in the community
- Improving interoperability between organisations
- Roll out of the STP prevention strategy with greater use of existing community assets via Community First
- Improved coordination of out-of-hours services, including NHS 111

In addition, the evolution of the Integrated Care Programme Boards into the STP Place-Based and Integrated Care workstream provides a forum for joint conversations and agreements between commissioners and community and acute providers.

²⁴ See 2016-17 BCF Plan, National Condition 6.

5. Risk

5.1 Our Approach to Risk Sharing

Risk management of the BCF is set out in the **Better Care Fund Risk Management Strategy** (see appendix 4) which provides a framework for the identification, management and review of the BCF risks. This strategy remains under the Section 75 (S75) agreement which outlines the legal risk management and risk sharing arrangements for the pooled funds. The S75 agreements have been reviewed so that they reflect recent developments in Hertfordshire's pooled budget arrangements. Further amendments to the S75 agreement will be added in 2017 in the form of 'Partnership Agreements'; these are designed to record the specific terms of agreement between Hertfordshire County Council and NHS partners in the commissioning, implementation, delivery, monitoring and evaluation of projects involving joint working / integrated care. These aim to bring greater rigour to the joint schemes already underway by presenting areas covered by the agreement, aims and objectives, key milestones, information sharing, roles and responsibilities, evaluation and risks as well as financials. While the Partnership Agreements in themselves are not legally binding they are intended to provide clarity over roles and responsibilities. Any amendments will be signed-off by the Strategic Partnership Boards.

It remains a key priority of the BCF that HCC, the CCGs and other partners' progress risk sharing arrangements. To reflect Hertfordshire's long-term vision and ambitions and to incorporate more of the overall BCF budget into pooled budgets and risk sharing arrangements, over the next two years work will continue to determine joint priority areas and the best method for achieving these. Introducing more robust scheme-specific risks for those areas jointly funded has been progressed in two areas – proposals for integrated commissioning through 'Continuing Health Care' and the establishment of a 'partnership agreement' and 'delegation of functions' underpinning the introduction of the new 'Hertfordshire Home Improvement Agency'. These are explored further below. Other key areas to be considered will likely include the funding for Intermediate Care beds.

Moving forward the risk sharing agreements will be further developed by identifying high-level system risks linked to minimum contributions for better management of overall BCF performance. For example: higher than estimated acute costs, services not achieving projected savings or other outcomes, and overspend. It will be a priority to establish the current baseline and to assess operationally how each partner is able to mitigate and lead the risk arrangements at project, organisation or system level.

5.2 Joint schemes and contract risks

From 2017 the Hertfordshire Better Care Fund will be introducing more robust scheme-specific risks for those areas jointly funded. This has been progressed in two areas – these are integrated commissioning through 'Continuing Health Care' and the establishment of a 'partnership agreement', and 'delegation of functions' underpinning the introduction of the new 'Hertfordshire Home Improvement Agency'. Each scheme has a different and tailored approach to joint funding and risk sharing demonstrated as follows:

5.2.1 Continuing Health Care (CHC)

During 2016-17 the Better Care Fund looked to develop a collaborative approach to Continuing Healthcare, including co-locating operational teams and developing integrated financial and commissioning processes. Through this approach, agreement has been reached by the then named Health and Community Services Management Board (now Adult Care Services Management Board) and E&NHCCG Organisation Performance and Delivery to proceed with detail around delegation of contracting for care from ENHCCG to HCC. A similar agreement is now being sought from HVCCG. A governance agreement is in development and the partners have agreed to set up a 'test fund' (Care Discharge Fund) for the provision of care. Progress has also been made in strengthening relationships between teams and providing shared space for joint working.

5.2.2 Hertfordshire Home Improvement Agency (HHIA)

During 2017 key partners from district and borough and the county council joined up to develop a shared Hertfordshire Home Improvement Agency (HHIA) and participate in a Shared Service for the purposes of providing home adaptations and associated services. This includes the discharge of duties relating to the provision and administration of Disabled Facilities Grants under the 1996 Act, the Care Act 2014, and the Better Care Fund requirements to disabled and vulnerable people residing within the districts of East Hertfordshire and North Hertfordshire, and the boroughs of Broxbourne and Watford.

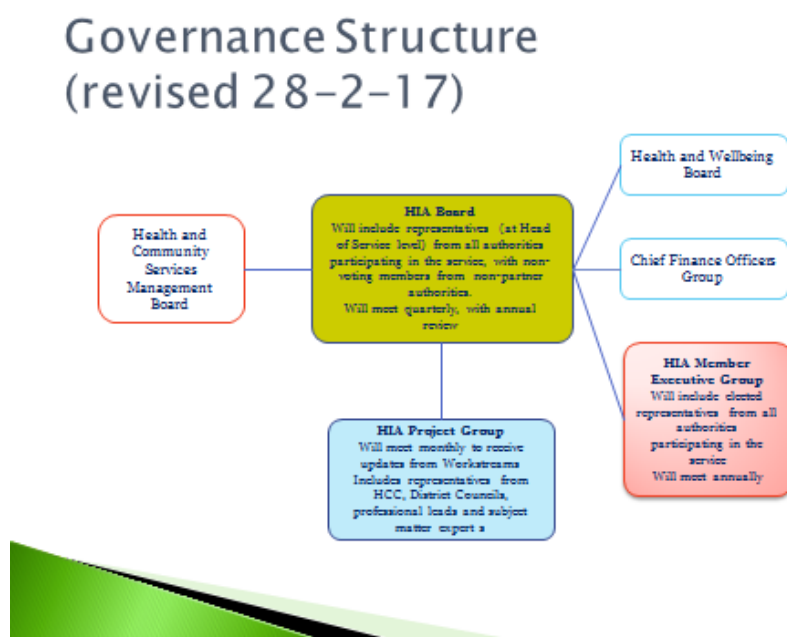
The HHIA has been developed in recognition that appropriate housing is key to keeping people well and independent and there is an alignment of DFG to BCF priorities. With the DFG Capital Grant moving into the BCF in 2014 this agency aims to create greater resilience and efficiency gains and will aim to measure its success through the increased spend of the DFG and increased reach to new people needing assistance. A number of small changes, such as those supported by the DFG, could have a big impact to the lives of our residents.

All parties have been working together to agree a contractual 'Partnership Agreement' and through achieving this have established a willingness to share risk and create arrangements which provide the incentive to make the system changes required. The Partnership Agreement has been designed to demonstrate the commitment of each party and the District Partner Authorities have individually and jointly consented to HCC annually transferring their financial allocations for the DFG within the Better Care Fund award made by central government each year to the HHIA.

In the first year of operation, fee income generated by the HHIA will be distributed among the Partner Authorities until each Partner Authority has reached a revenue neutral position as agreed. This entails each District Partner Authority being asked to contribute no more than their 2016-17 revenue budget for DFG. Any other surpluses will then be retained for joint investment in the service. There are many opportunities to engage with health, housing providers and third sector partners on future developments. These new schemes and opportunities for growth will be areas for further risk and incentive sharing between HHIA partners and new partners as they join in the coming years.

The financial commitment has been agreed by all partners for an initial three year period to mitigate risk to the service establishing and any partner authority acknowledges and confirms that it will remain liable for and will make any payments that are due in respect of its membership of the HHIA if they do not wish to be party to the agreement for the full period. Other authorities are encouraged to join the partnership and shared costs are anticipated to be paid to ensure all partners have made an equal investment in the HHIA.

Figure 13: Hertfordshire Home Improvement Agency Governance Structure



5.3 Our Approach to Managing Risk

As in previous years there is an agreed risk management approach adopted to manage and mitigate risks from the BCF organisation, BCF system and programme level and the project level. This approach is defined in the Better Care Fund Risk Management Strategy (see appendix 4) which has been reviewed and its main purpose is to provide a framework for the identification, management and review of the BCF risks. This strategy sits under the Section 75 agreement which outlines the legal risk management and risk sharing arrangements for the pooled funds.

The monitoring and reviewing of risks and the escalation process remains at the three levels set out in the strategy, i.e. at a project, system and organisational level. The establishment of the Strategic Partnership Boards (previously known as Joint Executive Meetings) for HV and ENH will continue and the terms of reference will be refreshed during 2017.

5.4 Risk Accountability & Responsibility Arrangements

The following roles and responsibilities for key personnel accountable for managing and monitoring the BCF plan have been reviewed for 2017 and remain consistent.

Table 14: Risk Management – Roles and Responsibilities

Role	Their Responsibilities are:
Health and Wellbeing Board	HWB are key stakeholders in reviewing performance of the BCF, providing strategic direction for the BCF, the delivery of integrated care, and future work as part of their statutory duty to encourage integrated working between commissioners.
CCG Accountable Officer	Have overall responsibility for risk management.
HCC's Director for Adult Care Services	Has delegated this responsibility to the Assistant Directors for Health Integration for the East and West of the County.
The Assistant Directors for Health Integration (East and West of the County)	<p>Are responsible for identifying high level Better Care Fund risks, the management and reporting of risks, the evaluation of mitigating actions, and smooth functioning of this risk management process.</p> <p>Are responsible for providing updates on the risk management to the Strategic Partnership Boards in the East and West of the County.</p> <p>Will be supported in their role by the teams they manage and in particular, the Integrated Care Programme Team who will be responsible for the day-to-day management of the risk register and risk management documentation.</p>
Chief Finance Officers	<p>Monitor BCF risks with direct financial considerations via the Chief Finance Officer group.</p> <p>The Chief Finance Officers may support the Assistant Directors in this role of reporting and ensuring the development and progress of risk management, particularly in relation to financial risks.</p>
Project Managers of BCF projects	They are responsible for identifying project-specific risks and escalating to the Assistant Directors when necessary.

5.5 Risk Register

The Better Care Fund Risk Register was first agreed in November 2014 between CCG Chief Finance Officers, the Principal Accountant, and the Assistant Directors for Integration for the East and West of the county. This Risk Register was formally approved by NHS England in January 2015 and has been updated prior to submission of the 2017-19 Plan (see appendix 5). Additionally, two of the three key barriers identified in the National Audit Office (NAO) report on Health and Social Care Integration (February 2017) have been reflected in existing risks in the risk register around:

- Workforce challenges – from case studies, differences in working culture, professional entrenchment and different terms and conditions across health and

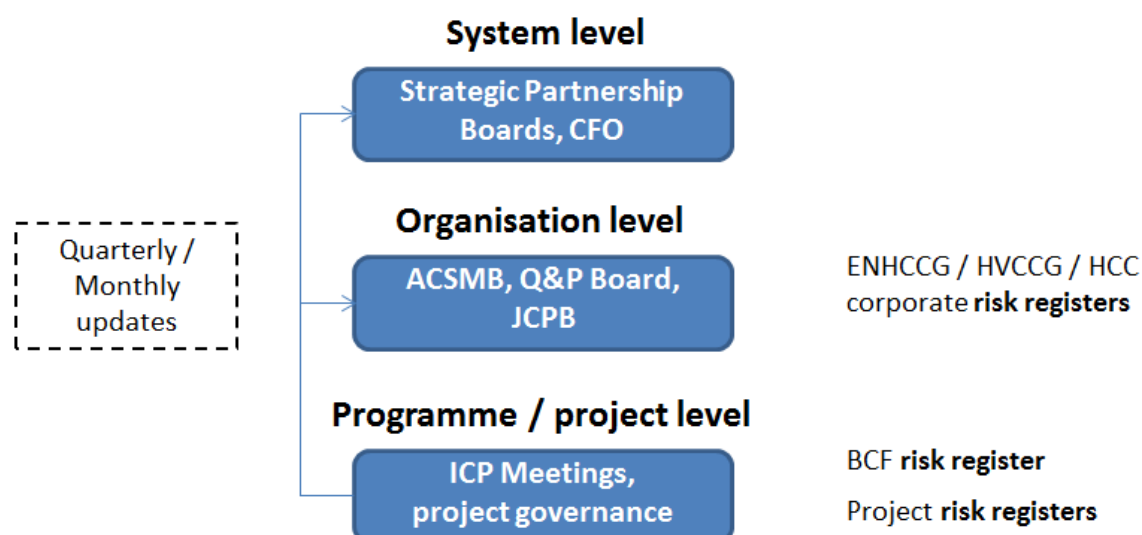
local government sectors remain barriers to integration and developing workforce. As well as recruitment and retention of staff in domiciliary care and residential care.

- Information-sharing – from case studies found that local bodies were still unsure of the legal requirements for data-sharing as a barrier and difficult to track patients through different care settings.

Identification of high-level BCF financial and delivery risks – for a list of current BCF risks and steps for mitigation, please see appendix 5. Key risks (marked ‘severe’ in the register) to be managed include:

Risk No	Risk Description
1	As a result of continued system pressures there is a risk that, despite benefits achieved as a result of the BCF, demand remains unchecked, the health and social care system becomes unsustainable and/or capacity to instigate change is curtailed
2	As a result of poor management there is a risk that contracts and projects fail to deliver agreed outputs or work cohesively together, which may lead to a failure to deliver the BCF vision, service user improvements and required efficiencies
5	As a result of continued market capacity and retention issues there is a risk that roles and services required for BCF plans are not recruited to or recruited with the appropriate skills, which may lead to failure to deliver key priorities, services and functions
7	As a result of not employing effective data-sharing there is a risk of not obtaining sufficient data or doing so through incorrect protocols, which may lead to an information governance breach and fine or being unable to monitor, deliver and assess integrated contracts and projects
8	As a result of limited financial system resources there is a risk of inadequate investment in BCF delivery, which may lead to failure to implement new and existing services and functions that result in more integrated care

Figure 14: Diagram to show the reporting and escalation process for monitoring risks noted in the BCF risk strategy



6. National Metrics

Taking learning from last year, Hertfordshire has developed jointly agreed targets and reporting frameworks for the BCF performance metrics. These were agreed following a review of activity trends to date and other relevant local performance indicators, and taking into account plans for the following two years including the High Impact Change Model.²⁵ Risks related to targets have been considered for each metric and incorporated into the BCF Risk Log – for a list of these and their steps for mitigation, please see the BCF risk log (appendix 5). As outlined in the Planning Template, targets are as below.

The Performance Metrics

- 1. Target total number of specific acute non-elective spells per 100,000 population** – The level of non-elective admission (NEA) activity Hertfordshire seeks to avoid is based on CCG targeted reductions as outlined in their Operational Plans and then inputted into the BCF Planning Template. These use county population projections over the next 2 years, and understand that effective prevention and risk management through integrated out-of-hospital services is key to avoiding preventable acute interventions. As CCG plans take account of integration plans, Hertfordshire does not plan on any additional reductions and therefore will not be putting in place a local contingency fund agreement on non-elective admissions.

Table 15: Non-Elective Admission Plan Totals

	Q1	Q2	Q3	Q4	Total
NEA target 2017-18	27,074	27,401	27,928	27,280	109,683
NEA target 2018-19	27,438	27,784	28,335	28,746	112,304

- 2. Long-term support needs of older people (65+) met by admission to residential and nursing care homes per 100,000 population** –

A number of aspects were considered when agreeing this measure including previous year's performance, national and regional benchmarking against other authorities, and planned improvement and changes being made to next year's services. Performance for 2016-17 was 570 against a target of 610. Despite growing demand for social care as well as rising complexity of care required for older people, it has been decided to aim for a similar target of **575** in 2017-18 and, subject to review, in 2018-19. This reflects expectations set out in the Adult Social Care Outcomes Framework as well as planned work detailed in the below metric.

- 3. Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services** – In 2016-17 the Council achieved an overall metric performance of 86%. The Council's strategy, for all demographics but particularly for Older People over the coming years, is centred on reducing the reliance on bed based care and increasing the ability for people to remain in their own homes and

²⁵ The process for this was the same as last year – see the 2016-17 BCF Plan, p. 59 for further details.

receive enabling care to manage down their long term needs where possible. Therefore it is anticipated that the new Specialist Care at Home Service will continue to provide reablement services to clients with wider ranging and, in certain circumstances, more intensive care needs than has previously been delivered.

As a result it is unlikely that there will be a significant increase on 2016-17 performance for this indicator. However, performance is expected to remain strong due to a number of pieces of work to improve the Specialist Care at Home pathway, including: integration of Enablement Occupational Therapists within Specialist Care at Home, improved access to community resources and equipment, a more discharge to assess and trusted assessor approach from Acute hospitals and improved social work practice around reviews. Last March also saw the development of adult social care 'Practice Principles'²⁶ – these will be used to help ensure partners, including providers, share a commitment to supporting individuals in regaining and maintaining their independence as well as living healthy and purposeful lives.

Performance for 2017-18 therefore has been set at **84.9%** to maintain the high performance of 2016-17 and take into account increasing service user need and increasing focus on delivering care in the community and managing down complex needs. Performance for 2018-19 has been set at **85.1%**.

4. Delayed transfers of care (delayed days) from hospital per 100,000 population (18+)

Hertfordshire's commitment to maintaining patient flow has resulted in ever closer joint working between partners over a number of years. We will continue to build on these strong operational relationships alongside the examples of local multi-disciplinary working we currently have in urgent care. We also recognise however that patient flow is affected by underpinning factors such as the availability of homecare, the fragility of the care sector and increasing demand and that we need to work together to address these systematic, long-term pressures. Targets for the next two years have been set by nationally by NHSE through the BCF performance framework – please refer to the Planning Template for more information.

Performance Monitoring

Over 2017-19, metric performance including against national averages, will be tracked using the monthly Better Care Fund Performance Dashboard and used for governance reporting.²⁷ Each integrated programme or project has their own set of measures which will be summarised in a Partnership Agreement outlining agreed objectives, benefits, roles and responsibilities and risk for ongoing monitoring of impact and outcomes. It is intended to bring these together alongside existing organisational and area measures into a performance monitoring framework aligned against the 7 statements. An example of what this might look like is included below.

²⁶ Available on request

²⁷ Available on request.

Table 16: Proposed Performance Monitoring Framework to be developed over 2017-18

Measure
1. Electronic record and data sharing
<ul style="list-style-type: none"> • Proportion of 65+ with shared care records in place accessible by all care manager teams
2. Early Identification
<ul style="list-style-type: none"> • Emergency admissions (65+) per 100,000 of 65+ population (BCF metric) • Number of people with a personal health budget / integrated personal budget per 100k population • Proportion of people using social care who receive self-directed support, and those receiving direct payments • Number of admissions due to a long-term conditions per 100k population • Social care service users / clients who find it easy to get information • Proportion of people who use social care services who report that they had as much social contact as they would like
3. Value for Money
<ul style="list-style-type: none"> • Number of new social care clients receiving short-term support to maximise independence • Number of social care clients who require no further services after short-term support • The average length of stay for clients in intermediate care • Permanent admissions to residential and nursing care homes per 100,000 population (BCF metric) • Number of social care records with an NHS number
4. Assessment & Care Planning
<ul style="list-style-type: none"> • Social care clients state that "I have access to easy-to-understand information about care and support which is consistent, accurate, accessible and up to date" • Social care clients state that "I have the information and support I need in order to remain as independent as possible"
5. Integrated Community Care
<ul style="list-style-type: none"> • Proportion of older people (65 and over) who were still at home 91 days after discharge (BCF metric) • Number of clients assisted by a rapid response service • Number of clients whose stay in enablement is more than 42 days • Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population 65+ (BCF Metric)
6. Timely and Safe Discharges
<ul style="list-style-type: none"> • Delayed transfers of care from hospital per 100k population (BCF metric) – by health and social care • Number of people supported by HCC to leave hospital
7. Integrated Urgent Care
<ul style="list-style-type: none"> • Integrated care teams in place and operating in an acute and non-acute setting • 90th percentile of length of stay for emergency admissions (65+) • Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation • Proportion of discharges (following emergency admissions) which occur at the weekend

Appendix 1 - Joined Up Care 2020 – vision, benefits and priorities

A system that delivers the right care and support at the right time and in the right place for individuals, their families and their carers

Developing a culture of prevention - to improve the health of the population and help our residents to avoid preventable health and social problems

Vision for Service User

Current Position and Achievements

2020 Targets

Electronic record and data sharing

"I and all professionals involved in my care can access my digital shared care plan – this means I only need to tell my story once"

- Limited sharing of information between integrated health & social care teams to improve coordination in community and hospital settings
- Prioritisation & resource of a business case on development of a shared care record between health & care organisations.

- A **digital shared care record** accessible by health and social care professionals
- Adapting the health and social care data systems for integrated care
- Increasing **data sharing** between health & social care, including hospitals & GPs
- **Networking the care home** market to enable the use of enhanced technology

Early identification

"I receive the right care, in the right place to prevent escalation in my care needs"
"I, my family or carer know where to go for support to manage my care needs"

- Limited use of risk stratification to identify people with high-risk of admission to hospital within 6-12 months
- Services in place across Herts to jointly plan and co-ordinate care for people with multiple or complex needs
- Limited adoption of integrated points of access and 'named professionals' representing health and social care services

- Wider use of **risk stratification** to target specific groups
- A **preventative approach** to care co-ordination and not just crisis interventions
- Streamlined **points of access** to care services
- Smooth transitions between adult and children's services

Value for money

"I receive the best possible level of care from the NHS and local authority"
"The quality of my care does not change if I move between different services"

- Most community services funded through pooled budgets
- Joint commissioning of mental health and learning disabilities services, and some intermediate care beds
- Improved use of the Disabled Facilities Grant through plans for a shared Home Improvement Agency
- MedeAnalytics tools developed to inform commissioning

- Using **joint commissioning** for shared contracts, market stimulation and budgets
- A joint approach to **Continuing Healthcare** services
- Commissioning decisions supported by more powerful tools for **joint analysis** of health and social care needs / demands of local populations
- An operational **Home Improvement Agency**

Assessment and care planning

"The NHS and social care work together to assess my care needs and agree a single care plan to cover all of the different aspects of my care"

- Joint care planning used by integrated community services e.g. HomeFirst and Multi-Specialty Teams
- Trials of 'My Plan' – a national shared care plan template.
- Limited piloting of joint assessment forms and triage for integrated services

- A **shared culture**, process and ways of working to deliver outcomes-based planning
- **Integrated personal commissioning** of direct payments and individual budgets
- **Trusted assessment** between health and social care professionals for a range of services

Integrated community care

"My GP, social worker or carer work with me to decide what level of care I need, and make sure I receive it"
"I only need to approach one point of contact to get my care needs met"

- Integrated community service models developed around the needs of those with complex care needs
- Improved coordination between health and social care services and the voluntary and community sector
- Support to care homes improved through the Vanguard programme

- More colocation, single lines of reporting, and shared leadership
- Greater joint working with **primary care**
- Greater understanding and use of the **voluntary sector** and community assets
- Rolling out **enhanced care in care homes** developed by the Vanguard

Timely and safe discharges

"If I go into hospital, health and social care professionals work together to make sure I'm not there for any longer than I need to be, even if waiting for an assessment"

- Ongoing integration of discharge teams in acute hospitals
- Specialist Care at Home service commissioned
- Limited use of discharge to assess models to short-term care home placements; trialling of enabling models of bed based care

- Further adoption of **integrated tools & working structures** e.g. live urgent care dashboards to track the movement of patients between services
- Shared **enablement** approach across health and social care partners minimising dependency across the area

Integrated urgent care

"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"

- Joint rapid response services provided to prevent admissions to hospital
- Successful piloting of early intervention vehicle
- Link social care workers in A&E to prevent admissions
- Health and social care workers in hospitals able to carry out certain elements of each other's' roles

- Use of **multi-disciplinary teams** in all areas
- **Integrated community teams providing timely interventions** keeping people safe & at home
- Wider roll-out of **early intervention vehicle** and other integrated models
- Improved co-ordination of out of hours services including NHS 111 .

Appendix Two – Breakdown of Project Milestones (*more detailed information is available in individual project plans*)

Scheme Name	Key Milestones	Date
Access to services for service users and services making onward referrals	<ul style="list-style-type: none"> • Workshop to scope workplan following review of all major health and social care access points • Development of options by the Joint Access Review Group, including alignment with locality approach • Agreement and implementation of preferred option • Continued alignment with out of hours service provision 	<p>Complete</p> <p>Oct 2017</p> <p>April 2018</p>
Community First	<ul style="list-style-type: none"> • Continuation of ‘Community Conversations’ across localities, enabling a social action approach • Development of a Community First Strategy that links to STP prevention workstream • Support roll-out of new community-focused assessment process with front-line teams • Working in partnership with Public Health to demonstrate impact and value of preventative approach 	<p>Complete</p> <p>Complete</p> <p>Nov 2017</p> <p>Dec 2017</p>
Community Navigators	<ul style="list-style-type: none"> • Review of the ‘social prescribing / navigator’ clinic at Maltings GP surgery with potential to expand to other surgeries • Scaling up use of volunteers, including at GP surgeries in areas of deprivation • Refining the cost model to determine impact • Developing a model to measure impact on wellbeing and management of long-term conditions • Participating as part of Hertfordshire’s contribution to the National Social Prescribing Network 	<p>Complete</p> <p>Ongoing</p>
Complex Care Framework , including Complex Care Premium to deliver training to care homes in complex care (Vanguard & HV)	<ul style="list-style-type: none"> • Improvement in data collection and analysis via the Vanguard Dashboard • London School of Economics evaluation on the preventative impact of the CCP scheme • CCP contract review • General review of CC Foundation scheme models in preparation mainstreaming services • Review of Complex Care model development into other areas, for example, homecare provision 	<p>Complete</p> <p>Complete</p> <p>Autumn 2017</p> <p>Autumn 2017</p> <p>Autumn 2017</p>
Continuing Healthcare , developing a collaborative approach to CHC in E&NH and HV	<ul style="list-style-type: none"> • Shared office space for E&NH operating teams • CHC Conference to raise professional awareness and understanding of the CHC process • Working up E&NH commissioning model for integrated contracting processes • Working up HV commissioning model for integrated contracting processes • Implementation of the developed model with new contracts in place, held and monitored by HCC 	<p>Complete</p> <p>Oct 2017</p> <p>April 2018</p> <p>April 2018</p> <p>April 2018</p>
Discharge to Assess , with medically fit patients discharged to a home setting for assessment of ongoing needs	<ul style="list-style-type: none"> • Finalisation of process mapping • D2A model signed-off • Initial model proof work completed and upscaling of project to wider geography • D2A normal procedure to follow for medically fit patients 	<p>Complete</p> <p>Complete</p> <p>2018</p>

Early Intervention Vehicle (Vanguard)	<ul style="list-style-type: none"> Continuation of E&NH EIVs staffed by a paramedic or emergency care practitioner Increased operational hours of the 7 day service from 80 to 147 hours a week Reviewing project scalability to expand the number of vehicles Reviewing potential to expand to other parts of STP (HV and West Essex) 	Complete Mar 2018 (subject to external review)
End of Life ABC Training (Vanguard)	<ul style="list-style-type: none"> Developing impact assessment measures with hospices To build into E&NH's End of Life Strategy 	Nov 2017
Enhanced Primary Care Support (Vanguard)	<ul style="list-style-type: none"> Developing the current service level agreement to meet both GP and care home needs Adapting to a place-based approach to delivery, including closer working of GPs with their localities 	Oct 2017 Autumn 2017
Frailty Service , supporting the care of frail residents in hospital and the community	<ul style="list-style-type: none"> Implementation of the frailty model Assessment for frailty established as a routine part of relevant medical interventions 	Complete Ongoing
Home Improvement Agency , using DFG more collaboratively	<ul style="list-style-type: none"> HIA Steering Group meeting in shadow form Appointment and starting of HIA head of service Contractor framework in place HIA team in place HIA service launch Potential for additional partners to join 	Complete Complete Autumn 2017 2018
Impartial Assessor , to speed up discharges from hospital to care homes (Vanguard)	<ul style="list-style-type: none"> Roll out of 6-day service with a second Assessor starting at Lister Hospital Review of Lister Contract Introducing Impartial Assessor at Watford General Hospital Introducing Impartial Assessor into Princess Alexandra Hospital (West Essex) 	Complete Oct 2017 Autumn 2017 Autumn 2017
Integrated Personal Budgets	<ul style="list-style-type: none"> Programme and governance arrangement in place with alignment to corporate programmes with All-Age Personalisation Steering Group set up Personalised care and support planning and personal health budgets for 50 people with LTCs, and evidence of mainstreaming PHBs for CHC patients Financial plan in place for releasing NHS funding beyond CHC Linked dataset for first cohort across NHS, social care and education (and appropriate) at person level Established peer support network and operationalised community capacity strategy Extended IPC to include at least two more cohorts Linked datasets for the second cohort across NHS, social care and education (and appropriate) at person level Minimum of 1 in 1000 of the population will have a PHB 1% of population or 50% of the first identified cohort to have person-centred planning support (1200 people), and available for 20% of the second 	Complete Sept 2017 Sept 2017 Dec 2017 Dec 2017 March 2018 March 2018 March 2018 March 2018
Integrated Discharge Teams , with fully	<ul style="list-style-type: none"> At Lister, establishing the existing integrated hospital team with joint processes at all stages A&E to discharge 	

integrated health and social care teams	<ul style="list-style-type: none"> • Review of wider patient flow, particularly IDT interfaces with community resource • Colocation of health and social care teams and harmonised working practices • Baseline metrics established for tracking and reporting against progress • Fully integrated discharge team working harmoniously with discharge to assess and 7-day working 	From April 2017
Locality Provider Delivery Boards	<ul style="list-style-type: none"> • Locality Boards formed and meeting using newly developed governance arrangements • Engagement for public and staff • Local Team development plans • Health pathway implementation plan in place 	Complete Ongoing Mar 18 Mar 18
Medicines in Transition	<ul style="list-style-type: none"> • Approval and implementation of workstreams identified in STP proposition document 	
Multi-Speciality Teams , working across professionals for coordinated care	<ul style="list-style-type: none"> • Review of MST and adaptation requirements for wider roll-out • Alignment of the MST to the locality approach, including local ownership 	
Out of Hours 111 Service	<ul style="list-style-type: none"> • New contract awards • Beginning of new service 	Complete
Red Bag to improve transitions between care homes and hospital	<ul style="list-style-type: none"> • Review of lessons from Jan-Mar 2017 pilot, including communications • Review of model and roll out to 60 E&N care homes and all HV care homes 	Complete Complete
Risk Stratification , for early identification, case management and business intelligence	<ul style="list-style-type: none"> • Additional GP data flows from across ENCCG and WECCG localities • Improve the Risk of unplanned hospital admission (the Homefirst case management) algorithm • Reformatting data so patient pathway is viewable along a timeline • Upskilling 'super users' across health and social care • Developing models of population health segmentation 	Complete Nov 17 Dec 17 Mar 18 Jan 18
Specialist Care at Home	<ul style="list-style-type: none"> • Reconfiguration of staff roles and responsibilities • Recruitment of enablement occupational therapists • Action plan to grow service capacity and improve service resilience for remainder of contract • Involvement in development of Discharge to Assess model • Creation of refined data following new ACSIS process • New multiagency governance to be set up to improve the service's practice and process 	Ongoing Complete Nov 2017 / ongoing Nov 2018 Date to be confirmed
Targeted Support in Care Homes (Vanguard)	<ul style="list-style-type: none"> • To work with 10 care homes identified as having higher than expected number of hospital admissions to implement small-scale interventions • Assess impact of above interventions with a view to wider adaptation • Case review 5 care homes to better understand why patients are being admitted to hospital – to inform wrap-around support approach 	Ongoing Ongoing Oct 2017
Technology in Care Homes (Vanguard)	<ul style="list-style-type: none"> • Deploying nhs.net email to all care homes • Engaging care homes to understand issues that technology could assist with • Top 3 technological solutions to be planned, tested and evaluated • Implementation (dependent on the above) 	Mar 2018

Appendix Three: E&NH Enhanced Care in Care Homes Milestone Plan

5.1 – Current delivery plan

AREA	Programme Stage	RAG	2017/18											
			Q1				Q2				Q3			
			A	M	J	J	A	S	O	N	D	J	F	M
Enhanced primary care support	Enhanced Primary Care contract	Green												
	Impartial Assessor - Lister	Green												
	Red Bag	Amber												
	Medicine Optimisation	Green												
	Targeted Support	Amber												
MDT	HomeFirst	Amber												
	EIV	Green												
	Frailty Service	Green												
High quality EoL care	EoL ABC training	Green												
Workforce development	Complex Care training (inc. support)	Green												
	Recruitment Toolkit	Red												
Harnessing data & technology	NHS.Net in Care Homes	Green												
	Harnessing Technology	Amber												
	MedeAnalytics	Green												

5.1 – Current delivery plan cont. – non Vanguard projects

AREA	Programme Stage	RAG	2017/18											
			Q1				Q2				Q3			
			A	M	J	J	A	S	O	N	D	J	F	M
Enhanced primary care support	Impartial Assessor - PAH	Green												
Reablement & rehabilitation	ICM procurement	Green												
	Discharge H2A	Green												
	Specialist Care at Home (SC@H)	Green												
	Navigators	Green												
High quality end-of-life care & dementia care	EoL Strategy	Green												
	EPACCS	Green												
	Post death audits	Green												
Workforce development	Complex Care HomeCare	Green												
Harnessing data & technology	QTUG in the Community	Green												
	Digital Practitioner	Green												

Appendix Four: BCF Risk Management Strategy

Better Care Fund Risk Management Strategy

June 2017

Version Information

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1. Introduction

- 1.1. The Better Care Fund (BCF) was set up following the June 2013 Spending Review to promote the integration of health and social care services.
- 1.2. Of the £3.8bn National Better Care Fund (BCF) monies, Hertfordshire was required to pool a minimum budget of £70.9million in 2015/16. However the Clinical Commissioning Groups (CCGs) and County Council (HCC) agreed an approach which pooled a larger budget and allowed for the joint commissioning of a wider range of health and social care services for older people. This remains the case in 2017/19 with the majority of CCG and HCC older people out-of-hospital budgets pooled. With minimum CCG minimum contributions of £69million the total BCF figure is £280million in 2017-18. This is to deliver a health and social care system that 'delivers the right care and support at the right time and in the right place for individuals, their families and their carers'. This is to:
- Deliver better care for patients and service users
 - Reduce reliance and spend on acute services
 - Meet national conditions to deliver against the metrics
 - Release efficiencies for Hertfordshire County Council and both CCGs to help deliver against efficiency targets.
- 1.3. The 2017/19 Hertfordshire BCF plan is awaiting confirmation of approval from NHS England. As in previous years, the current plan evidences how the Hertfordshire Health and Wellbeing Board aims to meet BCF national conditions, and deliver against the following national metrics (from April 2017, the dementia diagnosis is not monitored centrally) :

National metrics to monitor the impact of the local Better Care Fund	National Conditions on the local Better Care Fund
1. A reduction in non-elective admissions	Condition 1: Plans to be jointly agreed, signed off by the HWB
2. A reduction in permanent admissions to residential or nursing homes	Condition 2: NHS contribution to adult social care is maintained in line with inflation
3. An increase in the effectiveness of reablement (an increase in the number of 65+ discharged from hospital into an reablement or rehabilitation service)	Condition 3: Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care – this includes agreeing how Hertfordshire will use its share of the £1,018bn in 2017-18 and £1,037bn in 2018-19 previously used for the payment for performance fund in 2015-16, with appropriate risk shares
4. A reduction in delayed transfers of care	Condition 4: Managing transfers of care – this includes implementation of the below 'High Impact Change Model'

2. Purpose of the Risk Management Strategy

- 2.1. The purpose of the Better Care Fund Risk Management Strategy is to provide a framework for the identification, management and review of the BCF risks. This strategy sits under the Section 75 Agreement which outlines the legal risk management and risk sharing arrangements for the pooled funds.

3. Risk and Risk Management

- 3.1. There are numerous definitions for both risk and risk management, many of which cover similar points, for example, definitions have been published by the HM Treasury, CIPFA, Office of Government Commerce, the British Standards Institute, and the Australian and New Zealand Risk Management Standard, and many others.

- 3.2. However, the definitions that have been adopted for Integrated working between health and social care are as follows:

3.2.1. Risk - *"An uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives. A risk is measured in terms of a combination of the likelihood of a perceived threat or the opportunity occurring and the magnitude of its impact on objectives"* Source: Office of Government Commerce - Management of Risk 2007

3.3. Risk Management - *"The culture, process and structures that are directed towards the effective management of potential opportunities and adverse effects"* Source: Australian/New Zealand Risk Management Standard 2001

- 3.4. Essentially risk management is the process by which risks are identified, evaluated, and controlled. It is about managing resources wisely, evaluating courses of action to support decision making, protecting clients from harm, safeguarding assets and the environment and protecting the organisation's public image.

4. Compliance and Assurance

- 4.1. The NHS Clinical Commissioning Groups and Local Authority have clear compliance frameworks within their organisations for how health and social care funding must be managed and spent. However integrated projects and contracts have shared risks. In order to identify risks which might threaten the delivery of project and contract objectives and identify gaps in control/assurance, the relevant groups must have a comprehensive performance update when reviewing the integrated risk register.

- 4.2. The Local Authority Audit Committee, and /or auditors commissioned by CCGs, may request reports on the BCF Programme and associated risks at any time to review progress.

- 4.3. Hertfordshire NHS and social care organisations promote a fair and open culture within the workplace and employees will not be adversely impacted by highlighting new risks or raising concerns over existing risks on projects or contracts. All employees will be treated with respect, to promote a culture of honesty and openness to report any concerns.

5. **BCF Risk sharing**

- 5.1. The Risk Sharing arrangements for the BCF are outlined clearly in Clause 12 of the Section 75 Agreement (Referencing Appendix 3) and specifically for the BCF, in Clause 8 and Clause 15 of Schedule 1 Part 1.1 and Part 1.2.²⁸

6. **The Better Care Fund Risk Register**

- 6.1. The Better Care Fund Risk Register was first agreed in November 2014 between CCG Chief Finance Officers, the Principal Accountant of Adult Care Services (HCC), and the Assistant Directors for Integration for the East and West of the county. This Risk Register was formally approved by NHS England in January 2015 and has been updated as part of the 2017-19 BCF Plan submission.

- 6.2. The BCF Risk register highlights three risk types:

- **Project risks** - owned and managed by project governance arrangements
- **BCF system risks** – owned and monitored by Strategic Partnership Boards who may delegate responsibly and accountability of monitoring certain risks to other programme Boards or the Chief Finance Officer meeting.
- **BCF organisational risks** - Significant BCF risks which are escalated to organisational corporate risk registers, in a coordinated way, and managed / owned by organisational governance.

7. **Monitoring and Review**

- 7.1. **Project & Programme Risks** - Each BCF Project group is responsible for carrying out individual Equality Impact Assessments, Privacy Impact Assessments as appropriate, and maintaining Risk Registers as required by the Project Sponsor and organisational project framework. The assessment, rating and monitoring of risks will be in accordance with the risk management strategy of the organisation leading the project (either ENHCCG, HVCCG or HCC risk management policy). The Integrated Care Programme Team with CCG colleagues as appropriate will review the BCF Programme Risk register quarterly

- 7.2. **BCF System Risks** – BCF Programme or project risks deemed appropriate will be escalated according to the process outlined in 7.4.1 to the Strategic Partnership Boards on a quarterly basis. System-level oversight will take place at Strategic Partnership Boards quarterly. The Chief Finance Officer meeting will also monitor risks with direct financial considerations quarterly.

- 7.2.1. When risks need to be monitored more closely, the relevant group will appoint Adult Care Services Management Board (ACSMB), Quality and Performance Programme Group (HVCCG) or Joint Commissioning and Partnerships Board (ENHCCG) to monitor a risk or project on a monthly basis.

- 7.2.2. The Strategic Partnership Boards are able to request reasonable evidence to conclude that risk controls or mitigating actions have been undertaken or have been successful in controlling risks. Where there is insufficient evidence to provide assurance that the risk is being managed effectively, the Strategic Partnership Boards can request further or different assurance to ensure satisfactory risk control.

- 7.3. **BCF Organisational Risks** – The CCGs and Local Authority have all recognised the BCF Programme represents a corporate risk given the scale and extent of the work and changes. In 2015/16 the corporate risks relating to the BCF were not consistent or managed in a coordinated way, since they are managed via internal organisational risk management processes. The Strategic Partnership Boards between ENH and HV began the process of monitoring risks in a coordinated way across the county. Over 2017/18 it is intended

²⁸ May change subject to final agreement of the Section 75 this November 2017

that the corporate risk registers are reviewed and compared between partners to ensure the corporate risks presented by the BCF is consistent.

7.4. Escalation Process

7.4.1. Review by the Strategic Partnership Boards and Chief Executive Officer Group -

The BCF programme Risk Register will be reviewed by the Integrated Care Programme Team (ICPT) prior to the quarterly review by the Strategic Partnership Boards. This will include a review of whether change in one project risk score has a direct or indirect impact on other projects. Individual projects may also flag risks with system-wide implications for escalation. The ICPT will recommend the Strategic Partnership Boards and Chief Executive Officer Group (if financial) monitor programme risks according to the following criteria:

- Risks that currently score 'severe'
- Risks that have an increased risk score as compared to the previous quarter
- Risks which are deemed to be of particular interest to, or requested by, the Strategic Partnership Boards

Hertfordshire Adult Care Services Management Board (ACSMB), Quality & Performance Programme Group (HVCCG) or Joint Commissioning and Partnerships Board (ENHCCG) may also use their discretion to escalate risks to the Strategic Partnership Boards as required.

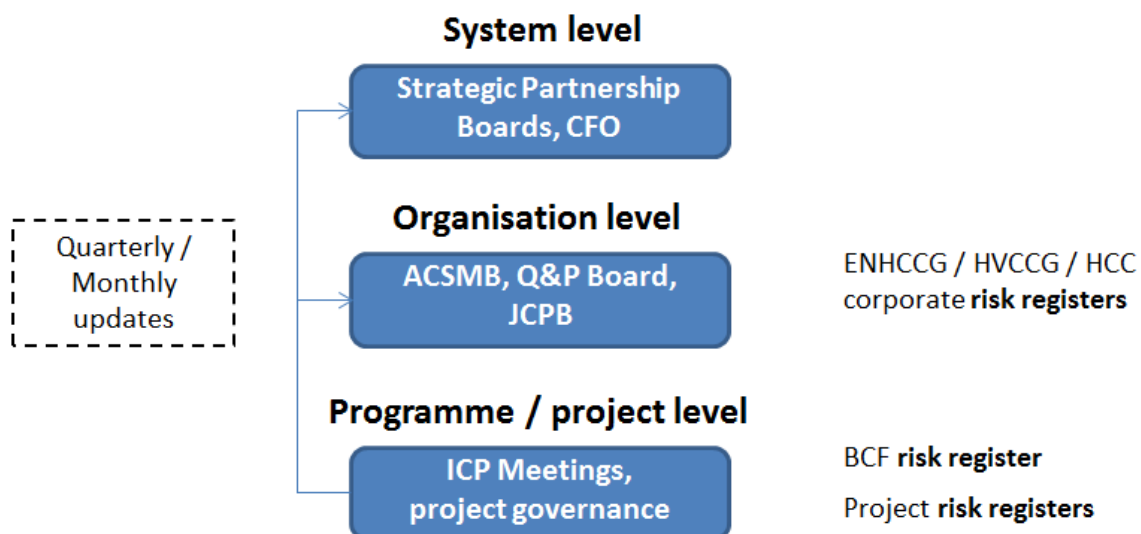
7.4.2. Review by ACSMB, Q&P Board or JCP Board -

7.4.3. The ICPT will recommend the ACSMB, Q&P Board or JCP Board monitor risks according to the below criteria. Individual projects may also flag risks with organisational implications for escalation.

- Risks relevant to respective Boards that are current score 'severe' or 'significant'
- Risks that have an increased risk score as compared to the previous quarter
- Risks which are deemed to be of particular interest to the respective Boards

7.4.4. The Strategic Partnership Boards or the Chief Finance Officers (CFOs) may request monthly monitoring of relevant risks by Adult Care Services Management Board (ACSMB), Quality & Performance Board (HVCCG, meets only quarterly), Joint Commissioning and Partnerships Board (ENHCCG).

7.4.5. See **Error! Reference source not found.** for a diagram summarising the monitoring and reporting process.



8. Accountability and Responsibility Arrangements

Role	Their Responsibilities are:
Health and Wellbeing Board	HWB are key stakeholders in reviewing performance of the BCF, providing strategic direction for the BCF, the delivery of integrated care, and future work as part of their statutory duty to encourage integrated working between commissioners.
CCG Accountable Officer	Have overall responsibility for risk management.
HCC's Director for Adult Care Services	Has delegated this responsibility to the Assistant Directors for Health Integration for the East and West of the County.
The Assistant Directors for Health Integration (East and West of the County)	<p>Are responsible for identifying high level Better Care Fund programme risks, the management and reporting of risks, the evaluation of mitigating actions, and smooth functioning of this risk management process.</p> <p>Are responsible for providing the updates on the risk management to the Strategic Partnership Boards in the East and West of the County.</p> <p>Will be supported in their role by the teams they manage and in particular, the Integrated Care Programme Team; who will be responsible for the day-to-day management of the programme risk register and risk management documentation.</p>
Chief Finance Officers	<p>Monitor BCF programme risks with direct financial considerations via the Chief Finance Officer group.</p> <p>The Chief Finance Officers may support the Assistant Directors in this role of reporting and ensuring the development and progress of risk management, particularly in relation to financial risks.</p>
Project Managers of BCF projects	They are responsible for identifying project-specific risks and escalated to the Assistant Directors when necessary.

8.1. For further details on the governance of the BCF refer to Schedule 2 of the Section 75 agreement 2016/17.

Appendix Five: BCF Risk Log – outlining key risks associated with delivery of the BCF workstreams and performance metric targets



BCF Risk Register -
2017-19 Draft v2.xls

Appendix Six: High Impact Change Model Implementation Plan

Change	Change Descriptor	Rating	What is Working Well	Key Challenges	What Needs to Happen
1	<p>Early Discharge Planning (EDP)</p> <p>In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.</p>	Plans in place	<ul style="list-style-type: none"> • Early discharge planning is taking place with, for example, a daily focus on stranded patients rather than DToC discussed by all relevant parties on a daily teleconference resulting in reduced lengths of stay (LOS) • Pilot rollout of red and green days and 'Safer' model • A health and social care professional from the Integrated Discharge Team (IDT) is on every board round on every ward in East & North (E&N) and on most in Herts Valleys (HV) • In E&N, A&E-based social work team and ring-fenced care is in place to assist prevention of ward admissions. To date, this has had a 90%+ success rate • Joint working around initial light touch assessment is robust • MDT update is happening every day at 11:00 and conference call at 15:00 • Integrated team meetings with the MDT are in place to facilitate early discharge planning 	<ul style="list-style-type: none"> • Consistently setting expected discharge dates within 48h of admission • Ensuring accuracy of planning and appropriate review • Managing EDP with changing estimated dates of discharge (EDD) due to medical reasons • Visibility of changing circumstances for EDDs • Gathering discharge information for complex cases in a timely manner • Multiple conversations and improving information available to professionals on patients preparing for discharge • Embedding cultural change in multi-disciplinary discharge teams 	<ul style="list-style-type: none"> • Understand the patient's needs earlier for early planning through closer working between integrated discharge teams and the ward staff • Improved ownership of administrative paperwork e.g. IDT issuing discharge notifications going forward • Strong system leadership to embed discharge planning and widespread understanding of roles and responsibilities for early discharge across staff in all teams • Further development of the IDT including greater trusted assessment and complete cohabitation • Maintaining good communications between health and social care within the IDT • In HV, appraisal of West Herts Hospital Trust (WHHT) performance in terms of success of early discharge notification
2	<p>Systems to Monitor Patient Flow.</p> <p>Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.</p>	Plans in place	<ul style="list-style-type: none"> • Daily acute and weekly non-acute dashboard being produced to agreed key system metrics to manage daily flow • Monthly dashboard discussed at System Resilience Group (SRG) showing critical KPIs with information used to agree and manage system escalation • Social care DToC dashboard moving close to live reporting • Engagement with stakeholders across the system including local authority, commissioners and providers as part of STP technology and data work stream • Business case for integrated urgent care dashboard has been approved by STP technology board ready to go to urgent and emergency work-stream for sign off – this will enable development of full business case and implementation • Local analysis of patient flow issues has been undertaken, along with ECIP stranded patient audits in acute and non-acute settings in 2017 • Digital shared care record from interoperability work-stream that would allow relevant health and social care access is at business case stage and likely to progress • Linked health and social care datasets with NHS number acting as the prime identifier – e.g. to date 94% of social care records have an NHS number 	<ul style="list-style-type: none"> • Availability / accessibility of live data from native systems • Daily data flows occurring between organisations that rely heavily on manual processes and data entry • Data not used systematically to help predict flow and capacity requirements • Still some inconsistency of metrics across different partners <p>Non acute DToC challenges include:</p> <ul style="list-style-type: none"> • Focus on manual, isolated work rather than that which is holistic and system-based • Inconsistency of data from providers and lack of joined up datasets 	<ul style="list-style-type: none"> • Working with NHS Digital to implement the adaptor product to help automate Assessment / Discharge / Withdrawal notices to improve real time data flows from health to social care, reduce the administrative burden and improve accuracy to assist operational decision making • Creation of integrated urgent care dashboard to give a live view of system flow across partners (hospitals, 111, ambulance service, social care) – to be rolled out winter 2017-18. • Opportunity to use linked data sets and data analysis to develop improved capacity management and planning • Finalisation of digital shared care plan business case in preparation for roll-out within the next 2 years • 99% of social care records to have an NHS number by 2018 • Social care dashboard developed to show live reporting • Federated wi-fi to be rolled out across the patch allowing acute and non-acute professionals universal internet access across Hertfordshire and West Essex GP surgeries

3	Multi-disciplinary/Multi-Agency Discharge Teams, including the Voluntary and Community Sector Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	Established	<ul style="list-style-type: none"> IDT team in place at all main acute sites under a single leadership role of an MDT, including social workers, nurses and therapy assessors and navigators, care home impartial assessors, care providers and the voluntary sector. Teams offer consistency of assessment of needs and access to various step down resources Strong and developing voluntary sector hospital discharge services, jointly commissioned under the BCF, in place to complement the Herts Help navigation system. 85% of the voluntary sector hospital discharge service do not get readmitted to hospital within three months 	<ul style="list-style-type: none"> Inconsistencies in the voluntary and community sector offer between hospital discharge and community based services in terms of ensuring ongoing support and consistent navigation across the county Limited access to health and social care systems for voluntary sector organisations 	<ul style="list-style-type: none"> Ongoing development of IDT arrangements on each site, to include further cohabitation, mutual access to systems and data, and single forms of leadership and oversight to ensure system ownership of discharge and patient flow. Development of a more complete and countywide voluntary sector discharge and navigation service, bringing together various commissioning arrangements and developing with iBCF monies to be implemented from November Performance monitoring and evaluation of pilot services after 18 months in preparation for mainstreaming services – this will involve using Public Health expertise to monitor activity
4	Home First/Discharge to Assess (DTA) Providing short-term care and re-ablement in people's homes or using 'stepdown' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	Plans in place	<p>East & North Herts – in place is:</p> <ul style="list-style-type: none"> BCF jointly commissioned intermediate care (IMC) and DTA bed based model in place in private sector beds totalling 59 beds, as well as community trust stroke and IMC beds, all gate kept by the IDT and Community Bed Bureau. Strong and multi-organisational arrangements in place to monitor performance and share best practice Enabling homecare service implemented under the BCF to discharge service users, enable and then complete full assessment of needs A successful model of 10 virtual 'supported discharge' beds in North Herts locality, offering rehabilitation and enabling care Two Discharge/Enablement flats in place with housing associations to allow discharge and assessment <p>Herts Valleys:</p> <ul style="list-style-type: none"> Moving from traditional homecare model to DTA and enabling homecare via Supported Care at Home (SC@H) to enable rapid discharge of patient Effective identification of three pathways for DTA model based on ECIP framework – this includes Discharge Home to Assess (DHTA), bed based services, and care home beds for complex cases Model aligned to supporting the mandated 95% assessment outside of hospital for medically optimised patients DTA team construction is underway Additional health care assistant (HCA) capacity available through HCT 'First' model Early Supported Discharge community team working with stroke patients county-wide to enable faster discharge and rehabilitation and reablement preceding assessment 	<p>East & North Herts:</p> <ul style="list-style-type: none"> More developed bed based model of discharge and IMC (pathway two and three), but more needs to be done in pathway one Private sector care home market not mature or stable enough to offer affordable and consistent models of intermediate care and discharge to assess. Development work to be undertaken. <p>Herts Valleys:</p> <ul style="list-style-type: none"> Difficulty implementing DTA model at scale and pace given operational pressures Dealing with capacity issues Effective identification of people with lower level needs Agreeing assessment documentation Managing family expectations from an early stage <p>Additionally:</p> <ul style="list-style-type: none"> Ensuring a consistent approach to multidisciplinary care planning for effective preventative work Embedding culture change to enable staff to take positive risks around DTA 	<p>East & North Herts:</p> <ul style="list-style-type: none"> Development of a fuller and multi-organisational Discharge Home To Assess model under 'Pathway One' building upon the success of the supported discharge model in North Herts, with strong alignment to the acute frailty service Capacity planning to be undertaken to understand longer term need for which patients require beds vs home Continued staff engagement with acute and non-acute providers to maximise buy-in to discharge to assess culture and taking positive risks Development of more consistent and effective monitoring and tracking of patient flow through all discharge pathways Development of a fuller Discharge Flat model as an alternative to use of care home capacity <p>Herts Valleys:</p> <ul style="list-style-type: none"> Reviewing pilots to select a final model option Communications around the model and system to be clearly understood, including by patient and family Improvement of assessment documentation Development of culture and public expectation around provision of care and supporting people moving on Exploit opportunities for integration of supported discharge pathways through the redesign of core community services, and other pathway based service redesign projects (e.g. Diabetes).
5	Seven-Day Service (7DS) Successful, joint 24/7 working	Established	<ul style="list-style-type: none"> CCGs, social care and acute trusts working towards 7DS national condition areas and clinical standards IDTs at all major sites have 7DS with some 	<ul style="list-style-type: none"> The reduction in staff working on Monday to Friday as a result of weekend working may lead to 'thin spread' pressures from rota arrangements, for example covering 	<ul style="list-style-type: none"> Resolve cross-organisational terms and conditions issues Establishing processes for starting new packages of care

	improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs		<p>commissioned services also operating a 7DS e.g. Age UK discharge service and some short-term care home beds</p> <ul style="list-style-type: none"> • Senior manager presence and 'familiarity / frequency' working balance is settling into a pattern • Consultation with provider organisation staff for 7DS has started • Weekend working enables assessments on Saturday and Sunday, ready for discharge on Monday/Tuesday and discharge at the weekend • Community rehab units have 'meet and greet' checklist, see people within 24 hours and 'mini teams' • Improvement in relationships between organisations arising from consistent staff presence at weekend 	<p>assessments from all wards on duty rota basis</p> <ul style="list-style-type: none"> • Maintaining a good level of staff morale can be challenging with social care proximity to health colleagues on weekend working • 	<p>and domiciliary care at weekends</p> <ul style="list-style-type: none"> • Review rota practice periodically to ensure efficiency and effectiveness of staff resources • Embedding of all clinical standards in all areas • Team building across health and social care to continue to develop and maintain staff morale across the whole week
6	<p>Trusted Assessor</p> <p>Using trusted assessors to carry out a holistic assessment of need avoids duplication and speed up response times so that people can be discharged in a safe and timely way</p>	Established	<ul style="list-style-type: none"> • An impartial Assessor model is established at the Lister Hospital to manage assessment between the acute and E&NH care homes, operating Mon-Sat 8:00 - 16:00 • Herts Care Providers Association hosts the service and assists with care home engagement with a majority of care homes using the service • Access to NHS systems through use of honorary contract has been valuable • Trusted Assessment is taking place more widely in other forms and is a key aspect of IDTs and other MDT arrangements • IDTs host Care Provider 'acute facilitator' roles which help to ensure trusted assessment and more streamlined discharge 	<p>For the Impartial Assessor service in relation to hospital discharge and care homes:</p> <ul style="list-style-type: none"> • Recruitment of nurses to the service to ensure the quality of the assessments remain high • Developing the Impartial Assessor model to the STP footprint. Assessors need access to multiple systems due to multiple organisations being involved in the project • Examples within the Urgent Care system remain of unnecessary professional or administrative assessment or triage which slows down discharge process 	<ul style="list-style-type: none"> • Work is underway to implement the Impartial Assessor service in Princess Alexandra Hospital (PAH) and Watford Hospital Development of the impartial assessor role to include self-funders, helping families to make the correct decisions about placement in a care home • Working across providers to ensure the removal of any unnecessary assessment or triage process
7	<p>Focus on Choice</p> <p>Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.</p>	Established	<ul style="list-style-type: none"> • Robust patient choice policy is in place at acute trusts and under continual review. 	<ul style="list-style-type: none"> • Policy in place in acute trusts but not always in place or as robustly applied in non-acute and private sector discharge capacity 	<p>East & North Herts:</p> <ul style="list-style-type: none"> • Close working between social care, community trust and mental health trust to ensure that choice policy is in place and applied consistently across all urgent care system • In HV, a target of achieving consistently been established over next three months • Working more closely with partners to ensure coherent responses for patients • Clarity on resource issues and availability to enable more consistent application of policy • Judgement of 'reasonability' regarding, for example, geographic provision of a bed outside of easy public transport access
8	<p>Enhancing Health in Care Homes</p> <p>Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital</p>	Established	<ul style="list-style-type: none"> • East and North Herts is a Care Home Vanguard, therefore over the last year different projects and programmes have been aligned to the framework. In HV, the Care Home Improvement Team has also been working to enhance care. • Training programme via the Complex Care Premium has helped raise staff awareness in complex care (2017 HSJ Value in Health awards) 	<ul style="list-style-type: none"> • Ensuring that all providers, including care homes, are bought into the E&N Vanguard programme or the work of the Care Home Improvement Team and have the commitment to try new ways of working • Capturing and sharing learning countywide • Collecting accurate and usable data to demonstrate impact of projects and overarching programmes • Recruitment to new posts that are temporary but also 	<ul style="list-style-type: none"> • Transition of pilots projects to long-term, more mainstream services and ensuring learning is captured effectively • Impartial assessor rollout to Princess Alexandra Hospital and Watford Hospital • Early Intervention Vehicle service extension • NHS.net rollout to all care homes with Information Governance toolkit

	as well as improve hospital discharge.		<p>winner for Workforce Efficiency)</p> <ul style="list-style-type: none"> GP surgeries are aligned to care homes in East and North Hertfordshire and complete weekly ward rounds and proactive care East and North Herts CCG care home pharmacist team visit care homes to review resident's medication and the care home's system and processes. Since Dec 2015 1,381 residents and 12,956 medicines have been reviewed of which 16% have been stopped. The Early Intervention Vehicle (7 day service) in East and North Hertfordshire is also making improvements by reducing ambulance conveyances. The Red Bag has been rolled out across all Older People Care Homes in Hertfordshire who admit into Lister Hospital or Watford Hospital 	<p>where there are already skills shortages e.g nurses, IG's</p> <ul style="list-style-type: none"> Scalability at pace of new models by end of year 2017/18 	<ul style="list-style-type: none"> Reviewing the current E&N model for primary care support into care homes to develop a more sustainable model with providers working together Piloting MDT care home support models through the HV community services redesign process
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