Herefordshire Council

Agenda

Health and wellbeing board

Date:	**Monday 14 October 2019**
Time:	**2.30 pm**
Place:	**Committee Room 1, Shire Hall, St. Peter's Square, Hereford, HR1 2HX**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Ben Baugh, democratic services** Tel: 01432 261882 Email: ben.baugh2@herefordshire.gov.uk

If you would like help to understand this document, or would like it in another format or language, please call Ben Baugh, democratic services on 01432 261882 or e-mail ben.baugh2@herefordshire.gov.uk in advance of the meeting.

Agenda for the Meeting of the Health and wellbeing board

Membership

Chairperson	Councillor Pauline Crockett	Herefordshire Council
Vice-Chairperson	Dr Ian Tait	NHS Herefordshire Clinical Commissioning Group
	Chris Baird	Director for children and families
	Ingrid Barker	2gether NHS Foundation Trust
	Russell Hardy	Wye Valley NHS Trust
	Councillor David Hitchiner	Herefordshire Council
	Jo Melling	NHS England
	Councillor Felicity Norman	Herefordshire Council
	Ian Stead	Healthwatch Herefordshire
	Simon Trickett	NHS Herefordshire Clinical Commissioning Group
	Stephen Vickers	Director for adults and communities
	Karen Wright	Director of public health

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES

To receive details of any member nominated to attend the meeting in place of a member of the board.

3. DECLARATIONS OF INTEREST

To receive any declarations of interests of interest in respect of schedule 1, schedule 2 or other interests from members of the board in respect of items on the agenda.

4. MINUTES 7 - 12

To approve and sign the minutes of the meeting held on 8 July 2019.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.

For details of how to ask a question at a public meeting, please see:

www.herefordshire.gov.uk/getinvolved

The deadline for the receipt of a question from a member of the public is Tuesday 8 October 2019 at 5.00 pm.

To submit a question, please email councillorservices@herefordshire.gov.uk

6. QUESTIONS FROM COUNCILLORS

To receive any written questions from councillors.

The deadline for the receipt of a question from a councillor is Tuesday 8 October 2019 at 5.00 pm.

To submit a question, please email councillorservices@herefordshire.gov.uk

7. HEREFORDSHIRE AND WORCESTERSHIRE LIVING WELL WITH DEMENTIA STRATEGY 13 - 56

To review the draft strategy with a view to ensuring it is effective in encouraging those who arrange the provision of any health or social care services in Herefordshire to work in an integrated manner for the purpose of advancing the health and wellbeing of the people of Herefordshire, and supports integration.

8. HEREFORDSHIRE'S BETTER CARE FUND (BCF) AND INTEGRATION PLAN 2019-20 57 - 136

To approve Herefordshire's better care fund (BCF) and integration plan 2019-20.

9. INTEGRATED CARE SYSTEM AND ONE HEREFORDSHIRE 137 - 162

To provide an update and overview of the developing Integrated Care System and One Herefordshire.

10. DATES OF FUTURE MEETINGS

The scheduled dates for board meetings in public are as follows:

Monday 9 December 2019, 2.30pm

Monday 10 February 2020, 2.30pm

Monday 20 April 2020, 2.30pm

The public's rights to information and attendance at meetings

You have a right to:

- Attend all council, cabinet, committee and sub-committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.
- Inspect agenda and public reports at least five clear days before the date of the meeting.
- Inspect minutes of the council and all committees and sub-committees and written statements of decisions taken by the cabinet or individual cabinet members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting (a list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
- Access to a public register stating the names, addresses and wards of all councillors with details of the membership of cabinet and of all committees and sub-committees. Information about councillors is available at www.herefordshire.gov.uk/councillors
- Have a reasonable number of copies of agenda and reports (relating to items to be considered in public) made available to the public attending meetings of the council, cabinet, committees and sub-committees. Agenda and reports (relating to items to be considered in public) are available at www.herefordshire.gov.uk/meetings
- Have access to a list specifying those powers on which the council have delegated decision making to their officers identifying the officers concerned by title. The council's constitution is available at www.herefordshire.gov.uk/constitution
- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage).
- Access to this summary of your rights as members of the public to attend meetings of the council, cabinet, committees and sub-committees and to inspect and copy documents.

Public transport links

The Shire Hall is a few minutes walking distance from both bus stations located in the town centre of Hereford.

Attending a meeting

Please note that the Shire Hall in Hereford, where the meeting is usually held, is where Hereford Crown Court is located also. For security reasons, all people entering the Shire Hall when the court is in operation will be subject to a search by court staff. Please allow time for this in planning your attendance at a meeting.

Recording of this meeting

Anyone is welcome to record public meetings of the council using whatever, nondisruptive, methods they think are suitable. Please note that the chairperson has the discretion to halt any recording for a number of reasons including disruption caused by the recording, or the nature of the business being conducted. Recording should end when the meeting ends, if the meeting is adjourned, or if the public and press are excluded in accordance with lawful requirements.

Anyone filming a meeting is asked to focus only on those participating actively.

If, as a member of the public, you do not wish to be filmed or photographed please let the democratic services officer know before the meeting starts so that anyone who intends filming or photographing the meeting can be made aware.

The reporting of meetings is subject to the law and it is the responsibility of those doing the reporting to ensure that they comply.

The council is making an audio recording of this public meeting. These recordings are made available for members of the public via the council's website unless technical issues prevent this. To listen live or to hear the entire recording once the meeting has finished navigate to the page for the meeting and click the larger blue arrow at the top of the agenda. To listen to an individual agenda item click the small blue arrow against that agenda item.

Fire and emergency evacuation procedure

In the event of a fire or emergency the alarm bell will ring continuously.

You should vacate the building in an orderly manner through the nearest available fire exit and make your way to the fire assembly point in the Shire Hall car park.

Please do not allow any items of clothing, etc. to obstruct any of the exits.

Do not delay your vacation of the building by stopping or returning to collect coats or other personal belongings.

The chairperson or an attendee at the meeting must take the signing in sheet so it can be checked when everyone is at the fire assembly point.

Herefordshire Council

Minutes of the meeting of Health and wellbeing board held at Committee Room 1, Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Monday 8 July 2019 at 2.30 pm

Present: **Dr I Tait (NHS Herefordshire Clinical Commissioning Group) (Vice-chairperson in the chair)**

J Alner	NHS Herefordshire Clinical Commissioning Group
C Baird	Director for children and families
Councillor D Hitchiner	Herefordshire Council
Councillor F Norman	Herefordshire Council
I Stead	Healthwatch Herefordshire
D Sutherland	2gether NHS Foundation Trust
Dr I Tait	NHS Herefordshire Clinical Commissioning Group
S Vickers	Director for adults and communities
K Wright	Director of Public Health

Officers: A Pitt (Head of integration and partnership, Herefordshire Council), Dr A Talbot-Smith (Director of strategy and transformation, NHS Herefordshire Clinical Commissioning Group), J Coleman (Democratic services manager, Herefordshire Council), A Neill (Chief executive, Herefordshire Council).

1. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Pauline Crockett, Ingrid Barker and Simon Trickett.

2. NAMED SUBSTITUTES

Duncan Sutherland substituted for Ingrid Barker and Jo-anne Alner for Simon Trickett.

3. DECLARATIONS OF INTEREST

None.

4. MINUTES

RESOLVED: That the minutes of the meeting held on 5 March 2019 be approved and signed by the chairperson.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

None.

6. QUESTIONS FROM COUNCILLORS

None.

7. BETTER CARE FUND QUARTER 4 REPORT 2018/19

The board was invited to review the better care fund (BCF) 2018/19 quarter four national performance and end of year feedback.

The head of integration and partnerships (HIP) presented the report. She noted that to meet the national deadline the content of the returns had been submitted using delegated powers. However, the report provided the board with the opportunity to review the returns and provide feedback.

She reported that the BCF guidance for 2019/20 had not yet been issued. There would therefore be no quarter one report. The expectation was that requirements would remain the same and work was underway to draw up the required plan on that basis. She had been informed that morning that the delay was a consequence of ongoing discussions nationally on the respective inflationary uplift between health and social care. The sum involved would not be significant in planning terms. The indication from government was that a decision was imminent, but that had been the indication for some time. The plan for 2019/20 had to be submitted by the end of September.

The director for adults and communities commented that the delay and uncertainty did represent a risk but this would be managed. A similar situation had arisen in preparing the 2018/19 plan.

It was observed that, although not large in overall budgetary terms, the outcome may have some service implications. It was proposed that when the outcome was known and guidance received the board should therefore be informed by correspondence and any implications highlighted, rather than waiting to report to a formal meeting of the board.

In response to a question about delayed transfer of care, the HIP commented that performance for April 2019 was below target, the local authority being slightly over target, the health service slightly below. It was noted that reporting was to change to provide a total for the system as a whole reflecting that the key point was the patient experience of the system as a whole and improved outcomes for them. For managerial purposes monitoring of the separate targets would continue, but it was to be hoped that the time the current system led each body to expend challenging the statistics of the other would reduce.

RESOLVED:

That (a) the better care fund (BCF) quarter four performance report at appendix one as submitted to NHS England, be received and the latest performance on delayed transfer of care and the move to measuring it in future at a system level be noted;

(b) on occasions when board meetings do not coincide with national submission dates, the director for adults and communities has delegated authority, following consultation with the accountable officer of the Clinical Commissioning Group (or their delegate), to approve the submission and to present this to the next available board meeting to enable review of performance and make recommendations for improvement;

(c) the director for adults and communities be authorised, following consultation with the chairperson of the health and wellbeing board and with the agreement of the accountable officer at the Clinical

Commissioning Group (or their delegate), to approve the 2019/20 BCF and Integration plan; and

(d) when the guidance on the BCF for 2019/20 including the financial settlement was received the board should be informed by correspondence and any implications highlighted.

8. ONE HEREFORDSHIRE AND INTEGRATION BRIEFING

The board was provided with an updated overview of the Sustainability and Transformation Programme (STP), One Herefordshire and Integration agenda for health and social care.

The director of strategy and transformation (DST) (NHS Herefordshire CCG and One Herefordshire), joint programme director (Herefordshire and Worcestershire Sustainability and Transformation Partnership) gave a presentation on the NHS long term plan, integrated care systems and one Herefordshire. The presentation was included with the agenda papers as an appendix to the report.

NHS Long Term Plan

The DST noted that an implementation framework for the plan had recently been received. Sustainability and Transformation Partnerships (STPs) / Integrated Care Systems (ICSs) had been asked to create their five-year strategic plans by November 2019 covering the period 2019/20 to 2023/24.

The following principal points were raised:

- On behalf of Healthwatch it was requested that there should be local engagement in the development of primary care networks to ensure the voice of local people was heard alongside that of health professionals. This was particularly important in a rural area where there were challenges to access to services.
- There was a danger that the national policy, of developing primary care networks with GPs working with other providers at locality level, which was written with an urban perspective, could prove complex in an area with a dispersed population. It was important to ensure that changes did not lead to poorer access to services. The plan's emphasis on digitally enabled care and the infrastructure required to support this was noted.
- The importance of ensuring the needs of Herefordshire continued to be served as part of a larger system was noted.

Integrated Care System / One Herefordshire

The DST noted that discussions continued to take place on how the work of the Children and Young People's Partnership would be accommodated within the One Herefordshire Plan. At the moment the two systems were working in tandem.

In discussion the following principal points were made:

- Potential barriers to joining up the system as intended were discussed. It was suggested that these might include: accountability mechanisms, the CCG deficit and lack of a common engagement strategy, and the separate governance arrangements of the partners in the absence of a common legal framework.
- The director for adults and wellbeing saw a need to avoid becoming bound up with governance and structures. He saw most potential in the communities agenda focussing on community development rather than on "health and social care" as the

only solution to meeting needs. He also commented on the need to be ambitious and not allow financial pressures to lead to short sightedness. Whilst in year savings were being made these were not at the cost of longer term plans.

- The director of public health commented that the organisations involved currently had different cultures and drivers and working towards joint commitments might offer benefit. Training had a role to play in this.
- Dr Tait agreed that differing performance management structures was an issue of significance and unless these were aligned organisations would be driven by different priorities. Staff within organisations were the biggest determinant of success. The board members between them were responsible for many employees. Users, carers the public and public representatives needed to be borne in mind. In a time of financial constraints it was also a question of empowering people to manage their own health and wellbeing needs and futures. He also highlighted the key role of educators, whether that be families or more formal structures like schools.
- The chief executive of Herefordshire Council was invited to speak. He expressed a concern that NHS led change had tended to focus on structural change and this had not been effective in securing successful outcomes for residents and communities. The local authority approach was to focus on communities. Within this context he thought the local authority was best placed to lead on health and social care commissioning given its breadth of experience and knowledge. In addition some of the terminology used by the NHS was impenetrable. It was important to talk to communities in a language they could understand. A clear definition was needed at the outset on what would be done differently and what would be achieved. A joint approach would be more effective than a set of different approaches or a top down approach based on structures.
- Dr Tait commented that the organisations involved had far more in common than divided them and whatever the perception was of how organisations approached a task the key challenge was to identify what they could do together by pooling efforts and resources.
- The One Herefordshire executive was focused on integrated system leadership.
- The director of public health commented that as employers and commissioners the organisations could have influence and suggested that a joint inequalities plan might have benefit.
- The DST commented that she considered the NHS long term plan and the move to integrated care systems did have a focus on form rather than function. It was important to be clear about Herefordshire's priorities, identify the barriers to achieving them that needed to be overcome and of ways of doing that whether as individual organisations or collectively.

The chairperson summarised the key points of the discussion as:

- The focus should be on health, wellbeing and the wider determinants of health, rather than narrow health services.
- Prevention should be at every level not just secondary (the NHS).
- Inequalities.
- Accommodating the work of the Children and Young People's Partnership within the One Herefordshire Plan.
- Practical steps that could be taken immediately within organisations as large employers for staff with impact on the health and wellbeing of a considerable amount of the county's population.
- Resilience and empowerment.

- Cultural change - clarity as to the shared benefits, accepting that organisations may have to give up some things for the good of the whole, creating investment in the outcomes.
- What is different in Herefordshire and its communities and the range of needs.
- Identifying the barriers to change that needed to be overcome.

The following year one priority areas had been set out in the report:

- Community resilience – Talk Community
- Integrated primary, community and mental health services - (it was suggested that it was important that rather than being top down this was as seen from the needs of the customer and those providing the service – a right first time solution)
- Urgent care, including frailty, dementia and end of life
- Elective care: musculoskeletal, ophthalmology, dermatology and outpatient redesign
- Digital and population health management

It was noted that expressing matters in simple intelligible language would be important.

It was suggested that prevention was a theme that ran through the whole system, not an add on. Digital and population health management should similarly be viewed as cross cutting themes and reflected accordingly in depicting the priorities. This thinking could be developed during the proposed workshop on the Talk Community project.

RESOLVED: **That the five year strategic plan be included in the board's work programme and informal workshops held on the Talk Community project, and the Children and Young People's Plan – focusing on what the issues faced were, what was being done to address them and any gaps, including the oral health plan.**

9. DATE OF NEXT MEETING

The board noted that the next scheduled meeting was on Monday 14 October 2019. Dates of the proposed workshops would be issued in due course.

The meeting ended at 4.36 pm **Chairperson**

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Monday 14 October 2019**
Title of report:	**Herefordshire and Worcestershire Living Well with Dementia Strategy**
Report by:	**Director of adults and communities**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose and summary

To review the draft strategy with a view to ensuring it is effective in encouraging those who arrange the provision of any health or social care services in Herefordshire to work in an integrated manner for the purpose of advancing the health and wellbeing of the people of Herefordshire, and supports integration.

Over the last five years the delivery of dementia care in Herefordshire and Worcestershire has evolved into a multi-agency approach with each county having separate strategies.

As strong as our foundations are, we know that we have more to do to ensure we provide timely diagnosis and that people with dementia and their carers get the right support whatever their individual circumstances.

We must continue to strive towards becoming more dementia friendly as a wider community. Our ambition is to ensure that people at whatever stage of their condition are given the best opportunity to live well, remain active, feel valued and connected within their family and community.

The 2019-2024 strategy sets out a shared vision for a collaborative approach across both counties. It will build upon the successes of our local dementia partnerships delivered by a wide range of local stakeholders who are key to supporting people living with dementia, their family, friends and communities.

Recommendation(s)

THAT: the board review the draft Herefordshire and Worcestershire Living Well with Dementia Strategy 2019-2024 (at appendix 1) and determine any recommendations it wishes to make to the council or relevant health bodies to improve the strategy and action plan alignment to the Herefordshire Health and Wellbeing strategy and/or to improve integration between health and social care.

Alternative options

1. There are no alternative options, this is a sustainability and transformation partnership (STP) pledge to work together to improve the health and wellbeing of people affected by dementia and is a shared priority health outcome area for both counties. The STP partners are committed to working together to achieve the strategy aims and encourage colleagues to join us in meeting this challenge by understanding our strategy and working with us to deliver it over the next five years.

Key considerations

Sustainability and transformation partnership (STP)

2. This is the first STP footprint strategy which is underpinned by the NHS England Well Pathway for Dementia Model and endorses continuation of the collaborative approach that exists in our counties to build dementia friendly communities. By both, continuing to work on improving dementia care from diagnosis to end of life, while at the same time developing more dementia aware and supportive communities, we aim to improve the lives of people with dementia and their carers.

3. A fundamental challenge is to address local stigma and negative image of dementia which is creating fear and a sense of hopelessness within our aging population

4. A new element of the strategy is a focus on preventing well. Opportunities will be created to raise public awareness of the link between vascular health and dementia risk and how adopting a healthy lifestyle can also have a positive impact on the brain helping to prevent some types of dementia.

5. The strategy reflects key messages we have heard from people affected by dementia via engagement events and surveys undertaken by the STP and partners such as Healthwatch.

6. The scale of the challenge is significant with an estimated 12,456 people currently living with dementia in Herefordshire and Worcestershire including more than 592 people with young onset dementia. We must respond to the growing number of people who are developing dementia later in life whilst still needing to work and many of whom often have another significant chronic condition.

Community impact

7. Dementia is a priority public health area identified by Herefordshire and Worcestershire health and wellbeing boards. The joint dementia strategy sets out a clear vision and commitment to take action on the key areas to be addressed to embed the Well Model across communities in both counties

8. The strategy has a key deliverable of improving the Herefordshire current rate of diagnosis (58%) to the nationally targeted rate of (67%)

Equality duty

9. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows: A public authority must, in the exercise of its functions, have due regard to the need to -

   (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

   (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

   (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

10. The council and the NHS Herefordshire Clinical Commissioning Group (CCG) are committed to equality and diversity using the public sector equality duty (Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity and foster good relations.

11. An Equality Relevance Screening has previously been completed in respect of these recommendations. The screening did not identify any potential Equality considerations requiring further consideration during implementation.

12. The CCGs undertook Equality Impact Assessments (EIA) and Quality Impact Assessments (QIA) as part of the response to an NHS England review which identified the need for development of joint strategy and establishing partnership group. It was identified that a joint EIA /QIA would be more helpful to be undertaken as part of dementia strategy implementation process.

13. In the strategy 'Preventing Well' action 2.3 commits that a joint EIA and QIA will be undertaken by CCG and council partners to support the strategy implementation.

14. The dementia strategy supports all communities across the two counties helping to reduce inequalities and reach and support the most vulnerable within our society. It is not envisaged that the recommendations in this report will negatively disadvantage the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity race, religion or belief, sex and sexual orientation.

Resource implications

15. There are no specific resource implications to the recommendations outside of business as usual and all actions associated with the strategy will be resourced from existing budgets.

Legal implications

16. There are no specific legal implications at this stage but all stakeholders must clearly comply with all relevant statutory duties that are placed on them. Consideration should also be given to the report functions of the board and any implications / compliance with requirements arising in the NHS constitution.

Risk management

17. The risks associated with not approving and delivering the strategy are an increasing number of residents living with dementia without an early, formal diagnosis and without support networks or responses to enable them to live as full lives as possible within the two counties.

Consultees

18. This strategy has built upon local engagement work led by the Herefordshire and Worcestershire dementia partnership boards, which has been further strengthened by partnership events and public surveys.

19. In terms of organisations, in addition to those that attend the local dementia partnership board such as the council / CCG / Herefordshire Carers, the events had attendance from care homes, e.g. Stretton Nursing Home, domiciliary care agencies (e.g. Radfield / Sure), voluntary and community sector (e.g. Age UK H&W, Onside, Healthwatch), and NHS providers (e.g. 2gether NHS Foundation Trust, Wye Valley NHS Trust).

Appendices

Appendix 1 Herefordshire and Worcestershire Living Well with Dementia Strategy 2019-2024 (agenda page 17)

Background papers

None identified

Herefordshire and Worcestershire's Living Well with Dementia Strategy

2019-2024

Produced by:

NHS Herefordshire Clinical Commissioning Group | NHS Redditch and Bromsgrove Clinical Commissioning Group | NHS South Worcestershire Clinical Commissioning Group | NHS Wyre Forest Clinical Commissioning Group in partnership with Herefordshire Council and Worcestershire County Council

1. Introduction

Early diagnosis and access to support for those living with dementia and their carers remains a priority for Herefordshire and Worcestershire. Our Strategy sets out the Herefordshire and Worcestershire ambition to support people to live well with dementia.

It reflects the national strategic direction outlined in The Prime Minister's Challenge on Dementia which details ambitious reforms to be achieved by 2020.

The Strategy is informed by what people have told us about their experiences either as a person living with dementia or as a carer and is written for those people; specifically those with memory concerns, those with a dementia diagnosis, their families and carers, communities and organisations supporting them.

1. Introduction continued

Hereford and Worcestershire's Living Well with Dementia Strategy 2019-2024 has been developed in partnership with local health, social care and the voluntary and community sector. An important focus of our strategy is to move towards delivery of personalised and integrated care.

We have used the NHS England Well Pathway for Dementia to give us a framework that puts the individual and their carer at the centre of service development and implementation across health and social care. As a partnership, we are committed to minimising the impact of dementia whilst transforming dementia care and support within the communities of Herefordshire and Worcestershire, not only for the person with dementia but also for the individuals who support and care for someone with dementia.

We want the well-being and quality of life for every person with dementia to be uppermost in the minds of our health and social care professionals.
https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

2. What is dementia?

‘Dementia describes a set of symptoms that include loss of concentration and memory problems, mood and behaviour changes and problems with communicating and reasoning. These symptoms occur when the brain is damaged by certain diseases, such as Alzheimer’s disease, a series of small strokes or other neurological conditions such as Parkinson’s disease’ **‘Prime Minister’s Challenge on Dementia 2020’**

Prime Minister’s Challenge on Dementia 2020

Dementia is most common in people over the age of 65 but there are also a smaller cohort of people who develop ‘young onset’ or ‘working age’ dementia from as young as 35.

For most people the cause is unknown but there are some known causes or risk factors such as:

- Diseases and infections that affect the brain e.g. Alzheimer’s disease or meningitis
- Pressure on the brain e.g. brain tumour
- Lack of blood and oxygen supply to the brain e.g. stroke and head injuries
- Cardiovascular insufficiencies.

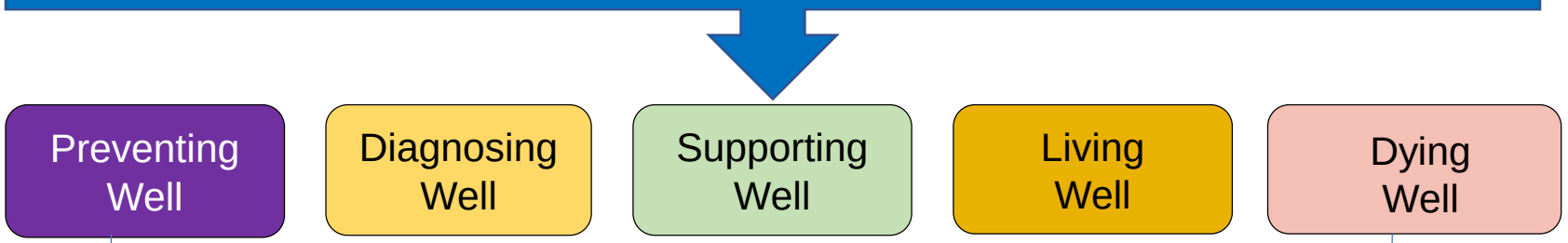
There is clear evidence that the earlier into the disease that dementia is diagnosed the better the outcomes for those with the illness and their informal carers, it will help with decision making and preparing the individual and their family for choices they will need to make in the future.

Links to further information about the different types of dementia are provided at the end.

3. Vision, guiding principles and aims

This strategy has been guided by principles developed by NHS England in their transformation framework. This 'Well Pathway for Dementia' is based on NICE guidelines, the Organisation for Economic Co-operation and Development framework for Dementia and the Dementia We-statements from The National Dementia Declaration.

Our vision is that in Herefordshire and Worcestershire people with dementia can live well through the following guiding principles:

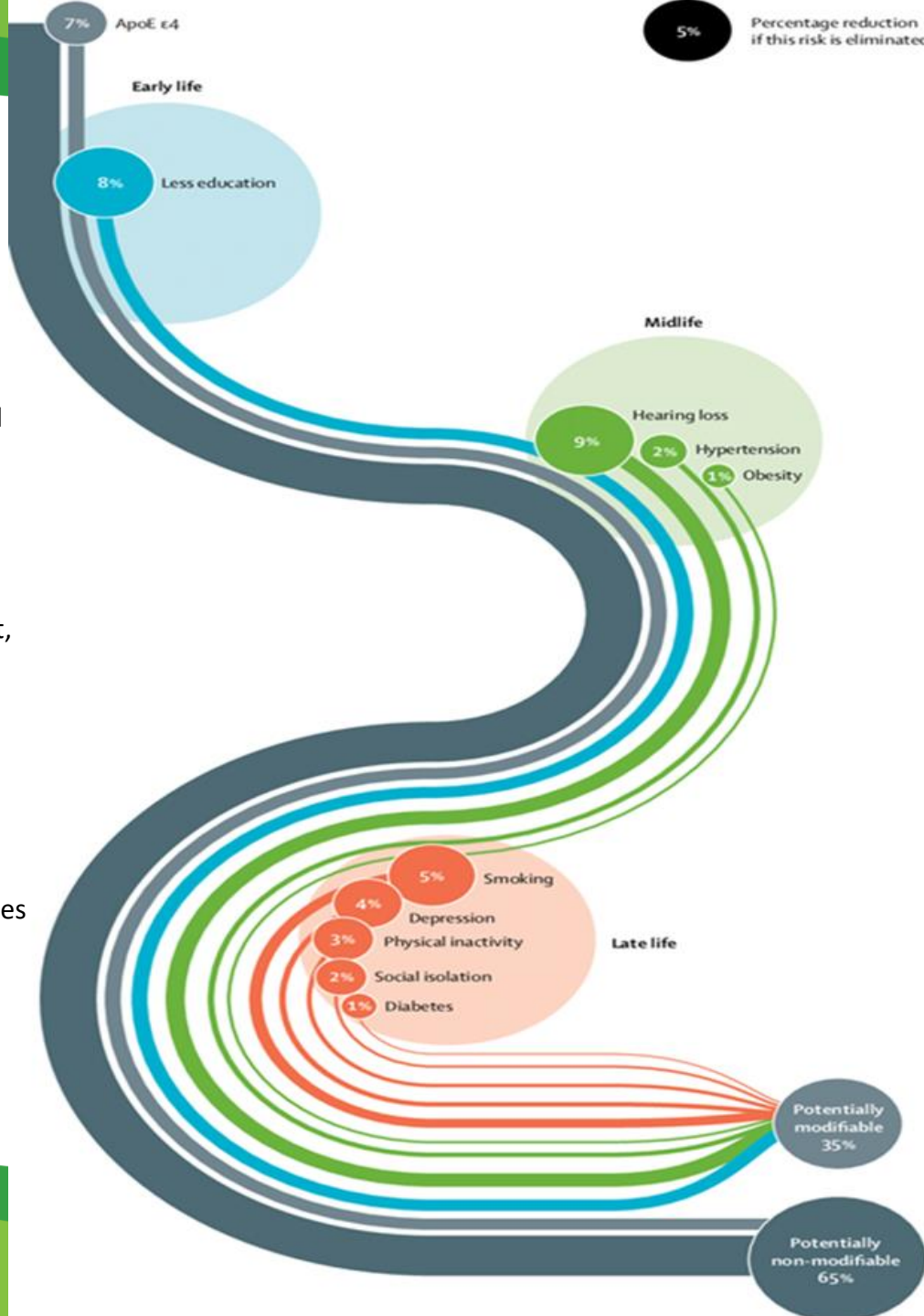


Our new strategy focuses on people and patients so that every person with dementia, their carers and families have access to and receive compassionate care and support not only before diagnosis but after diagnosis and through to end of life.

3.1 Preventing Well: Risk Factors to Dementia

- Age is the biggest risk factor but lifestyle, from childhood through mid-life and later life, has a considerable impact.
- A major study[1] estimated 35% of cases of dementia are attributable to a combination of modifiable risk factors: education to age 11–12 years, midlife hypertension, midlife obesity, hearing loss, later-life depression, diabetes, physical inactivity, smoking and social isolation (see Figure). Other factors could also be important, and further add to the preventable fraction. Recent data[2] supports the impact of higher alcohol consumption (>14 units/week) in increasing dementia risk. Other risk factors have biological plausibility but not yet conclusive evidence, including visual impairment, depression, sleep, living close to major road (air pollution) and dietary factors.
- Incidence could be therefore be decreased by reducing risk factors.[1,3] Supporting increasing healthy behaviours (stop smoking, be more active, reduce their alcohol consumption, improve their diet), loss of weight/maintaining a healthy weight, maintaining social engagement and managing hypertension in middle age, hearing loss, depression, diabetes and obesity all have potential to delay and prevent onset of dementia.

[1] Livingston et al, Lancet 2017. [2] Sabia et al, BMJ 2018. [3] NICE guideline NG16, 2015



4. National context and background

There are a number of national drivers that shape and influence the way the UK should address dementia as a condition

Prime Minister's Challenge on Dementia 2020

In February 2015, the Department of Health published a document detailing why dementia remains a priority and outlined the challenges the UK continues to face in relation to dementia.

The priorities identified within this are:

1) To improve health and care
2) To promote awareness and understanding
3) Research

Legislation

- Care Act 2014
- Equality Act 2010

Context

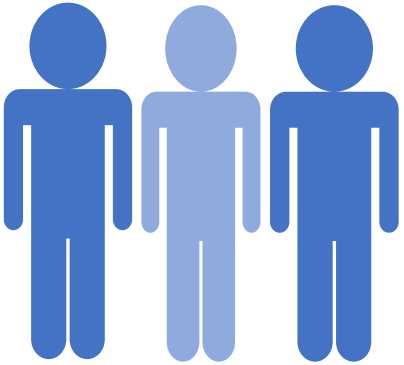
- Living Well with Dementia 2009
- Dementia 2015
- NHS & Adult Social Care Outcomes Frameworks and NICE Guidelines
- Fix Dementia Care 2016

National picture

There are currently 850,000 people living with dementia in the UK. 42,325 of these have early onset dementia.

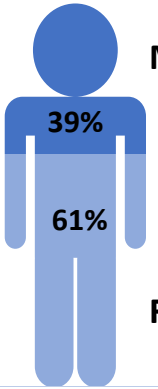
The number of people with dementia is forecast to increase to 1,142,677 by 2025 – an increase of 40%.

It is estimated that 700,000 (1 in 3) people in the UK will care for someone with dementia in their lifetime



In the UK 61% of people with dementia are female and 39% are male. There are a higher proportion of women with dementia as women tend to live longer, however, this does reverse when considering the data for people with early-onset dementia.

Gender

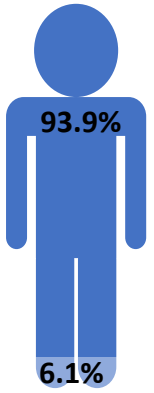


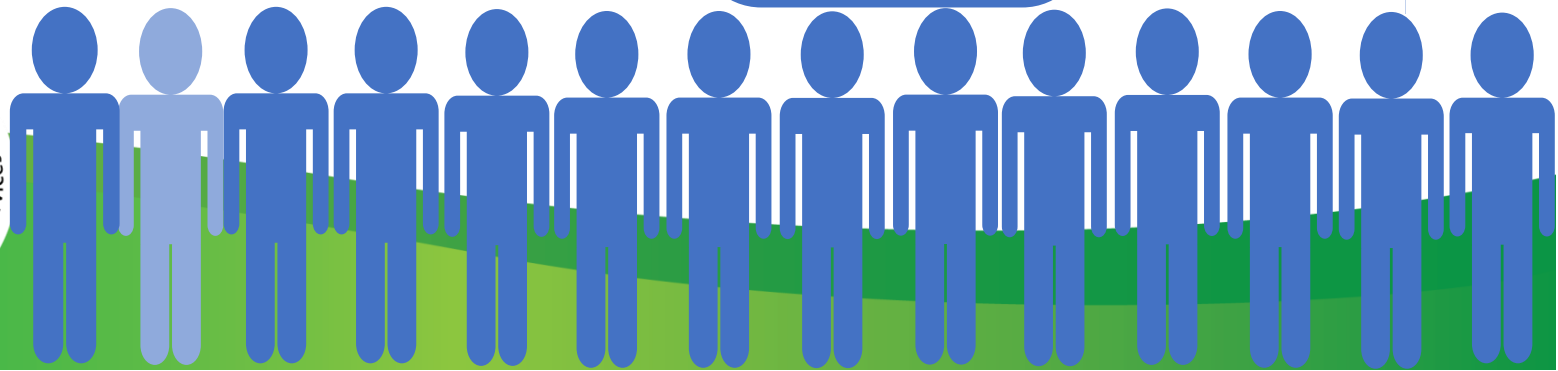
1 in every 14 of the population over 65 years has dementia

1 in 3 people who die over the age of 65 years have dementia. Dementia now accounts for 11.6% of all recorded deaths in the UK.

It is estimated that there are 11,392 people from black and minority ethnic (BME) communities who have dementia in the UK. 6.1% of all those are early onset, compared with only 2.2% for the UK population as a whole, reflecting the younger age profile of BME communities.

Dementia and Ethnicity





Herefordshire and Worcestershire Living Well with Dementia Programme 2019-2024

National Outcomes

1. PM's Dementia Challenge 2020 Visit

- Reducing Risk
- Improved Health + Social Care
- Awareness + Social Action
- Research

2. NHSE Well Framework/Pathway

- Prevent well
- Diagnose well
- Support well
- Live well
- Dying well

H &W Outcomes

- **Driving STP wide culture change** through raising awareness and understanding
- **Early Dementia Diagnosis** and access to support
- **Supporting people** affected by dementia ensuring they have choice and control in decisions affecting their care and support
- **End of Life** Ensure person living with dementia dies with dignity and their families/carers experience compassionate support

Key Influencers

Priorities:

- Increase Dementia Diagnosis Rates (DDR)
- Integrated Community Dementia Pathway via Neighbourhood/locality teams
- Dementia Awareness &Support

NHSE

- Ambition DDR 67%
- 6 week referral to treatment by 2020
- Improved post diagnostic support
- Reduced inequalities
- Increased Advanced Care Plans (ACP)
- Proactive case finding
- NICE 2018

Dementia Strategy and Programme 2019– 2024

5 Core outcomes:
Prevent well
Diagnose Well
Supporting Well
Living Well
Dying Well

Supporting Initiatives

Increase DDR

- Pro-active case finding
- Improve coding in primary care (Data Quality Toolkit 2017)
- Harmonisation of GP register and specialist mental health
- DiADeM and DeAR GP Tools

Care Homes

- Collaborative approach to support Care Homes

Neighbourhood Locality Teams

- Place based approach
- Integrated community team

Communication and Engagement

- Shared vision and Campaigns

Education and Workforce Development

- Education Strategy to build dementia friendly practice across pathway delivery including Advanced Care Planning and End of Life care

DDR

- DDR Recovery Plan
- IST findings/action plan

Referral

- MAS pathway review to improve patient flow
- Steps to diagnosis
- Diagnosis of dementia (care homes)

Learning Disability (LD)

- Increase awareness & inclusion of LD in dementia services
- Align with LD strategy

Mild cognitive Impairment (MCI)

- Pathway in collaboration with WMSCN
- Pilot (locality)

Shared Care protocol to support medicines prescribing

Joint delivery plan across all partners

Workforce Development

Align with Frailty (ICOPE)

Dementia friendly Community

- Dementia Action Alliance
- Dementia Partnership
- Community resilience and capacity; Meeting Centre; Singing for The Brain, Dementia Cafés, Carers Support, Dementia Voices , young on-set
- Dementia Friends
- Dementia Connect and WISH
- IST Work Programme

Herefordshire and Worcestershire Safe and effective health and care services

5. Local context and background

The Sustainability and Transformation Partnership (STP) in H&W is a partnership committed to improving health and social care to enable us to plan and be responsive to the needs of the whole population. This includes a dementia work stream to deliver the Well Pathway for Dementia

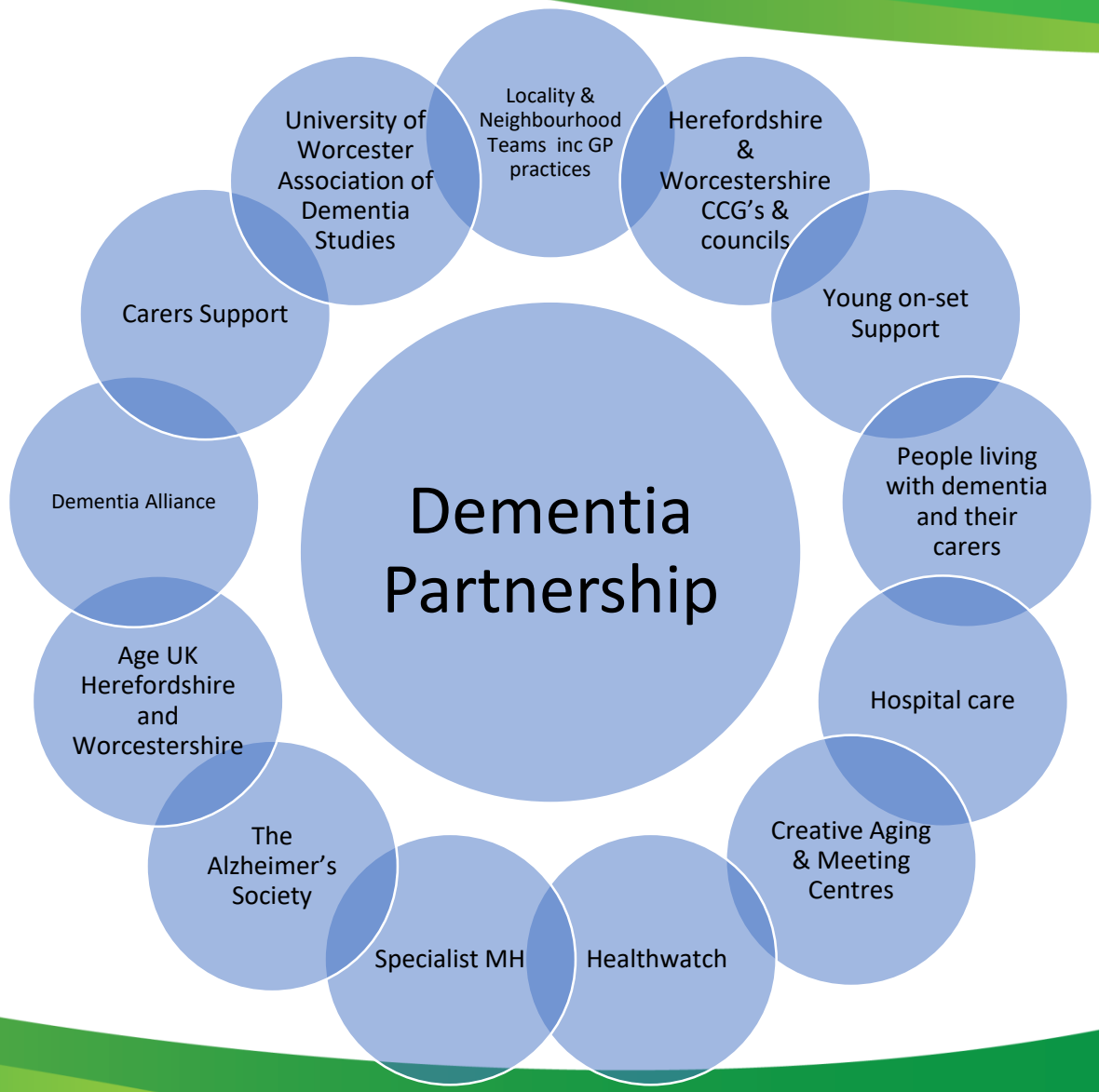
Local Dementia Delivery Plans reflect the key findings and recommendations of a dementia review undertaken by NHSE Intensive Support Team 2017
A further review was undertaken Oct 2018

Herefordshire and Worcestershire Safe and effective health and care services

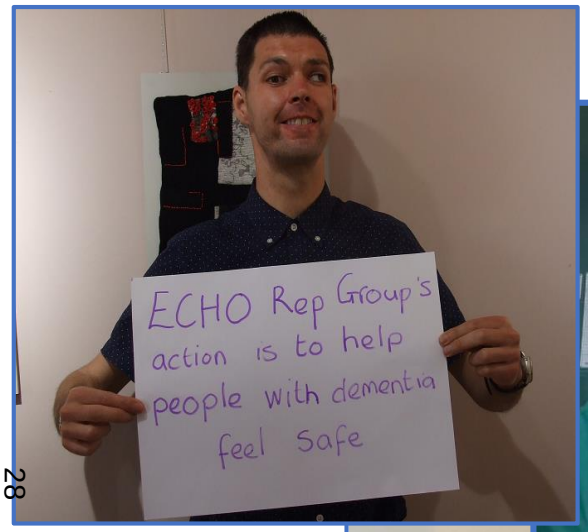
5. Local context and background

Each county has a Dementia Partnership Programme Board overseeing the development of a refreshed strategy and high-level delivery plan. The multi- agency partnership works to ensure that interdependencies are identified including but not limited to:

- Integrated locality Neighbourhood teams
- Carers Support
- Primary care
- Community and voluntary organisations
- Secondary Care
- Urgent and emergency care
- Planned care
- Mental health
- Prevention
- Medicines Management
- Learning disabilities
- End of life
- Continuing health care and personal budgets
- Information and support- WISH, ART



5. Local context and background



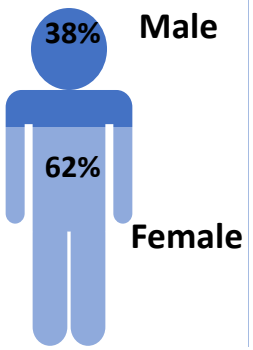
"Having contact with the Dementia Adviser Service has helped me to continue to be part of my community by enabling me to participate in the Focus on Dementia Network" (a local service user).

Local Picture

There are currently 12,456 people living with dementia across Herefordshire and Worcestershire (this number is set to increase to 18.669 by 2035).
592 of these people have early onset dementia.

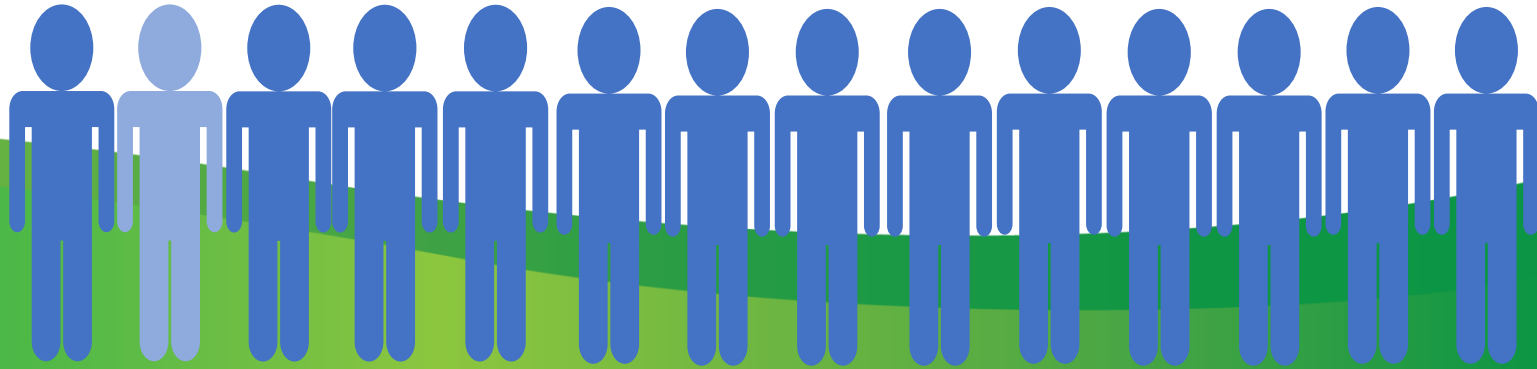
Across H&W 62% of people with dementia are female and 38% are male. This reflects the national trend.

Gender



It is estimated that there are 84985 carers across H&W. For further information relating to carers, see the draft H&W Carers Strategy.

1 in every 15 of the population of H&W over 65 years has dementia, reflective of the national trend



Local Picture

The dementia diagnosis indicator compares the number of people thought to have dementia with the number of people diagnosed with dementia. The target set by NHS England is for at least two thirds of people with dementia to be diagnosed (67%). The national prevalence of dementia is 1.3% of the entire UK population equating to approximately 850,000 individuals.

Local NHS Diagnosis Rates (people over 65 years)

Herefordshire	South Worcs CCG	Redditch & Bromsgrove CCG	Wyre Forest CCG
58.9%	56.4%	64.6%	58.9%

(Percentages represent the proportion of people living with dementia that have a formal diagnosis as of Aug 2019)

Herefordshire

- Total Population 187,878
- 3116 individuals thought to be living with dementia
- 2966 of these are 65 years or over
- 150 individuals living with Young Onset Dementia
- The total population of people aged 65 years or over is 46,102 which equates to 6.43% of this cohort of the population living with dementia

Worcestershire

- Total Population 607,971
- 8,748 individuals thought to be living with dementia
- 8306 of these are 65 years or over
- 442 individuals living with Young Onset Dementia
- The total population of people aged 65 years or over is 127,811 which equates to 6.5% of this cohort of the population living with dementia

Local Picture - What people tell us

Local Picture

"Having support from a DA has reduced my anxiety and made me feel that I am not so dreadfully alone"

"memory clinic referral went smoothly along with appointment was an overview of what to expect .. experience was good, ongoing support excellent we have a remarkable CDN"

Person attending a Memory Morning Drop In
"It was a friendly setting where I was able to talk freely about my concerns without family members talking for me."

"Thank you so much for all the help you have given over the years. We would have been lost without you."

"'As always your support and advice is very much appreciated. You are such a help for people like us as individuals, and for the community as a whole"

"People really like the meeting centre as it runs for a good amount of time. For one gentleman, it gave his wife (carer) a break and he wishes there was more things like it where he could go on other days of the week."

Person with LD and dementia
"I do like the signs and I want to put my photo on my bedroom door."

Family carer of person with LD
"There is a definite change where my learning disabled daughter lives. I observe the person who has learning disability and dementia now listening to music through headphones, and the environment is dementia friendly. The rugs and patterns are all gone; the carers have really embraced the learning. The impact on other people who have a learning disability who live there is that they are more relaxed. They have stopped telling her to be quiet."

Local Picture

Don't forget that those with a diagnosis of dementia may have other health issues , pathways must accommodate this as risk of overshadowing can occur without proper integration

"We need more drops-ins". Lots of groups in the area but not enough coordination between them, for example, everything seems to happen at the same time/day.

You will need to train your workforce to attune to the needs of younger, physically fitter people being diagnosed with dementia. How will they wish to be supported by you? People will expect to stay active, working and engaged in their community

Support staff to develop knowledge skills and confidence in advanced care planning at an appropriate time for the person and their carer, and managing end of life when the time comes

We need to keep talking about dementia and all risk factors associated with it …
Knowledge is Power

(Carer) "Professionals need to understand dementia can make people intolerant of waiting; noisy places but few have taken this on board"

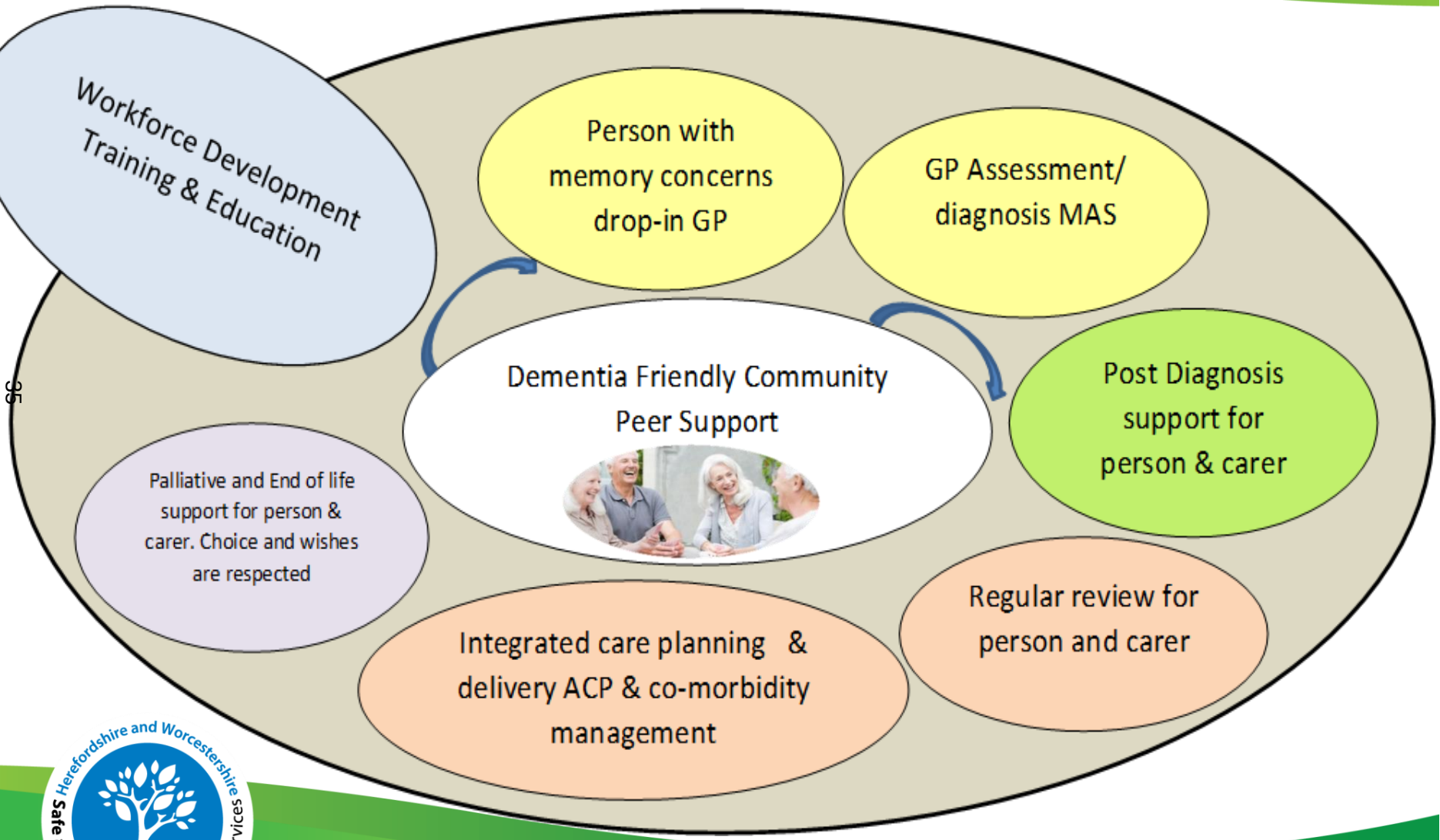
Dementia can be a very lonely place, encourage open discussion and easier access to help available so that people are not scared of diagnosis and feel confident to make the necessary adjustments to live well

Reach out to communities to address their negative attitudes towards living next door to someone with dementia & how they can support them – its not all about the staff/professionals. We all have a role to play in addressing stigma

"Hard to find affordable, short-term, ad hoc respite – mother is settled at home and it would be better if someone could come to the home even if it was just for a few hours." - Family member

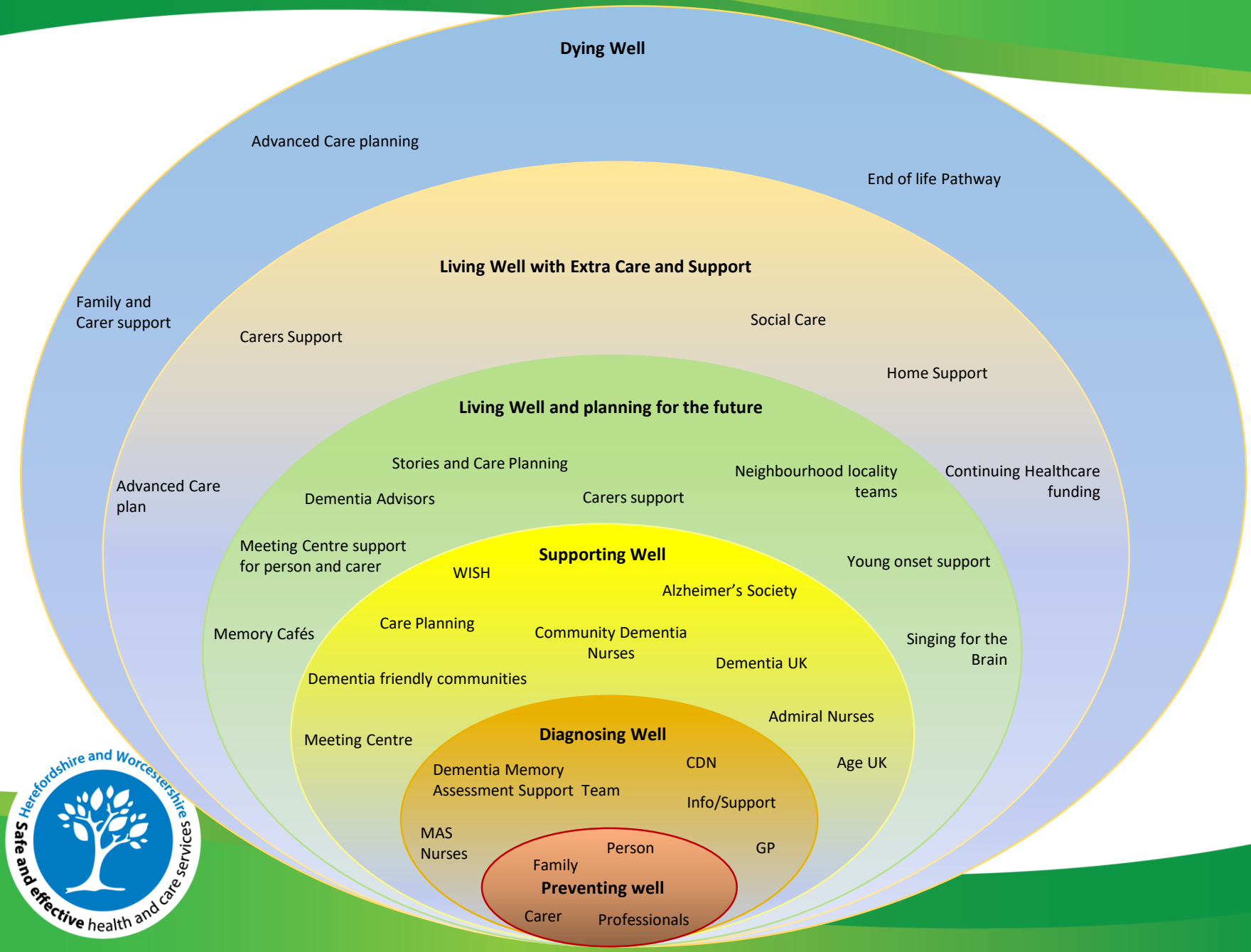

Dying Well
Living Well with Extra Care and Support
Living Well and planning for the future
Supporting Well
Diagnosing Well
Preventing well

A persons journey living with dementia



Herefordshire and Worcestershire
Safe and effective health and care services

Herefordshire's and Worcestershire's Vision For Dementia



7. Achievements of the previous Worcestershire Strategy 2009-2016

GP's have been supported to understand and promote key preventative messages as well as developing health checks and a dementia focused GP toolkit.

The memory pathway is well embedded across the area with good connections from primary care, an award winning memory clinic, post diagnostic support services through the voluntary and community sector and adult social care.

There has been a modernisation of the older adult mental health services to ensure that key objectives are met and to ensure that specialist services can complement the more generic development of health and social care services across the county. A new community and hospital based Dementia Pathway has been developed with a single point of access for people with dementia, carers and professionals

Worcestershire has a fully integrated personalised approach to dementia support, including an Admiral Nurses who have specialist dementia nursing expertise

Models of Peer Support have been developed to increase access to services.

Engagement with people living with dementia and their carers has been undertaken across the area to understand their experiences of the health and social care system to inform future work

Awareness raising has been undertaken by the Voluntary and Community Sector in the form of pop up road shows, GP training.

7. Achievements of the previous Worcestershire Strategy 2009-2016

Carers are supported through specific services, including advice, information, training and respite

Worcestershire has many Dementia Action Alliances and a number of dementia friendly practices.

The Johns Campaign has been adopted by all hospital trusts in all hospital settings

The Dementia CQUIN for assessment has been embedded in all hospital settings

A bespoke group has been set up specifically for people with Young Onset Dementia for PWD carers their family and professionals to meet

A Dementia training programme for Care Homes, Domiciliary Care and the wider community has been completed.

8. Achievements of the previous Herefordshire Strategy

Herefordshire Dementia Integrated Care Pathway promotes a person centred approach and is well embedded across the county with effective team working across GP practices, Memory Assessment Service and community dementia support offering post diagnostic support in collaboration with voluntary and community sector and adult social care.

Herefordshire continues to strive towards the 67% national target in relation to diagnosis rates with appropriate referrals being made to memory assessment services, underpinned by a shared care agreement

A review of our strategic approach helping to facilitate effective participation and involvement across programme board; partnership and alliances to maximise impact and productivity

There has been extensive work to improve clinical coding (DQT), data reconciliation across stakeholders within the pathway helping to improve communication and information sharing and ensure people have access to and receive timely diagnosis, information and support.

Expert voice of people living with dementia raising awareness of Living Well with dementia contributing to society and changing perceptions.

Auditing public services and spaces suggesting improvements which have been implemented Old Market, Cathedral.
Working on GP audit tools; participating in service improvement audits; staff development days & Co-facilitating dementia friends sessions

Carers are supported through specific services, including advice, information, training and respite care. Carers attend cafes and Singing for the Brain along with the person who has dementia. Dementia Advisors support the partnership of carer and cared for.

8. Achievements of the previous Herefordshire Strategy

Significant Awareness raising has been undertaken via Dementia Partnership and Dementia Alliances and Dementia Friendly communities who work diligently to help build a dementia friendly Herefordshire. Herefordshire Dementia Action Alliance achieved Dementia Friendly Status in January 2017.

Meeting Centre at Leominster and Ross on Wye offering a membership model where carers and people with dementia are enabled to be actively involved and included in their community

Partnership working has enabled the roll out and buy in to Dementia Friends at strategic level with people living with dementia actively involved in the delivery. There are over 5,000 dementia friends across the county helping to promote awareness and support communities and businesses to take actions towards a dementia friendly Herefordshire. A number of GP practices are already working to become dementia friendly practices

A partnership commitment to building awareness has led to a county wide communication network approach which continues to promote events; news; opportunities and strengthening links between WISH and Alzheimer's Society Dementia Information and Support web pages

Listening to people living with dementia and their carers to understand their experiences of the health and social care system to inform future work. Engagement with rural communities and older people via Healthwatch continues to help inform our delivery plan

8. Achievements of the previous Herefordshire Strategy

A bespoke support group has been set up specifically for people with Young Onset Dementia for people with dementia; carers; family and professionals to meet

Reaching into Under-participating groups: Learning disability and dementia a project led by Alzheimer's Society has helped build awareness and understanding across stakeholders and actions to improve experience of people living with LD and dementia and their ability to live well for longer

Memory Mornings – reaching into rural communities where people worried about their memory can talk access support in a non-clinical setting.

Building resources and continuous shaping of support for people affected by dementia. Admiral nurses are a new resource for Autumn 2018. A Dementia training programme for Care Homes, Domiciliary Care and the wider community has been completed along with clinical updates for various professional groups of staff.

Launch of supportive assessment tools to support diagnosis (DiaDem) and care planning
(ReSPECT) to ensure we establish early diagnosis and plan care more effectively in partnership with person and care/ family

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

To monitor achievements an annual dementia dashboard and highlights report will be produced for the Health and Wellbeing Board

The most important outcome of Herefordshire and Worcestershire Dementia Strategy is to ensure more people with dementia are able to live safely and with as good a quality of life as possible at home or in a homely setting for as long as they and their family wish.

To achieve this we have a key over-arching actions to ensure there is good information, advice and support for people living with dementia and for their carers and families so that people are more confident that they can live well and independently with dementia and have access to appropriate support and services when required

Overarching

	High Level Actions	Lead	Outcomes	Measure
1.1	**Priority 1** Strengthen leadership and accountability for delivery of the strategy	Clinical and Organisational Lead roles both counties. Dementia Partnership Programme. Programme Board	Dementia partnership programme board includes clinical and executive level leadership and accountability from across the system Clinical and Organisational Leadership roles are well established, promoted and recognised across partners Awareness of Dementia and the link with physical and mental health is clearly articulated within relevant strategies (including CYP; older people, LD LTC strategies (ICOPE/frailty/ageing well). An Annual dementia recognition awards recognises contributions to the following: 1. Communication 2. Leadership and management 3. Learning and Improvement 4. Special Achievement	Evidence of refreshed TOR and Meeting Notes Annual review of strategies via programme board Innovation and Achievements are recognised and rewarded
1.2	**Priority 2** Develop pro-active dementia support model within Locality and neighbourhood teams	Locality /neighbourhood teams (GP clinical leads; clinical/care leads across partner organisations)	Locality and neighbourhood teams have received dementia friends training and have access to tools and approaches to be pro-active in recognising dementia and providing care and support to people affected by dementia Training to support use of and increased use of contingency & ACP planning in care plans to include ReSPECT tool ReSPECT form content shared with family members where appropriate Shared care pathway in place Increased uptake and use of assistive technology	% of dementia friendly practices & no. teams with dementia friends Training Dialogue has occurred between health and social care professionals and/or advanced care plan in place No. of people using assistive technology at home

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Overarching

	High Level Actions	Lead	Outcomes	Measure
1.3	**Priority 3** Maintain effective engagement processes with people living with dementia and their carers	Dementia Partnership Programme Board	There is an established model which partners follow to support patient and carer involvement and participation in pathway design and service improvement processes Patient and carer feedback are utilised to inform service improvement and enhance patient/carer experience Partners collaborate creating shared opportunities facilitating patient and carer involvement and participation Patients and carers participate in the dementia partnerships.	Evidence of Patient and carer satisfaction and working with people affected by dementia through: Task and finish groups • 1:1 meeting • Surveys • DPB • Working with community & voluntary organisations • Healthwatch
1.4	Partner organisations ensure their wider policies, strategies and specifications are dementia friendly, i.e. support preventing, diagnosing and living well with dementia; and all partners are aware of their safeguarding responsibilities	CCG's, Public Health, Herefordshire Council, Worcestershire County Council & Dementia Partnership Dementia Programme Board	Health and wellbeing of people affected by dementia are central to the decision-making of partner organisations All partners are aware of potential safeguarding and risk of harm for people affected by dementia and are clear on their roles and responsibilities and are familiar with local procedures to follow where there are concerns.	Evidence of dementia focus within key strategy, policies and specifications
1.5	Promote opportunities to participate in research to people living with dementia and their carers throughout the entire dementia pathway Implement Join Dementia Research (JDR) NHS toolkit NHS JDR Toolkit	Dementia Programme Board	Contracts with providers include a commitment to facilitate access to research opportunities People with dementia and their carers participate in national and local research opportunities Research Opportunities are discussed and promoted at Partnership meetings	Number of research opportunities available in the county
1.6	Undertake forward planning to ensure diagnosis and post-diagnostic support is designed to meet growth in dementia prevalence in over 65s and aligns with relevant strategies (Housing Frailty and EoL Strategy) PHE Fingertips Data and Rightcare and CCG data packs	CCG's, Herefordshire Council, Worcestershire County Council and Partnership	There is a regular programme of joint strategic needs assessment between LA and CCG commissioners which is used by all partners to inform local dementia service planning.	Timetable is a regular agenda item for programme board With task and finish as required

Herefordshire and Worcestershire Safe and effective health and care services

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Preventing Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
2.1	**Priority 1** Ensure **lifestyle interventions** (e.g. MECC, NHS Health Checks, workplace initiatives) and communication campaigns maximise the opportunity to reduce risk factors and raise the prevention message around dementia (e.g. using Public Health Dementia Risk Reduction Toolkit messages	CCG's, Public Health, Herefordshire Council and Worcestershire County Council	Increase in healthy behaviours that reduce the risk of dementia Increased awareness and understanding of risk factors for dementia across the life course. Increased awareness of Dementia and the link with Physical and mental health An ongoing local coordinated campaign across health and social care economy, led by Public Health, informing the public about; • Dementia risk reduction • Signs/symptoms of dementia (leading to timely diagnosis) • Benefits of early diagnosis • Preventative actions e.g. NHS HC uptake; physical activity Reducing modifiable risk factors e.g. smoking in key populations; alcohol consumption, early hearing loss detection and utilisation of hearing aids to improve independence and prevent cognitive decline. Behavioural Insights methodology is used to engage, understand and change behaviours (e.g. lifestyles or seeking diagnosis) in key at risk communities	Awareness of Dementia and the link with physical and mental health is clearly articulated within relevant strategies (including CYP; older people, LD LTC strategies (ICOPE/frailty/ageing well). All healthy living messages with reference dementia alongside heart disease and cancer. MECC is widely embedded Number of people trained in MECC; and where available, records of MECC healthy conversations on risk behaviours Evidence of close monitoring via increased uptake of NHS HC and effective follow-up and management of core dementia risk factors diabetes, blood pressure, obesity, high groups including Parkinson's, Stroke, smoking, embedded in Primary Care. Public Health have a lead role in the Dementia Partnership & Programme Boards	A time table for annual review of relevant strategies via programme board by Dec 2019 Dec 2019 Public Health Data/ Monitoring in place by Dec 2019 Sept 2019
2.2	**Priority 2** **Use of insights and intelligence** to understand the current picture across the Strategy areas and to target insights to understand and change behaviours.	Public Health and CCG's	Locality/Neighbourhood teams have access to and are acting upon data on dementia prevalence and expected prevalence and performance (Dementia Dashboard).	JSNA provides up to date intelligence at a local and STP wide scale, including data for forward planning. Dementia, and risk factors, are included in Locality /Neighbourhood team profiles For local action	Current timeframes may require review to align future JSNA at county & STP level Sept 2019

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Preventing Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
2.3	**Priority 3** **Reduce inequalities:** Addressing inequalities around accessing a dementia diagnosis and services is a key strand of our pathway work and fundamental to early diagnosis and support A joint Equality Impact Assessment and Quality Impact Assessment will be undertaken by CCG's and Council partners to support strategy implementation. Work with partners to continue to ensure clearly signposted, robust culturally competent and locally informed services and post-diagnostic support pathways	CCG's, Public Health, Herefordshire Council, Worcestershire County Council & Dementia Partnership Dementia Programme Board NHS England (Prison Health)	Identify the key inequalities in dementia diagnosis. Targeted initiatives to promote prevention and increase early diagnosis, and tailored support for people living with dementia, identified through intelligence. This may include; • People with Learning Disabilities • People from BAME communities • Rural and farming communities • Prisoners • Other seldom heard groups	Campaign/Programme of initiatives agreed i) targeted activity to address the inequalities ii) ii) reduction in inequalities (where feasible within time period	Programme outline n place for Dec 2019 Targets agreed from April 2020

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Diagnosing Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
3.1	**Priority 1** *Find, treat and support*: further reduce the diagnosis gap and inequalities in diagnosis by Delivering a timely diagnosis in line with national ambition and patient wishes Promoting memory pathway and use of supportive diagnostic tools Ensuring care home residents with dementia are included on dementia registers and by working with professionals looking after patients with vascular related conditions to identify memory problems earlier Proactively targeting hard to reach or seldom heard groups Maintain a high standard of data recording and completeness across dementia diagnosis and care pathways	Dementia Programme Partnership Primary Care, CCG's, MH Trusts, Admiral Nurses & CCG Quality Care Home Team, Health and social care partners	An established proactive case-finding culture across services and a referral pathway between MAS and Long-term condition services (diabetes, heart failure, Parkinson's disease, MCI, stroke service, Learning Disability and expert patient programmes) is in place to support seamless transition into the dementia pathway. DeAR GP tool is used to support care home staff and enhance communication between care homes and GP practices. DiADeM Tool is widely used to support diagnosis in the community.	Dementia Diagnosis rates in Herefordshire and Worcestershire are in line with national ambition (NHSE) including for people with LD. There is evidence of robust data recording and reporting processes across partner organisations and a rolling programme of data harmonisation and peer reviews in place across all pathways. DDR work programme continues each county in line with Deep Dive self -assessment 2018 Monthly meetings with NHSE Plan and process agreed and implemented.	Sept 2019 Monthly DDR monitoring /reporting Ongoing End Sept 2019 End of Sept 2019
3.2	**Priority 2** Address local stigma and negative image of dementia which is creating fear and a sense of hopelessness within our aging population	Public Health, CCG & Dementia Partnership and Programme Boards, Herefordshire Council and Worcestershire County Council	Communities are empowered to champion the benefits of early diagnosis Neighbourhood/Locality support is available for people who are reluctant to be assessed and receive diagnosis	All partnership/programme board members are dementia friends Communication and engagement strategy established to achieve consistent language used to describe dementia and the promote the benefits of early diagnosis. Local Media are partners in dementia communication and engagement delivery. Patients and carers participate in promoting positive messages about living with dementia. Herefordshire and Worcestershire are working towards becoming dementia friendly counties with local supportive communities	Sept 2019 Dec 2019 Dec 2019 Ongoing Sept 2019

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Diagnosing Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
3.3	**Priority 3** Review local Pathways to include Mild Cognitive Impairment Frailty and Ageing Well	CCG and providers, Memory Assessment Services Community Dementia Service Primary Care CCG/Specialist MH provider	A recognised and fully supported pathway in place to; • Identify, code and review patients with MCI. • People with MCI and their carers have access to drop ins at locality/neighbourhood level which provide information and support about self-care and when to seek further help. • The Rockwood clinical score is used to identify patients with frailty to support early intervention. • The diagnosis pathway includes access to appropriate IAPT services for people living with dementia and those with a non-dementia diagnosis (MCI) and their carers • IAPT workforce and services are trained and skilled to provide interventions which support people with dementia and MCI and their carers	Process and pathway agreed for implementation In place In place In place In place	May 2020 Sept 2019 Sept 2019 Sept 2019 Sept 2019
3.4	**Priority 4** Expansion of memory drop-ins across both counties, delivered collaboratively by dementia professionals and volunteers in partnership with people with dementia.	Dementia Partnership and Specialist community dementia team (CDN/DA) Alzheimer's Society/Age UK/ Admiral Nurses	Support is available, reaching into and tailored to rural and BME communities, offering support for those pre-diagnosis and the worried well.	Review of current provision in progress to determine future provision	Dec 2019

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Supporting Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
4.1	**Priority 1** **Workforce Development Education and Competency Development** A co-ordinated approach to ensure the principle of personalised dementia care is embedded and we achieve high levels of expertise throughout the dementia pathway Increased training and support for informal carers to support them in their carer's role and to facilitate improved health and wellbeing for carers Consider ways in which the Dementia Core Skills Education and Training Framework (including tiers 1, 2 and 3) can be utilised Dementia Training Standards Framework	STP One Herefordshire Education/Workforce Development Dementia Partnership Carers Support Advocacy Providers	Education and training review across all partners Improved and increased education, training and opportunities for skills development for all (including informal carers) who are involved in the care and support for people affected by dementia Training opportunities are available and aligned to the different stages of dementia progression. Care Home and Domiciliary Care staff at all levels have access to specialist level dementia education to enhance knowledge, skills and competencies enabling them to identify people with symptoms of dementia and deliver person centred care Dementia skills training is embedded within all contracts with Care Home and Domiciliary Care Providers Carers programme offering specific support for people caring for someone with dementia All partners deliver assessment, management and support for people living with dementia and their carers in accordance with NICE Guidelines (NG97) Increased awareness and utilisation of advocacy services amongst health professionals to signpost people with dementia and their carers.	Establish baseline Training programme in place Contracts Audit (annual) Number of referrals to advocacy from all areas in the dementia pathway	Dec 2019 2019 and on-going April 2020 Commence March 2020 Monitoring of referrals in place from April 2019
4.2	**Priority 2** Review and promote dementia information and support to ensure it includes the well pathway stages with appropriate signposting to local community support opportunities /groups. Develop Information and advice resources to be made available for people attending peer support groups (e.g. drops-ins; Meeting Centres) Ensure information and advice resources are accessible to and accessed by people with additional needs or challenges to reduce health inequalities	CCG, Memory Assessment and community dementia teams with Dementia Partnership	There is an established consistent approach to ensure everybody affected by dementia has timely access to information advice and support People living with dementia and their carers have access to a range of trusted information – (including digital and non-electronic options). A single point of access (SPA) and road map signposts people to local dementia information, care and support MAS and Hospital and provider services use standardised information packs for people who are newly diagnosed and carers packs for their family/friends Standardised welcome/Information packs are also issued at community support including cafes, drop ins and meeting centres Visible local media campaigns are part of an on-going programme of communication and engagement	All partners are signed up to local communication strategy to achieve consistent approach	2019 commencement and aim to achieve within 12 months

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Supporting Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
4.3	**Priority 3** **Putting Technology Enabled Living at the heart of dementia care** Commission Ensure Technology Enabled Living services (TELS) to provide appropriate responses and support for dementia –and train staff and voluntary groups in the potential for technology to support people with dementia and their carers. Commission TELS to make best use of Assistive Technology Opportunities within Dementia and by doing so move from Reactive to Proactive support models, including: • Prompts/reminders – supporting activities of daily living Passive monitoring of activity and trends Social Isolation – encouraging connectivity • Prompts/reminders – reminiscence robotics	Herefordshire Council & CCG Commissioning Herefordshire Council Adults & Communities WVT Operational Delivery STP	Progressing to a proactive, personalised and predictive approach to technology enabled integrated health & care services Condition-specific management providing services tailored to the unique needs of each patient, improving safety and user experience Monitoring and responsive moving from reactive provision to personalised, proactive and predictive care. Social engagement keeping users engaged in their community, fostering social inclusion and its associated benefits. Selfcare & wellness supporting users to take an active role in their wellbeing with positive lifestyle choices. Care planning & administration reducing waste, automating common tasks and co-ordinating to maximise efficient use of resources. Activities of Daily Living reassuring friends and family and supporting greater independence for longer.	This will be measured through a robust outcome-based quality monitoring programme.	Commission from 2020 and on-going
4.4	Improve knowledge of and access to risk reduction lifestyle activities for people with a diagnosis of dementia through signposting and referral pathways as appropriate (e.g. leisure and informal physical activity, healthy lifestyle service, community brokers) from health care professionals, including primary care and MAS.	Public Health/Memory Service/ Community Dementia /Primary care	Increased uptake of healthy lifestyle activities by people with dementia (especially vascular dementia) and people diagnosed with MCI Information sharing on community activities and other services implemented as part of drop-ins and post diagnosis support groups (link with Talk Communities)		Commence 2019 and review annually
4.5	Improve provision of care and support at home and residential care for people living with advanced or complex dementia workforce access Dementia Care Training Standards Framework	CCG's, Herefordshire Council and Worcestershire County Council	People living with advanced or complex dementia have access to a range of local care options including access to personal health budgets in line with CHC criteria.	Maintain current assessment framework and processes Personalisation and meaningful day initiatives	Ongoing Review in accordance with national guidance Annual Quality Assurance visits

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Supporting Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
4.6	Continue to create responsive community services which promote reablement and effectively manage crises for people affected with dementia either at home or in a care home Review and implement Enhanced Health in Care Homes Vanguard Learning Guide	Locality Teams In-reach team; CCG quality nursing team; Dementia Wellbeing Service (AGE UK HW) Admiral palliative care team	Neighbourhood and Locality teams have access to • Hospital avoidance service (out-reach support) • Specialist advice and support when managing a crisis • Responsive home care services to help dementia patients maintain independence and reduce social isolation A network of support for care homes facilitates advanced dementia care planning including implementing palliative care and End of Life care pathways. Non-clinical community support is key to enabling people to remain at home within their communities. Wide promotion of the Community Dementia Service and Dementia Wellbeing Service (including easy access through the Wellbeing Hubs).	Evidence of increased access/utilisation of these services via wellbeing hubs	Agree process for monitoring by end of Dec 2019 with view to annual review
4.7	Continue to focus on improving the in-patient experience and hospital discharge pathways	Acute & community trusts, CCG's, locality teams, Herefordshire Council, Worcestershire County Council	Hospital wards and departments are dementia friendly environments and are signed up to NDAA Dementia Friendly Hospital Charter Dementia Champions are identified and work collaboratively to increase dementia awareness Patient experience questionnaires confirm patient choice and control is respected Patients with deteriorating dementia are identified earlier for additional support during the discharge process Carers are supported and encouraged to participate in care and discharge planning.	Discharge pathways reviewed and changed where appropriate Dementia is reflected in discharge plans including care home capacity	Sept 2020
4.8	Continue to develop integrated dementia palliative and end of life care delivered at locality and neighbourhood team level so that planning for last days of life is a seen as a crucial element of good dementia care. Alignment with Ageing Well/ Frailty/ Palliative and EoL programme of education about a range of topics on recognising and supporting people in the advanced stages of dementia (GP master class/sessions)	CCG/ all dementia providers and partners community dementia services	A skilled multi-professional neighbourhood/locality team supported by dementia end of life specialist and care home liaison teams working together to identify, register and support people in the community and in care-homes who need palliative and EoL care. Local professionals feel confident in having conversations about: • death and dying; • completing advanced care plans and ReSPECT forms. discussions & conversations about death and dying; • encouraging people to complete living Wills and lasting powers of attorney so that personal end of life wishes is recorded and respected Carers and families receive emotional support when the person they are caring for is in the last days of life. Monitoring and review of care home residents with dementia includes palliative and advance care planning and this is accurately recorded on EMIS.	No of people on locality teams EoL registers Locality Team (MDT) meetings Evidence of representation where applicable	Agree process for monitoring by end of Dec 2019 with view to annual review

Herefordshire and Worcestershire Safe and effective health and care services

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Living Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
5.1	**Priority 1 CARERS -** Develop joint working with Carers across the two counties, to ensure they are recognised as partners in care and fully involved in and supported for all elements of the process	CCGs & Dementia Partnership All Providers	Carers are included in decisions made about the person with dementia who they care for. Carer feels listened to and information about the cared for person is appropriately shared Carers are valued and supported in their role and their own needs are recognised. Carers have access to information, advice and support to assist them in their caring role, enabling them to look after their own health and wellbeing, including support with form filling and education sessions for carers.	This will be measured through a robust outcome-based quality monitoring programme including; • a survey of family carers, to assess the extent to which they feel recognised as partners in care, involved valued and supported and have access to information and advice flexible and aligned to their needs.	from 2020 and on-going
5.2	**Priority 2** Continue to build and extend dementia friendly communities through the contribution of community and partnership working http://www.dementiafriends.org.uk Dementia friendly communities Housing charter http://www.dementiaaction.org.uk	LA Education Dementia Partnership CCGs & Dementia Partnership All Providers Dementia Action Alliance Locality /neighbourhood teams (GP clinical leads; clinical/care leads across partner organisations)	An established protocol to support organisations to become dementia friendly There is greater awareness and involvement by the community in local drop-ins A Dementia Friendly Housing Charter and guidance toolkit in place with all housing partners signed up Dementia friendly local environments (e.g. Hairdressers) to support people to remain connected to their local community Schools/Colleges are participating in dementia friends training and intergenerational activities promote dementia awareness and understanding A network of dementia friendly community pharmacists, podiatrist, dentists, opticians supporting people with dementia linking in with drop-ins to help with sign-posting and earlier identification for diagnosis and support. Primary Care Networks promote dementia friendly opportunities. Locality and neighbourhood teams have received dementia friends training and have access to tools and approaches to be pro-active in providing care and support to people affected by dementia. GP's with special interests in each locality routinely share best practice Increased use of contingency & ACP planning in care plans ReSPECT Tool implemented to guide ACP process across professionals and teams Shared care pathway Increased update and use of assistive technology (DOLS)	This will be measured through a robust outcome-based quality monitoring programme including; • a survey of groups including people with dementia, family carers, service providers, religious organisations to assess the extent to which the counties are dementia friendly and the action needed. • A review of the establishment of local alliances to implement dementia friendly communities involving people with dementia and family carers. The Dementia Action Alliances provide a co-ordinated approach in delivery of priorities An increase in the number of organisations, businesses, Council departments and community groups signed up to the local Dementia Action Alliance working together to achieve dementia friendly status.	from 2020 and on-going

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Living Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
5.3	**Priority 3** Work collaboratively to achieve a co-ordinated patient-centred pathway across partners	CCG's, Herefordshire Council, Worcestershire County Council and Dementia Partnership All Providers	Patients and carers are partners in care planning Partners collaborate to achieve a seamless pathway which promotes and respects patient and carer choice and control The Red Bag Initiative is adopted	A clear pathway and process exists enabling adaptations in the home and access to assistive technology to support independent living	from 2020 and on-going
5.4	**Priority 4** Ensure commissioned carer support services are evidence based and service monitoring captures delivered activity including; provision and uptake of community respite care, respite beds and a range of options.	CCG's, Herefordshire Council, Worcestershire County Council	Respite care is available when needed to support carers in their carer role A range of responsive and flexible respite options available in localities and neighbourhoods.	Maintain current assessment framework and processes Evidence of personalised and responsive respite initiatives	Ongoing Review in accordance with national guidance Annual Quality Assurance visits

9. H&W Dementia Strategy Delivery Plan 2019 – 2024

Dying Well

	High Level Actions	Lead	Outcomes	Measure	Timeframe
6.1	**Priority 1** Continue to develop integrated dementia palliative and end of life so that planning for last days of life is a seen as a crucial element of good dementia care. Alignment with Frailty/ Palliative and EoL programme of education about a range of topics on recognising and supporting people in the advanced stages of dementia Strengthen links with carers support, frailty and End of Life work streams (including the introduction of ReSPECT and EoL integrated pathway development).	CCG/ all dementia providers and partners community dementia services	A skilled multi-professional neighbourhood/locality team supported by dementia end of life specialist and care home liaison teams working together to identify, register and support people in the community and in care-homes who need palliative and EoL care. Staff supported with Advanced Communication Skills as a key competence. My future wishes advance care planning for people with dementia Professionals feel confident in having conversations about: • Death and dying • **Advance care planning** and completing the ReSPECT tool • encouraging people to complete living wills and lasting powers of attorney so that personal end of life wishes are recorded and respected. Carers/Families have access to GP services during OOH for support with crisis management (behavioural, psychological symptoms of dementia) Monitoring and review of care home residents with dementia includes palliative and advance care planning and this is accurately recorded on EMIS. Carers and families receive emotional support when the person they are caring for is in the last days of life and have access to bereavement support. The provision of responsive services is comparable with those for people with terminal physical health conditions with hospice standard care.	Evidence of representation where applicable Increased numbers of patients receive ACP	2019 Commencement and work in tandem with Palliative Care and End of Life work programmes
6.2	**Priority 2** People with dementia are supported to die in their preferred place of death, taking account of their expressed wishes end of life care plan.	Herefordshire & Worcestershire palliative care team network/forum, CCG and GP leads	Established baseline for the proportion of people with dementia who die in their preferred place of death, or other end of life care planning discussions. An audit processes is in place to monitor; **a)** Number of people living with dementia with a recorded preference of place of death **b)** Number of people with dementia who are supported to die in their preferred place of death **c)** An audit has been undertaken to confirm; discussions to support planning of last days of life are undertaken and appropriately acted upon. *This could benefit from working with the wider Herefordshire & Worcestershire palliative care teams networks/forums*	Established Baseline and audit process Service Specifications are designed to facilitate an improvement in these figures.	2019 Commencement and work in tandem with Palliative Care and End of Life work programmes Ongoing into 2020

10. Useful websites and Supporting Documents

Context

NHS England Well Pathway for Dementia: england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

Further information about the different types of dementia: nhs.uk/conditions/dementia-guide/Pages/dementia-choices.aspx and alzheimers.org.uk/info/20007/types_of_dementia

Prime Ministers Challenge on Dementia: gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

Living Well with Dementia: gov.uk/government/uploads/system/uploads/attachment_data/file/168221/dh_094052.pdf

Dementia 2015 – Aiming Higher to Transform Lives (report by the Alzheimer's Society): alzheimers.org.uk/info/20093/reports/253/dementia_2015

NHS Outcomes Framework & Adult Social Care Outcomes Framework Nice Guidelines

https://www.nice.org.uk/guidance/ng97 https://www.nice.org.uk/guidance/ng16https://www.nice.org.uk/guidance/ta217

https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions

Fix Dementia Care 2016: https://www.alzheimers.org.uk/our-campaigns/fix-dementia-care

NHS Digital Patients Registered at GP Practice (as of 1st November 2018): https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/november-2018

Application of prevalence rates from Dementia UK 2014 Update: https://www.alzheimers.org.uk/about-us/policy-and-influencing/dementia-uk-report

RCGP and Marie Curie Daffodil Standards UK General Practice Core Standards for Advanced Serious Illness and End of Life Care https://www.eolc.co.uk/uploads/20180423-Daffodil-briefing-v3.pdf

A guide to the support people should get from local services in England if they or someone they know have been diagnosed with dementia https://www.gov.uk/government/publications/after-a-diagnosis-of-dementia-what-to-expect-from-health-and-care-services

Hidden No More APPG Report Dementia and Disability https://www.alzheimers.org.uk/about-us/policy-and-influencing/2019-appg-report

Assistive Technology https://www.wmahsn.org/what-we-do/Digital_Health

10. Useful websites and Supporting Documents

Legislation

Care Act 2014: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Equality Act 2010: https://www.gov.uk/guidance/equality-act-2010-guidance

Local Policy

Herefordshire Council Health and Wellbeing Strategy 2015-2019: https://www.herefordshire.gov.uk/download/downloads/id/3677/health_and_wellbeing_strategy.pdf

Worcestershire County Council Health and Wellbeing Strategy 2016-2021 http://worcestershire.moderngov.co.uk/documents/s8318/Health%20and%20Well-being%20Strategy.pdf

Herefordshire Carers Strategy: https://www.herefordshire.gov.uk/directory_record/3416/carers_strategy

Worcestershire Carers Strategy: http://worcestershire.moderngov.co.uk/documents/s5437/6b%20Carers%20Strategy%20Draft%20Final%20DRAFT%2030%204%202015.pdf

Herefordshire Housing Strategy:

https://www.herefordshire.gov.uk/download/downloads/id/8436/interim_housing_strategy_2016-2020.pdf

https://www.herefordshire.gov.uk/directory_record/4808/homelessness_review_and_prevention_strategy

Herefordshire Learning Disability Strategy: http://councillors.herefordshire.gov.uk/ieDecisionDetails.aspx?ID=5164

Herefordshire JSNA: https://factsandfigures.herefordshire.gov.uk/understanding-herefordshire

Worcestershire JSNA: http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment

Alzheimer's Society Local Dementia Profile Herefordshire: https://www.alzheimers.org.uk/sites/default/files/2019-07/ldp_herefordshire.pdf

Alzheimer's Society Local Dementia Profile Worcestershire: https://www.alzheimers.org.uk/sites/default/files/2019-07/ldp_worcestershire.pdf

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Monday 14 October 2019**
Title of report:	**Herefordshire's Better Care Fund (BCF) and integration plan 2019-20**
Report by:	**Director of adults and communities**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose and summary

To approve Herefordshire's better care fund (BCF) and integration plan 2019-20.

The BCF is a national programme across both local government and the NHS which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. In summary, the report identifies the following points:

- the four key national conditions and national metrics for the BCF remain consistent from 2018-19;
- Herefordshire partners remain committed to working together to deliver a local system 'where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people';
- The council and NHS Herefordshire Clinical Commissioning Group (CCG) continue to work together to deliver on the key priorities within the plan to achieve service redesign and improve the delivery of service in order to achieve the priorities of the health and wellbeing strategy in the most cost effective way;
- Herefordshire's BCF and integration plan 2019-20 details the local approach to integration, plans to achieve metrics and plans for ongoing implementation of the high impact change

model (HICM) for managing transfers of care. The plan maintains the key schemes identified in the 2017-18 submission; and

- the plans are intended to move our health and social care system to a new service model in which patients get more options, better support and properly joined up care at the right time in the optimal care setting will support communities to remain within their own homes and reduce the need for hospitalisation and long-term care.

Recommendation(s)

That:

(a) the Herefordshire Better Care Fund and integration plan 2019-20 at appendix 1 be approved.

Alternative options

1. The board could decline to approve the submission. Although, in accordance with national deadlines, the content of the plan has already been submitted, the board may request changes prior to formally approving the plan on the basis of improving alignment with strategic plans and priorities or to provide further efficiencies. It is a national condition that the plan is approved by the health and wellbeing board (HWB). If it is not approved then the national BCF escalation process, as detailed within appendix 3, will be implemented to support and ensure compliance.

Key considerations

2. Partners throughout the health and social care system in Herefordshire continue to be committed to working together to deliver a local system 'where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people'.

3. The better care fund (BCF) provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

4. The BCF in 2019-20 will continue to provide a mechanism for personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital.

5. The BCF and integration plan is the health and social care strategic and delivery plan for Herefordshire and is therefore fully aligned with the joint local vision for the county. The BCF plan is also aligned to a number of other key plans including the Herefordshire public health plan, adults and communities plan, health and wellbeing strategy, Talk Community plan and the CCG operational plan.

6. The BCF guidance (appendix 3), issued during July 2019, sets out national conditions which are the key requirements for the better care fund plan 2019-20, these are:

    a) That **a jointly agreed BCF plan**, must be signed off by the health and wellbeing board (HWB)**,** and by the constituent council and clinical commissioning group (CCG**)**;

b) A demonstration of how the area will **maintain the level of spending on social care services** from the CCG minimum contribution in line with the uplift to the CCG's minimum contribution.

c) That a specific proportion of the area's allocation is invested in **NHS commissioned out of hospital services**, which may include seven day services and adult social care; and

d) That a clear plan on **managing transfers of care**, including the implementation of the high impact change model (HICM) managing transfers of care is in place. As part of this, all HWBs must adopt the centrally-set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their plans.

7. The BCF policy framework (appendix 2) sets out the four national metrics for the BCF 2019-20, as follows:

   a) non-elective admissions (specific acute);

   b) admissions to residential and care homes;

   c) effectiveness of reablement; and

   d) delayed transfers of care (DToC)

8. The continuation of the national conditions and requirements of the BCF from 2017-19 to 2019-20 provides opportunities for health and care partners to build on their plans from 2017 to embed joint working and integrated care further.

9. Herefordshire's BCF submission, at appendix 1, details the local approach to integration, plans to achieve metrics and plans for ongoing implementation of the HICM for managing transfers of care. The changes between the previous plan and the 2019-20 plan are minimal. Partners across the system are continuing to work together towards their shared vision. As per the requirements for the national programme, this was submitted by the national deadline of 27 September 2019. A regional assurance process will be undertaken by 5 November 2019 and approval letters should be received week commencing 18 November 2019.

10. The section 75 agreement and the approval of the 2019-20 BCF spend will be taken to cabinet on 28 November 2019.

11. At a strategic level, the BCF and integration plan intends to support the One Herefordshire alliance to achieving the following aims:

    a) to improve the health and wellbeing of everyone in Herefordshire by enabling people to take greater control of their own health and the health of their families and helping people to remain independency within their own homes and communities;

    b) to reduce inequalities in health (both physical and mental) across and within communities in Herefordshire, resulting in additional years of life for citizens with treatable mental and physical health conditions;

    c) to improve the quality and safety of health and care services, thereby improving their positive contribution to improved wellbeing and enhancing the experience of service users; and

    d) to achieve greater efficiency, making better use of resources.

12. Our One Herefordshire Integrated Care model is based on the practice of 'helping you to help yourself'. We are committed to developing our primary and locality (community

health mental health and social care services) networks and making best use of the resources to support people to live well as close to home as possible, on the principle that 'your own bed is best'.

13. Herefordshire's approach to integrating care around the person includes the Talk Community programme. This is a partnership approach, led by the local authority, which links three fundamental elements to promote and maximise independence and wellbeing within Herefordshire's communities. Talk Community focuses on the people that make up our communities; the place and space, which those communities occupy; and the economy in which those communities work. At the heart of Talk Community is an ambition for innovation to make independence and wellbeing for Herefordshire citizens inevitable.

14. In addition to the prevention and areas identified above, the Herefordshire health and care system are committed to delivering and embedding key integrated areas that have been described in previous plans. These include:

    a) urgent care investment;

    b) trusted assessor model for care homes;

    c) investment and delivery of a D2A model for pathway two and three; and

    d) increasing and aligning community health and care capacity that supports early discharge and prevents (where possible) admissions to hospital, further investment from 2019/20 BCF will be invested in this part of the system to increase capacity further.

15. The existing governance arrangements for the BCF will remain in place for 2019-20, where the HWB is responsible for agreeing the BCF plan and for overseeing delivery through quarterly reports from the joint commissioning board. The BCF plan and the programmes of integration work that are within the BCF and integration plan are reported to a number of council, system and CCG boards. The integrated care alliance board (ICAB) is overseeing the development of integrated community services across all providers in Herefordshire and includes representatives from Herefordshire Council, Wye Valley NHS Trust, 2gether NHS Foundation Trust, St Michaels Hospice and Taurus GP federation.

Community impact

16. The BCF and integration plan is set within the context of the national programme of transformation and integration of health and social care. The council and CCG continue to work together to deliver on the key priorities within the plan to achieve savings and improve the delivery of service in order to achieve the priorities of the health and wellbeing strategy in the most cost effective way.

17. The BCF and integration plan is aligned and integral to delivering the NHS Long Term Plan by providing services at a locality level and supporting the council's corporate objective to 'enable residents to live safe, healthy and independent lives.'

18. The plans are intended to move our health and social care system to a new service model in which patients get more options, better support and properly joined up care at the right time in the optimal care setting will support communities to remain within their own homes and reduce the need for hospitalisation and long-term care. This will support our objectives of building community resilience and tackling health inequalities.

19. The BCF plan is a critical component of One Herefordshire, and financially supports many of the integration services and redesign. One Herefordshire is our place based

partnership; a five-year integration plan is currently being developed and the vision is for Herefordshire to be a county of healthy individuals living within healthy communities.

20. It will support One Herefordshire partners in improving wider wellbeing and population outcomes, as well as addressing their statutory duties around health inequalities. Citizens have the right to expect their NHS to assess the health requirements of their community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.

Equality duty

21. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

    A public authority must, in the exercise of its functions, have due regard to the need to -

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and

    (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

22. The council and CCG are committed to equality and diversity using the public sector equality duty (Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. All equality considerations are taken into account. It is not envisaged that the recommendations in this report will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender, reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

23. The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the act. This is through improving the health and wellbeing of people in Herefordshire by enabling them to take greater control over their own homes and communities. There are no negative impacts for looked after children or with respect to the council's corporate parenting role.

24. Where appropriate, an Equality Impact Assessment (EIA) is undertaken for separate schemes and services that are within the BCF. Where large changes are planned via the BCF, an EIA will be completed.

Resource implications

25. Herefordshire's minimum fund contributions and additional contributions from each partner for 2019-20 are summarised below:

Herefordshire Better Care Fund Financial Summary 2019/20

	£'000
Planned Social Care Expenditure	5,564,774
NHS Commissioned Out of Hospital Care	7,378,088
Total Minimum Mandatory Contribution from CCG	**12,942,862**
Disabled Facilities Grant (Capital)	1,999,424
Total Pool 1	**14,942,286**
Pool 2– Additional Voluntary Contributions	
Herefordshire CCG Care Home Package Costs	9,610,521
Herefordshire Council Care Home Package Costs	24,941,863
Total Pool 2	**34,552,384**
Pool 3- Improved Better Care Fund	
IBCF Grant	5,702,807
Total Pool 3	**5,702,807**
Pool 4- Winter Pressures Funding	
Winter Pressures Grant	880,614
Total Pool 4	**880,614**
Total Better Care Fund	**56,078,091**

26. The Herefordshire BCF and integration plan 2019-20 maintains the key schemes identified in the 2017-18 submission. These include the integrated community equipment store, falls first response service, Home First service, Hospital at Home, brokerage, support for carers and discharge to assess.

27. The Disabled Facilities Grant (DFG) is a mandatory grant provided under the Housing Grants, Construction and Regeneration Act 1996. A clear DFG spending plan is in place, as instructed by BCF requirements.

28. The grant determination for Winter Pressures funding was issued in April 2019. In 2019-20, the grant determination sets a condition that this funding must be pooled into BCF

plans. The grant conditions also require that the grant be used to support the local health and care system to manage demand pressures on the NHS with particular reference to seasonal winter pressures.

29. Grant conditions for iBCF also require that the council pool the grant funding into the local BCF and report as required. Sufficient non-financial resources are also in place to deliver the proposed plan.

Legal implications

30. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund, which brings together health and social care funding. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding. The council is legally obliged to comply with grant conditions, which have been complied with.

31. The agreed budget will be managed through a section 75 agreement between the council and the CCG, which is currently in place until 31 March 2020. The spring budget 2017 provided that the improved Better Care Fund (iBCF) funding for adult social care in 2017-9 must be pooled into the local Better Care Fund.

32. Section 75 of the National Health Service Act 2006 contains powers enabling NHS bodies (as defined in section 275 and 276 of the NHS Act 2006) to exercise certain local authority functions and for local authorities to exercise various NHS functions. The parties entered into a section 75 agreement in exercise of those powers under and pursuant of the NHS Regulations 2000. Once the plan has been formally approved, the section 75 will be updated and signed to cover the duration of the plan.

33. The iBCF is paid directly to the council via a section 31 grant from the DCLG. The Government has attached a set of conditions to the section 31 grant to ensure it is included in the BCF at local level and will be spent on adult social care. The council are legally obliged to comply with the grant conditions set.

Risk management

34. A risk register, specific to the BCF and integration plan 2019-20, has been developed. Risks are also identified and managed through the adults and communities directorate risk register. Key risks are detailed below:

Risk / opportunity	Mitigation
Failure to agree a joint plan and meet the national conditions	Plan has been developed in partnership. Delivery and progress to be monitored on an ongoing basis.
Fail regional assurance process	The council and CCG have worked through the national guidance and requirements to ensure a robust response and that a comprehensive and detailed plan is submitted.
Submitted plan not approved by cabinet.	The director of adults and communities will ensure that cabinet members are provided

	with regular updates regarding the BCF and integration plan 2019-20 throughout the regional assurance process.
Schemes that have investment do not achieve the desired outcomes and impact planned	Implementation milestones and clear outcomes have been agreed for each scheme, the delivery of which will be monitored on a regular basis by a dedicated project manager and reported to the better care partnership group. Existing schemes are monitored on a quarterly basis to ensure key performance ambitions are achieved. Evaluations of iBCF schemes are currently being collated.
Increasing demand due to the demography of expected older age population could outstrip the improvements made.	A number of the schemes support both prevention and the urgent care parts of the system to spread the risk. In addition, the local authority is leading development with communities and implemented strengths based assessments to reduce demand where possible.
Failure to achieve national metric ambitions	A robust process for monitoring activity on a monthly basis is in place and will be monitored through the better care partnership group and escalated to the joint commissioning board when required.

Consultees

35. The director for adults and communities confirmed the content of the BCF and integration plan 2019-20 on behalf of the HWB prior to the national deadline of 27 September 2019, following consultation with the chairperson of the HWB and with the agreement of the accountable officer at the CCG. Views were sought from key stakeholders from across the health and social care system prior to submission, including Wye Valley NHS Trust and Herefordshire CCG.

Appendices

Appendix 1 Herefordshire's BCF and integration plan 2019-20 submission (agenda page 65)

Appendix 2 2019-20 better care fund policy framework (agenda page 91)

Appendix 3 Better care fund planning requirements 2019-20 (agenda page 103)

Background papers

None.

Better Care Fund 2019/20 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Clicking on the corresponding 'Cell Reference' column will link to the incomplete cell for completion. Once completed the checker column will change to 'Green' and contain the word 'Yes'

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we collect email addresses to communicate with key individuals from the local areas for various purposes relating to the delivery of the BCF plans including plan development, assurance, approval and provision of support.
We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.
Please let us know if any of the submitted contact information changes during the BCF planning cycle so we are able to communicate with the right people in a timely manner.

4. Strategic Narrative (click to go to sheet)

This section of the template should set out the agreed approach locally to integration of health & social care. The narratives should focus on updating existing plans, and changes since integration plans were set out until 2020 rather than reiterating them and can be short. Word limits have been applied to each section and these are indicated on the worksheet.

1. Approach to integrating care around the person. This should set out your approach to integrating health and social care around the people, particularly those with long term health and care needs. This should highlight developments since 2017 and cover areas such as prevention.
2 i. Approach to integrating services at HWB level (including any arrangements at neighbourhood level where relevant). This should set out the agreed approach and services that will be commissioned through the BCF. Where schemes are new or approaches locally have changed, you should set out a short rationale.
2 ii. DFG and wider services. This should describe your approach to integration and joint commissioning/delivery with wider services. In all cases this should include housing, and a short narrative on use of the DFG to support people with care needs to remain independent through adaptations or other capital expenditure on their homes. This should include any discretionary use of the DFG.
3. How your BCF plan and other local plans align with the wider system and support integrated approaches. Examples may include the read across to the STP (Sustainability Transformation Partnerships) or ICS (Integrated Care Systems) plan(s) for your area and any other relevant strategies.

You can attach (in the e-mail) visuals and illustrations to aid understanding if this will assist assurers in understanding your local approach.

5. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund (BCF) plan and pooled budget for 2019/20. On selected the HWB from the Cover page, this sheet will be pre-populated with the minimum CCG contributions to the BCF, DFG (Disabled Facilities Grant), iBCF (improved Better Care Fund) and Winter Pressures allocations to be pooled within the BCF. These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from Local Authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be utilised to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact England.bettercaresupport@nhs.net

6. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and utilised to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Condition 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- While selecting schemes and sub-types, the sub-type field will be flagged in 'red' font if it is from a previously selected scheme type. In this case please clear the sub-type field and reselect from the dropdown if the subtype field is editable.

5. Planned Outputs

- The BCF Planning requirements document requires areas to set out planned outputs for certain scheme types (those which lend themselves to delivery of discrete units of delivery) to help to better understand and account for the activity funded through the BCF.
- The Planned Outputs fields will only be editable if one of the relevant scheme types is selected. Please select a relevant unit from the drop down and an estimate of the outputs expected over the year. This is a numerical field.

6. Metric Impact

- This field is collecting information on the metrics that a chem will impact on (rather than the actual planned impact on the metric)
- For the schemes being planned please select from the drop-down options of 'High-Medium-Low-n/a' to provide an indicative level of impact on the four BCF metrics. Where the scheme impacts multiple metrics, this can be expressed by selecting the appropriate level from the drop down for each of the metrics. For example, a discharge to assess scheme might have a medium impact on Delayed Transfers of Care and permanent admissions to residential care. Where the scheme is not expected to impact a metric, the 'n/a' option could be selected from the drop-down menu.

7. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

8. Commissioner:

- Identify the commissioning entity for the scheme based on who commissions the scheme from the provider. If there is a single commissioner, please select the option from the drop-down list.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.

9. Provider:

- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

10. Source of Funding:

- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop-down list
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

11. Expenditure (£) 2019/20:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

12. New/Existing Scheme

- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2019/20 and will inform the understanding of planned spend for the iBCF and Winter Funding grants.

7. HICM (click to go to sheet)

National condition four of the BCF requires that areas continue to make progress in implementing the High Impact Change model for managing transfers of care and continue to work towards the centrally set expectations for reducing DToC. In the planning template, you should provide:
- An assessment of your current level of implementation against each of the 8 elements of the model – from a drop-down list
- Your planned level of implementation by the end March 2020 – again from a drop-down list

A narrative that sets out the approach to implementing the model further. The Narrative section in the HICM tab sets out further details.

8. Metrics (click to go to sheet)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2019/20. The BCF requires plans to be agreed for the four metrics. This should build on planned and actual performance on these metrics in 2018/19.

1. Non-Elective Admissions (NEA) metric planning:
- BCF plans as in previous years mirror the latest CCG Operating Plans for the NEA metric. Therefore, this metric is not collected via this template.

2. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from ONS subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
- Please include a brief narrative associated with this metric plan

3. Reablement (REA) planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.
- Please include a brief narrative associated with this metric plan

4. Delayed Transfers of Care (DToC) planning:
- The expectations for this metric from 2018/19 are retained for 2019/20 and these are prepopulated.
- Please include a brief narrative associated with this metric plan.
- This narrative should include details of the plan, agreed between the local authority and the CCG for using the Winter Pressures grant to manage pressures on the system over Winter.

9. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2019/20 for further details.

The Key Lines of Enquiry (KLOE) underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

10. CCG-HWB Mapping (click to go to sheet)

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity figures.

Better Care Fund 2019/20 Template

2. Cover

Version 0.1

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2019/20.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Herefordshire, County of
Completed by:	Amy Pitt
E-mail:	amy.pitt@herefordshire.gov.uk
Contact number:	07792 881896
Who signed off the report on behalf of the Health and Wellbeing Board:	Councillor Crockett
Will the HWB sign-off the plan after the submission date?	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	14/10/19

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Pauline	Crockett	pauline.crockett@herefordshire.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Simon	Trickett	simon.trickett@herefordshireccg.nhs.uk
	Additional Clinical Commissioning Group(s) Accountable Officers		Jo-anne	Alner	Jo-Anne.Alner@herefordshire
	Local Authority Chief Executive		Alistair	Neill	Alistair.Neill@herefordshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Stephen	Vickers	Stephen.Vickers@herefordshire.gov.uk
	Better Care Fund Lead Official		Amy	Pitt	amy.pitt@herefordshire.gov.uk
	LA Section 151 Officer		Andrew	Lovegrove	Andrew.Lovegrove@herefordshire.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

Checklist

2. Cover ^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes

Sheet Complete	Yes

4. Strategic Narrative ^^ Link back to top

	Cell Reference	Checker
A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	No

Sheet Complete	Yes

5. Income ^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure ^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes
Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete	Yes

7. HICM

^^ Link back to top

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete	Yes

8. Metrics

^^ Link back to top

	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

Sheet Complete	Yes

9. Planning Requirements

^^ Link back to top

	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes
PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes

Sheet Complete	Yes

^^ Link back to top

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Herefordshire, County of

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,999,424	£1,999,424	£0
Minimum CCG Contribution	£12,942,862	£12,942,862	£0
iBCF	£5,702,807	£5,702,807	£0
Winter Pressures Grant	£880,614	£880,614	£0
Additional LA Contribution	£24,941,863	£24,941,863	£0
Additional CCG Contribution	£9,610,521	£9,610,521	£0
Total	£56,078,091	£56,078,091	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£3,677,994
Planned spend	£7,378,088

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£5,564,774
Planned spend	£5,564,774

Scheme Types

Assistive Technologies and Equipment	£200,000
Care Act Implementation Related Duties	£880,636
Carers Services	£530,164
Community Based Schemes	£431,846
DFG Related Schemes	£1,999,424
Enablers for Integration	£10,611,247
HICM for Managing Transfer of Care	£4,613,739
Home Care or Domiciliary Care	£343,205
Housing Related Schemes	£82,475
Integrated Care Planning and Navigation	£705,453
Intermediate Care Services	£0
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£0
Prevention / Early Intervention	£837,066
Residential Placements	£34,842,836
Other	£0
Total	£56,078,091

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Mature
Chg 2	Systems to monitor patient flow	Established
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Exemplary
Chg 4	Home first / discharge to assess	Mature
Chg 5	Seven-day service	Established
Chg 6	Trusted assessors	Established
Chg 7	Focus on choice	Mature
Chg 8	Enhancing health in care homes	Mature

Metrics >>

Non-Elective Admissions	Go to Better Care Exchange >>
Delayed Transfer of Care	

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	549.673439

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.8

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes

NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
	PR8	Yes
Metrics	**PR9**	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: Herefordshire, County of

Please outline your approach towards integration of health & social care:

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

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes

Your approach to integrating care around the person, this may include (but is not limited to):

- Prevention and self-care
- Promoting choice and independence

Remaining Word Limit: 25

Partners throughout the Health and Social Care system in Herefordshire continue to be committed to working together to deliver a local system "where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people".

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

At a strategic level, the Integration and BCF plan intends to support the One Herefordshire alliance to achieving the following aims:

* To improve the health and wellbeing of everyone in Herefordshire by enabling people to take greater control of their own health and the health of their families & helping people to remain independency within their own homes & communities;
* To reduce inequalities in health (both physical and mental) across and within communities in Herefordshire, resulting in additional years of life for citizens with treatable mental and physical health conditions;
* To improve the quality and safety of health and care services, thereby improving their positive contribution to improved wellbeing and enhancing the experience of service users;
* To achieve greater efficiency, making better use of resources.

Joint System Blueprint

A joint system blueprint has been developed that demonstrates the adoption of the vision described above. Our philosophy is centred on the interconnected principles of information, prevention and enablement. The essence of this approach is that it is better if people are able to maintain a good level of wellbeing, drawing on their community, on an ongoing basis. Nonetheless, we recognise that people will at times experience situations where they are unable to cope on their own, even with the support of their local networks. Information and prevention are the central features here. In these circumstances, our joint philosophy is based on the belief that the best approach is to focus on helping people to regain as much control over their own lives, as quickly as possible. Ways of working that are grounded on the principle of enablement form the foundation of this.
Fundamental to delivering the prevention agenda and delivering the One Herefordshire vision to embed prevention into all our work Herefordshire is developing the following:

- Providing a 'healthy environment'; linking with public sector and wider partners on policy and planning for housing, transport, education, economic regeneration etc to shape a 'healthy place'
- Ensuring our locality/emerging primary care networks are focused on prevention, through proactive anticipatory care and a strengths based approach to support self-management, as well as targeted health improvement activities
- Re-energising 'making every contact count' (MECC), to systematically address lifestyle behaviours
- Integrating community resilience into our models, as well as working with the voluntary and community sector around key priorities

Community Development and Talk Community

The Local Authority is leading on community development and resilience as part of the Talk Community programme in Herefordshire. This is a partnership approach that links three fundamental elements to promote and maximise independence and wellbeing within Herefordshire's communities. Talk Community focuses on the people that make up our communities; the place and space which those communities occupy; and the economy in which those communities work. At the heart of Talk Community is an ambition for innovation to make independence and wellbeing for Herefordshire citizens inevitable.

Talk Community sets out to address local wellbeing challenges by looking through a 'community lens' that focuses on how people support themselves, can be supported and how communities develop around local need. This is set into four 'themes' which collectively will help to achieve the ambition of Talk Community:

- Community cohesion, safety and integration
- Community infrastructure
- Community information and intelligence
- Community enterprise

Talk Community will be implemented through detailed plans in six key areas;

- Talk Community Hubs
- The Commissioning approach
- Talk Community Business
- Talk Community Safety & Cohesion
- Talk Community public health
- Operational developments

Talk Community is being developed into the wider Herefordshire health and social care system and aligns to the Primary Care Network developments. A One Herefordshire Talk Community board has been established to develop the system wide work programme under this agenda to upstream prevention and support individuals earlier in their journey.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements - Alignment with primary care services (including PCNs (Primary Care Networks)) - Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

^^ Link back to top

Remaining Word Limit:	43

** Herefordshire's Integrated Community and Primary Care Programme **
The aim of Herefordshire's Integrated Community and Primary Care Programme is to right size our workforce and estate capacity and skills (including the voluntary sector) to help the population to help them selves and enable people to stay in their own homes for as long as possible. Herefordshire has agreed 6 outcomes of our service model with the public and with our staff. An Integrated Care Alliance Board is led by an independent lay chair providing leadership to our staff and systems to support
them to deliver seamless care to patients, that reduces unnecessary duplication and enables people to control their care.

The PCN is at the heart of our system model and statutory services, including social care, are reorganising their operations to ensure that local integrated leadership through the locality management team can exercise autonomy and authority over the way resources are managed and deployed to reduce waste and maximise outcomes for people. This will be done within a clear accountability and governance framework that implements learning at pace across the system. Service delivery will be 'right sized' and developed iteratively so that the balance between supported self care, care at home and bed based care is fit for purpose and designed to provide best value for money for Herefordshire public service resources.

The key programmes of work are:
* Programme 1: Integrated Governance and programme management
* Programme 2: Community Resilience and Prevention - Talk Community
* Programme 3: Integrated Service Delivery
    - Discharge 2 Assess pathways, End of Life care pathway, Frailty care, Dementia Care, Admission Prevention
    - Integrated Psychology Pathway Operational Teams (PCN and Locality development) Integrated Homefirst Team,
    - Integrated Out of Hours Team, First Contact Practitioners, Integrated Pharmacist Team.

Our One Herefordshire Integrated Care model is based on the practice of 'helping you to help yourself' We are committed to developing our primary and locality (community health mental health and social care services) networks and making best use of the resources to support people to live well as close to home as possible, on the principle that 'your own bed is best'.

Alignment of services
Herefordshire Council and Wye Valley Trust have developed an integrated discharge team and are currently providing a number of seperate community services to support individuals to remain within their own home or to transfer home from hospital. These cover the county of Herefordshire and provide a range of therapeutic, nursing and domiciliary care, and a number of different stakeholders make referrals through a number of separate functions. During 2019-20 a full review has been completed with a clear set of objectives that will be achieved from an agreed integrated future model of delivery:
    o Support interventions to enable individuals to return or remain in their own bed;
    o Align capacity to provide a rapid community service for individuals in Herefordshire;
    o Streamline processes and pathways to reduce duplication and inappropriate transfers;
    o Explore trusted assessor models where appropriate, whilst ensuring statutory responsibility are met;
    o Ensure timely community capacity information to the Huddle and Integrated Discharge Team (IDT) to ensure the appropriate decision is made for discharges;
    o Review health and social care systems to enable sharing of key information;
    o Support improvement to the length of stay; and
    o Support with reducing the number of delayed transfers of care;
    o Reducing the need for long term formal care

(ii) Your approach to integration with wider services (e.g. Housing), this should include:	
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the	
Remaining Word Limit:	149

^^ Link back to top

The current Home Adaptations and Assistance Policy approved in March 2018 identifies the range of support that is currently available from the Promoting Independent Living Services Teams to meet identified areas of housing and support needs for people with disabilities and their carers. The support is available falls within a number of assistance areas namely:

1. Mandatory Disabled Facilities Grants
2. Professional and Technical advice
3. Emergency Repayable Grant
4. Discretionary Disabled Facilities Grant
5. Discretionary Fast Track Adaptations Scheme
6. Relocation Grant
7. Minor Adaptations & Handyperson Scheme
8. Technology Enabled Care Services

These areas of assistance aim to ensure that support with provision of adaptations to maximise independence, wellbeing and safety is available to those who are at need of either advice, practical support and/or financial assistance to procure these, and include options to provide essential housing repairs, or a move to more suitable housing where appropriate. This year the council is expecting to complete approximately 200 mandatory DFGs and approximately 20 discretionary DFGs or emergency grants.

The minor adaptations & handyperson scheme typically provides approximately 2,000 minor adaptations to the residents of Herefordshire, to maintain independence and safety at home, and in addition to facilitate a safe and timely discharge from hospital.

The inclusion of the Technology Enabled Care Services within the scope of this policy reflects the government aim to ensure that support to people to maintain their independence at home is maximised by making this available through a range of different means appropriate to their situation.

In addition to the current provision of standard alarms, environmental alerts and monitoring systems, this year the council will also be trialling a range of new technology systems that will enable people to maintain their independence, health and wellbeing in their own home for as long as possible; to remain independent at home and to minimise the need for long term care.

The vision is to deploy an integrated suite of technologies that will keep clients connected to family, friends, care and support providers, and healthcare professionals.
The proposal is to run 2 distinct but linked projects:

1) The 'Reablement & Assessment Pilot' which deploy technology in people's homes through Herefordshire's Home First service, which is a strength-based service, built upon an enabling ethos, to support people to regain skills and enable independence.
2) Personalised outcomes – increasing independence within Learning Disabilities
3)The 'Preventing Frailty and Reducing Falls using Predictive Technology Pilot' which is mentoring a behavioural change approach and early alert recognising the onset of frailty and an increased risk of falls.
4) Managing Long Term Conditions – avoiding unnecessary hospital admissions
Within the DFG budget for 2018-2019 a sum of £30k was made available for an updated stock conditions report for Herefordshire to enable Housing Commissioners and relevant teams to identify where the areas of greatest need may lie within the county with regards to housing conditions.
The report was successfully commissioned during last year and early this year, and the final version of the report is now available. The information identified within the report will help identify areas of priority for the council to consider when reviewing the housing needs of the county, and it is expected that this will help inform any changes required to the Housing Adaptations and Assistance Policy from April 2020 when the policy is due for review.
The local authority is also developing a 'Technology Enabled Living' strategy to set out, with partners, the approach to further developing the strengths based model to supporting people to remain independent. There is a clear role for technology in supporting the delivery of health, social care and housing outcomes, both for the service users and patients across Herefordshire and for the wider public to continue to support prevention, self-care and to find solutions to help those they care for

C) System level alignment, for example this may include (but is not limited to):

- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans
- A brief description of joint governance arrangements for the BCF plan

^^ Link back to top

Remaining Word Limit:	403

The Herefordshire and Worcestershire STPs ambition is to develop towards an Integrated Care System (ICS) in the next 12-18 months. There are proposals to develop the operating model, governance and supporting infrastructure, to enable partnership working, integration and transformation. The key intention for the ICS is to make system working the default option, transitioning to a streamlined approach and removing duplication so that this way of working becomes 'business as usual'. Whilst boards and governing bodies are ready to work together, with greater joint ownership of system issues, they are still cognisant of statutory accountabilities; our proposed operating model recognises this and describes how the system will work collectively to discharge these.

Herefordshire and Worcestershire's plan is to be working as an ICS in shadow form by April 2020.

Throughout this journey our new integrated ways of working will remain focussed on the delivery of our STP wide objectives, providing genuinely joined up, personalised and anticipatory care, working collectively to:

- Improve health and wellbeing outcomes, and reduce health inequalities
- Improve quality and performance by better use of system capacity
- Return the system to financial balance

There is a strong Alliance governance which provide forums and a mechanism through which partners from health, social care, voluntary sector, housing and others meet on a monthly basis to review integrated working.

The Herefordshire and Worcestershire STP vision which is fully aligned to One Herefordshire and BCF vision is:

'Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people'.

The One Herefordshire is the place based integration plan across Herefordshire partners for a whole system plan on functional integration and integrating at the point of delivery, delivering shared efficiencies and not about shifting risk from one partner to another. Our vision is for Herefordshire to be a county of healthy individuals living within healthy communities:

- Herefordshire residents will be supported and enabled to keep themselves well at home.
- When needed they will have joined up care, underpinned by specialist expertise, delivered in the best place by the most appropriate people.
- Our services will be clinically and financially sustainable, working in partnership to make best use of the 'Herefordshire pound' within the Herefordshire and Worcestershire Integrated Care System (ICS).

The place based model is the delivery function for ICS's and key to implementing the PCN and integration at a local level. The aim of the place model is to embed prevention and population health management, improving outcomes and reducing inequalities, improved quality and performance and financial efficiency.

The Integration and BCF plan is the health and social care strategic and delivery plan for Herefordshire and is therefore fully aligned with the joint local vision for the county. The Integration and BCF plan has invested in a number of key integrated models that has supported the place based model and improved outcomes as well as improving performance in areas such as delayed transfers of care. The Integration and BCF plan is also aligned to a number of other key operations plans including the Herefordshire Public Health plan, Adults Wellbeing plan, Health and Wellbeing Strategy, Talk Community Plan and the CCG Operational plan.

Joint Governance Arrangements for the BCF plan

The Herefordshire Health and Wellbeing Board is responsible for agreeing the BCF plans and for overseeing delivery through quarterly reports from the Joint Commissioning Board. The BCF plan and the programmes of integration work that are within the BCF and Integration plan are reported to a number of local authority, system and CCG boards. The Integrated Care Alliance Board has oversight on a number of projects and includes membership from across the system including GP's.

Herefordshire has a developed HWB strategy and priorities with key areas of focus across the health and care system. These include priorities to improve childhood obesity and dental health. The board has continued to undertake its statutory functions of oversight of the BCF and Integration plan and reporting, however with a recently appointed new administration and cabinet and changing health and care landscape the board is undertaking a review of future working. There is a commitment to develop the board into a system wide supportive but challenging infrastructure that leads, assures and holds accountable the delivery of its priorities and future changes.

In partnership with the Local Government Association, the Health and Wellbeing Board will be undertaking a review of it's structure in the new health and care landscape to ensure the board is used as effectively as possible to improve the wellbeing of people of Herefordshire and the BCF and Integration plan is integral to this delivery.

There are a number of operational delivery groups and the Better Care Partnership Group (BCPG), which reports to the Joint Commissioning Group, includes representation from commissioning organisations and is responsible for overseeing implementation of the action plan and for the continuing review and development of the BCF and Integration. Oversight and responsibility for the BCF is embedded within the Senior Leadership Teams of both Adults and Wellbeing within the council and the Clinical Commissioning Group. In both cases, this is in the form of a senior leader who is able to maintain the profile of this agenda and ensure linkages to wider health and social care matters, as well as connection to the corporate council agendas in the case of Adults and Communities.

The BCPG is a dedicated multi-agency group which supports focus and progression of the Better Care Fund and acts as the key problem-solving vehicle and is accountable to the Joint Commissioning Board.

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Herefordshire, County of

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Herefordshire, County of	£1,999,424
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,999,424**

iBCF Contribution	Contribution
Herefordshire, County of	£5,702,807
Total iBCF Contribution	**£5,702,807**

Winter Pressures Grant	Contribution
Herefordshire, County of	£880,614
Total Winter Pressures Grant Contribution	**£880,614**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Herefordshire, County of	£24,941,863	Nursing & Residential Home Placements
Total Additional Local Authority Contribution	**£24,941,863**	

CCG Minimum Contribution	Contribution
NHS Herefordshire CCG	£12,942,862
Total Minimum CCG Contribution	**£12,942,862**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS Herefordshire CCG	£9,610,521	CHC Nursing Home Placements
Total Addition CCG Contribution	**£9,610,521**	
Total CCG Contribution	**£22,553,383**	

	2019/20
Total BCF Pooled Budget	**£56,078,091**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Herefordshire, County of

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,999,424	£1,999,424	£0
Minimum CCG Contribution	£12,942,862	£12,942,862	£0
iBCF	£5,702,807	£5,702,807	£0
Winter Pressures Grant	£880,614	£880,614	£0
Additional LA Contribution	£24,941,863	£24,941,863	£0
Additional CCG Contribution	£9,610,521	£9,610,521	£0
Total	£56,078,091	£56,078,091	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£3,677,994	£7,378,088	£0
Adult Social Care services spend from the minimum CCG allocations	£5,564,774	£5,564,774	£0

Link to Scheme Type description

						Planned Outputs		Metric Impact				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	First responders to fallers			Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£40,848	Existing
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	First responders to fallers			Medium	Not applicable	Not applicable	Not applicable	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£124,230	Existing
51	Community Resilience & Prevention	Community Development	Community Based Schemes					Medium	Low	Medium	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£431,846	New
51	Community Resilience & Prevention	WISH Service	Integrated Care Planning and Navigation	Other	Web-based information and signposting			Low	Low	Low	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£93,432	New
52	Hospital Discharge Support	ICES Service	Assistive Technologies and Equipment	Community Based Equipment				Low	Medium	Low	Low	Social Care		LA			Private Sector	Minimum CCG Contribution	£200,000	Existing
52	Hospital Discharge Support	Integrated Discharge Lead	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge				Not applicable	High	Not applicable	Not applicable	Social Care		LA			NHS Acute Provider	Minimum CCG Contribution	£35,012	Existing
52	Hospital Discharge Support	Home First Service	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	High	Low	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,882,021	Existing
52	Hospital Discharge Support	Home First OT Service	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	High	Low	High	Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£92,417	Existing
52	Hospital Discharge Support	Housing Hospital Discharge	Housing Related Schemes					Low	High	Low	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£82,475	New
52	Hospital Discharge Support	Brokerage	HICM for Managing Transfer of Care	Chg 7. Focus on Choice				Not applicable	Medium	Low	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£234,392	Existing
52	Hospital Discharge Support	Social Care Urgent Care Team	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge				Not applicable	High	Low	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£744,583	Existing

52	Hospital Discharge Support	Discharge to Assess Beds	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Not applicable	High	Low	Medium	Community Health		CCG			Private Sector	Minimum CCG Contribution	£781,740	Existing
53	Integrated Services	Head of Partnerships & Integration	Enablers for Integration	Implementation & Change Mgt capacity				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£77,082	Existing
54	Social Care Services	DoLs / AMHPs	Care Act Implementation Related Duties	Deprivation of Liberty Safeguards (DoLS)				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£731,186	Existing
54	Social Care Services	Social Care Practice Lead	Enablers for Integration	Integrated workforce				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£45,283	Existing
54	Social Care Services	Social Care Specialist Services	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£393,021	Existing
57	Carers' Support	Support for Carers	Carers Services	Carer Advice and Support				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£250,000	Existing
52	Hospital Discharge Support	Rebalancing Community Services	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Medium	High	Low	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£231,176	New
57	Carers' Support	Acorns Children's Hospice	Carers Services	Respite Services				Not applicable	Not applicable	Not applicable	Not applicable	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£30,694	Existing
57	Carers' Support	St Michael's Hospice	Carers Services	Respite Services				Not applicable	Not applicable	Not applicable	Not applicable	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£249,470	Existing
60	Community Health Services	Integrated Community Care	Enablers for Integration	Integrated workforce				Medium	Medium	low	low	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£6,191,954	Existing
151	Community Resilience & Prevention	Community Catalyst	Enablers for Integration	Market development (inc Vol sector)				Not applicable	Not applicable	Not applicable	Low	Other	Community Prevention	LA			Charity / Voluntary Sector	iBCF	£12,667	Existing
151	Community Resilience & Prevention	Talk Community	Prevention / Early Intervention	Social Prescribing				Not applicable	Not applicable	Not applicable	Low	Other	Community Prevention	LA			Local Authority	iBCF	£264,441	New
151	Community Resilience & Prevention	Care Navigator Frequent Fallers	Integrated Care Planning and Navigation	Care Coordination				High	Not applicable	Low	Not applicable	Other	Community Prevention	LA			Charity / Voluntary Sector	iBCF	£44,000	Existing
151	Community Resilience & Prevention	Community-based Resilience Planning	Prevention / Early Intervention	Risk Stratification				Low	Not applicable	Not applicable	low	Other	Community Resilience	LA			Charity / Voluntary Sector	iBCF	£47,904	Existing
151	Community Resilience & Prevention	Dementia Admiral Nurses	Prevention / Early Intervention	Other	Community Dementia Support			Not applicable	Low	Not applicable	Not applicable	Mental Health		LA			NHS Acute Provider	iBCF	£113,177	Existing
151	Community Resilience & Prevention	Community Brokers	Prevention / Early Intervention	Other	Community Resource Development			Not applicable	Not applicable	Not applicable	Not applicable	Other	Community Resilience	LA			Local Authority	iBCF	£246,466	Existing
152	Hospital Discharge Support	Trusted Assessors	HICM for Managing Transfer of Care	Chg 6. Trusted Assessors				Not applicable	High	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	iBCF	£98,748	Existing
152	Hospital Discharge Support	Discharge to Assess Beds additional costs	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Not applicable	High	Low	Medium	Community Health		CCG			Private Sector	iBCF	£195,000	Existing
153	Integrated Services	Digital Delivery Programme Manager	Enablers for Integration	Shared records and Interoperability				Not applicable	Not applicable	Not applicable	Not applicable	Other	CCG Staffing to deliver LDR	CCG			CCG	iBCF	£64,654	Existing
153	Integrated Services	Joint Strategic Finance Lead	Enablers for Integration	Integrated workforce				Not applicable	Not applicable	Not applicable	Not applicable	Other	Joint staff to deliver integration	LA			CCG	iBCF	£92,848	Existing

153	Integrated Services	Minor Investments Fund	Enablers for Integration	Implementation & Change Mgt capacity				Not applicable	Not applicable	Not applicable	Not applicable	Other	Promotion & Support of Integration	LA			Private Sector	iBCF	£15,000	Existing
153	Integrated Services	Integrated County Social Work Teams	Enablers for Integration	Integrated workforce				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£553,733	Existing
153	Integrated Services	Integrated Locality Social Work Teams	Enablers for Integration	Integrated workforce				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£3,222,924	Existing
154	Social Care Services	Specialist Assessments Contract	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£175,000	New
154	Social Care Services	Advocacy Service	Care Act Implementation Related Duties	Other	Independent Advocacy Services			Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£149,450	New
156	Care Market Development	Care Workforce Development Programme	Enablers for Integration	Market development (inc Vol sector)				Not applicable	Not applicable	Not applicable	Not applicable	Other	Care Workforce Development	LA			Private Sector	iBCF	£15,559	New
156	Care Market Development	Enhancing Health In Care Homes (Project IQ)	HICM for Managing Transfer of Care	Chg 8. Enhancing Health in Care Homes				Medium	Not applicable	Not applicable	Not applicable	Community Health		LA			CCG	iBCF	£277,540	Existing
156	Care Market Development	Enhancing Health In Care Homes (Project IQ)	HICM for Managing Transfer of Care	Chg 8. Enhancing Health in Care Homes				Medium	Not applicable	Not applicable	Not applicable	Community Health		LA			NHS Community Provider	iBCF	£41,110	Existing
153	Integrated Services	Partnerships & Integration	Enablers for Integration	Implementation & Change Mgt capacity				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£72,586	New
258	Social Care Placements	Rural Home Care Fee Increase	Enablers for Integration	Fee increase to stabilise the care provider market				Not applicable	High	Not applicable	Not applicable	Social Care		LA			Private Sector	Winter Pressures Grant	£246,957	New
258	Social Care Placements	BUPA Nursing Home Beds	Residential Placements	Nursing Home		Placements	4.0	Not applicable	High	Not applicable	Not applicable	Social Care		LA			Private Sector	Winter Pressures Grant	£114,196	New
258	Social Care Placements	Radis Home Care Placements	Home Care or Domiciliary Care			Hours of Care	3,422.0	Not applicable	High	Not applicable	Not applicable	Social Care		LA			Private Sector	Winter Pressures Grant	£61,500	New
258	Social Care Placements	Katherine Harriot Home Care Placements	Home Care or Domiciliary Care			Placements	8.0	Not applicable	High	Not applicable	Not applicable	Social Care		LA			Private Sector	Winter Pressures Grant	£281,705	New
258	Social Care Placements	Respite Care	Residential Placements	Nursing Home		Placements	20.0	Low	High	Not applicable	Not applicable	Social Care		LA			Private Sector	Winter Pressures Grant	£176,256	New
33	Disabled Facilities Grant	DFG	DFG Related Schemes	Adaptations				Not applicable	Not applicable	Medium	Medium	Social Care		LA			Private Sector	DFG	£1,999,424	New
34	Care Home Market	CCG Care Home Placements	Residential Placements	Nursing Home		Placements	98.0	Not applicable	Not applicable	Not applicable	Not applicable	Continuing Care		CCG			Private Sector	Additional CCG Contribution	£9,610,521	New
34	Care Home Market	LA Care Home Placements	Residential Placements	Nursing Home		Placements	957.0	Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Private Sector	Additional LA Contribution	£8,391,943	New
34	Care Home Market	LA Care Home Placements	Residential Placements	Care Home		Placements	426.0	Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Private Sector	Additional LA Contribution	£16,549,920	New

^^ Link back up

Scheme Type	Description	Sub Type
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	Telecare Wellness Services Digital Participation Services Community Based Equipment Other
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	Deprivation of Liberty Safeguards (DoLS) Other
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	Carer Advice and Support Respite Services Other
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	Adaptations Other
Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.	
High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	Chg 1. Early Discharge Planning Chg 2. Systems to Monitor Patient Flow Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams Chg 4. Home First / Discharge to Access Chg 5. Seven-Day Services Chg 6. Trusted Assessors Chg 7. Focus on Choice Chg 8. Enhancing Health in Care Homes Other - 'Red Bag' scheme Other approaches
Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	

Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	Care Coordination Single Point of Access Care Planning, Assessment and Review Other
Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.	Bed Based - Step Up/Down Rapid / Crisis Response Reablement/Rehabilitation Services Other
Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	Personal Health Budgets Integrated Personalised Commissioning Direct Payments Other
Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	Social Prescribing Risk Stratification Choice Policy Other
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	Supported Living Learning Disability Extra Care Care Home Nursing Home Other

Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board: Herefordshire, County of

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including: - Current performance issues to be addressed - The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan - Anticipated improvements from this work
Planned admissions have early discharge planning in place and this needs to be equitable with emergency admissions which includes EMIS roll out in A&E. Consistent and formalising the involvement of the voluntary sector in discharge planning. Trusted assessment to be in place for care homes to assess on weekends. To understand the demand and increased capacity needed for weekend working to improve flow. Strengths based assessment process and training to be developed for health and social care discharge staff and wards. Valuing patients time to be embedded across the hospital for discharge planning and audit to be undertaken on this process. Dementia discharge to assess modle to be developed and scoped. Care homes to be embedded within the Primary Care Networks across the localities.

		Please enter current position of maturity	**Please enter the maturity level planned to be reached by March 2020**	**If the planned maturity level for 2019/20 is below established, please state reasons behind that?**
Chg 1	**Early discharge planning**	Mature	Mature	
Chg 2	**Systems to monitor patient flow**	Established	Established	
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Mature	Exemplary	
Chg 4	**Home first / discharge to assess**	Established	Mature	
Chg 5	**Seven-day service**	Established	Established	
Chg 6	**Trusted assessors**	Established	Established	
Chg 7	**Focus on choice**	Established	Mature	
Chg 8	**Enhancing health in care homes**	Mature	Mature	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	Partners are committed to working together to continue to provide community services which support individuals to remain in their own home and avoiding admission into an acute setting where possible. There is system recognition of enhancing clinical care to support care and treatment where people usually live. Proposals for enhanced clinical model are being actively explored. Investment into services to achieve this will continue throughout 2019-20, including the Falls Response Service, Home First, Hospital at Home and the Care Navigators Frequent Fallers Service. Herefordshire will continue to build on primary care network models and delivery of the NHS LTP which will support this area. The LA is also developing a community resilience strategy called Talk Community to develop and enhance the community offer. In addition, a scoping and review excercise has recently been completed which focussed upon a number of community services across health and social care in Herefordshire (including Home First and Hospital at Home). Recommendations resulting from this include a number of key areas of integration including the introduction of a multi agency rapid response pilot. The aim of this integrated team would be to prevent unplanned and avoidable admissions into hospital by providing care for people in their home, within 2 hours of a referral being received. The pilot would support individuals who have an urgent and immediate crisis that, if not treated or supported in the community, would result in an admission. Additional invest into community services and rebalanacing of community provision during 2019-20 will increase service capacity and assist in achieving NEA ambitions. The acute hospital have also embedded a frailty front door service/team to focus on older age individuals with frailty to reduce admissions where possible and when individuals are admitted the pathway is clear to support the discharge process.

Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	13.4	Achieving the ambitions set in relation to Delayed Transfers of Care (DToC) is a challenge to partners across the system, however significant improvements have been made to meet the ambition set. The integration developments in Herefordshire evidence the work being undertaken to improve the transfer of care position for the system through continued investments from both the BCF and iBCF, which include the Integrated Community Equipment Store, Home First service, brokerage function, social care urgent care teams, Integrated Discharge lead, Housing hospital discharge, Trusted Assessors and the Discharge to Assess scheme. Continual investment has been made from the BCF and Local Authority to increase capacity in the urgent care system and improve pathways. This will be continued by rebalancing of community services by reviewing community hospitals beds and increasing community services at home. The commencement of the Integrated Discharge manager and introduction of an integrated discharge team has improved working and discharge systems across health and social care. These improvements and enhanced working practices, including support and education for ward staff, will continue to be embedded throughout 2019-20. A DToC peer review has been completed which highlights several area of focus - a system wide action plan has been developed to reflect the recommendations and is currently being implemented. In addition, an iBCF schemes has been established to work with local care homes the Integrated Care Home team are supporting increased confidence in hospital discharge plans so that individual patient discharges can be progressed in a more timely manner. Seven day services continue to be delivered for key services, including Home First, Hospital at Home and the Falls Response service. This seven day coverage assists partners across the Health and Social Care system in reducing delays in transfers of care. Winter pressures funding continues to be utilised to fund additional capacity through block contracts for domicilary care, nursing care beds and respite provision. This supported the pressures in the system for delayed transfers of care and contributed to the improvements made.

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

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	551	550	Partners across the system are committed to supporting people to remain in their own home as long as possible. A number of community developments will be delivered throughout 2019-20 to enable this, as described above and previously in this template. The local authority has also developed and embedded a strengths based approach to the social work practice, assessment and delivery of services to support individuals to self help and link into community assets to improve their wellbeing. This approach has ensured that individuals have been linked into community resources and their communities to meet their needs. As a system we are utilising an increased range of technology and digital interventions to support independence, self-management and wellbeing where people usually live.
	Numerator	257	260	
	Denominator	46,625	47,301	

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

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2016 based Sub-National Population Projections for Local Authorities in England;

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	80.0%	The Home First Service, provided by Herefordshire Council, has made vast improvements and will continue to develop throughout 2019-20. Whilst the demand continues to be high, service improvements have been made. Transitioning to a new service structure with new staff during the past 12 months has meant that this ambition target will be acheived. Herefordshire has also seen a rapid improvement in achieving this target following the improvements made to the service. During 2019-20 further invest from the BCF will assist in increasing service capacity and recent integration recommendations will support the service to deliver an integrated model of community services. An integrated community therapy service is expected to impact upon the number of people who remain at home 91 days following completion of reablement.
	Numerator	80	80	
	Denominator	100	100	

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

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Herefordshire, County of

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes			

NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	**PR6**	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes			
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on? Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box) Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter? **Has funding for the following from the CCG contribution been identified for the area?** - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Yes			
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes			
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes			

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

2019-20 Better Care Fund

Policy Framework

Published 10 April 2019

Contents

1. Introduction 2
Person-centred Integrated Care 2
Progress on the Better Care Fund and Integration 2
2. The Better Care Fund in 2019-20 5
What the BCF will look like in 2019-20 5
Funding and conditions of access for 2019-20 5
National Conditions & Metrics for 2019-20 7
The assurance and approval of local Better Care Fund plans for 2019-20 8
3. The Better Care Fund, Housing and Wider Integration Initiatives 10

1. Introduction

Person-centred Integrated Care

1.1 The Government is committed to the aim of person-centred integrated care, with health, social care, housing and other public services working seamlessly together to provide better care. This type of integrated care is the key to strong, sustainable local health and care systems which prevent ill-health (where possible) and the need for care, and avoid unnecessary hospital admissions. It also ensures that people receive high-quality care and support in the community. For people who need both health and social care services, this means only having to tell their story once and getting a clear and comprehensive assessment of all their needs with plans put in place to support them. This means they get the right care, in the right place, at the right time.

Progress on the Better Care Fund and Integration

1.2 Since 2015, the Government's aims around integrating health, social care and housing, through the Better Care Fund (BCF), have played a key role in the journey towards person-centred integrated care. This is because these aims have provided a context in which the NHS and local authorities work together, as equal partners, with shared objectives. The plans produced are owned by Health and Wellbeing Boards, representing a single, local plan for the integration of health and social care in all parts of the country.

1.3 In every year of its operation, most local areas have agreed that the BCF has improved joint working and had a positive impact on integration. In 2017-18, for example, 93% of local areas agreed that delivery of the BCF had improved joint working between health and social care in their locality, whilst 91% agreed that delivery of BCF plans had a positive impact on the integration of health and social care. Additionally, since its inception, local areas have voluntarily pooled at least £1.5 billion above the minimum required, in each year, with approximately £2.1 billion planned in voluntary pooled funding in 2018-19.

1.4 There are signs of real progress in joining up care and wider integration:

(a) The **New Care Model Vanguards** have provided valuable lessons for Sustainability and Transformation Partnerships, which are now being taken to the next stage by the emerging Integrated Care Systems. The Vanguards have seen a positive impact on emergency admissions, with community

models demonstrating the benefits of a more proactive approach that helps keep people independent for longer. Vanguards made progress in reducing the pressure on A&E. Emergency admissions in Vanguards on average grew by 0.9% in Multispecialty Community Providers and 2.6% in Primary and Acute Care Systems compared with 6.9% in the rest of the NHS. For Enhanced Health in Care Home Vanguards, emergency admissions from care residents flatlined compared with an increase of 9% for care homes that were not part of a Vanguard.

(b) The **Integration Accelerator Sites**, building on the work previously conducted through the Integrated Personalised Commissioning programme, continue to make encouraging progress in empowering people to manage their healthcare, and the better integration of services across health, social care and the voluntary and community sector. Integrated personal budgets are one way of delivering more integrated and personalised care. Covering both health and social care, they have been developed based on the lessons learned through personal budgets, personal health budgets, and direct payments. NHS England has now published Universal Personalised Care: Implementing the Comprehensive Model - co-produced with partners in social care - which sets out the road map to deliver the Long Term Plan's objective to deliver the Comprehensive Model for Personalised Care to 2.5 million people by 2023-24.

(c) We are committed to creating a technology infrastructure that allows systems to communicate securely, using open standards for data and interoperability. This will enable health and care professionals to have access to the information they need to provide care. We are encouraging local areas to ensure data is collected consistently and made available to support joined-up and safer patient care by investing in the development of Local Health and Care Record Exemplars. This will enable data to be accessed as patients move between different parts of the NHS and social care. The first five Exemplars cover 23.5 million people and will each receive up to a total of £7.5 million over two years.

(d) Both the NHS and social care have been working hard to **reduce delays and free up beds**. Since February 2017, more than 2,280 beds per day have been freed up nationally by reducing NHS and social care delays. This has been supported by the Better Care Fund and targeted funding from Government through the improved Better Care Fund (iBCF).

1.5 The Shifting the Centre of Gravity report on making person-centred, place-based integrated care a reality was published in October 2018, and produced by the Association of Directors of Adult Social Services, Association of Directors of Public Health NHS Confederation, NHS Clinical Commissioners, NHS Providers and the Local Government Association. The report noted that there are now many more examples of joined-up working across the country than there were at the time of the previous report, Stepping up to the Place, in June 2016.

1.6 The NHS Long Term Plan outlines objectives for joined-up care across the system with commitments to increased investment in primary medical and community health services to support new service models including an urgent response standard for urgent community support; integrated multi-disciplinary teams; NHS support to people living in care homes; the NHS Personalised Care model; an integration index; reducing Delayed Transfers of Care; and supporting local approaches to blend health and social care budgets, amongst other initiatives.

1.7 The forthcoming Adult Social Care Green Paper will also build on the approach to joined-up, person-centred integrated care.

2. The Better Care Fund in 2019-20

What the BCF will look like in 2019-20

2.1 The BCF in 2019-20 will retain the same National Conditions as in 2017-19. Areas will be required to set out how the National Conditions will be met in jointly agreed BCF Plans signed off by Health and Wellbeing Boards. The Government will continue to require NHS England to put in place arrangements for CCGs to pool a mandated minimum amount of funding. The Government will also require local authorities to continue to pool grant funding from the improved Better Care Fund, Winter Pressures funding and the Disabled Facilities Grant.

2.2 2019-20 is to be a year of minimal change for the Better Care Fund. Any major changes from the BCF Review will be from 2020 onwards. The only notable changes for 2019-20 are that requirements for narrative plans have been simplified with areas not required to repeat information they previously provided in their 2017-19 plans, and for more meaningful information on the impact of the BCF to be collected through the planning process.

2.3 Further information on how this will work in practice will be set out in the Planning Requirements.

Funding and conditions of access for 2019-20

2.4 This Policy Framework covers 2019-20.

2.5 The mandate to NHS England and the annual remit for NHS Improvement for 2019-20 will include an expectation of a minimum CCG contribution of £3.84 billion to establish the BCF in 2019-20. The amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations. NHS England will look to include conditions that allow the recovery of funding, in consultation with the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, where the National Conditions are not met. These powers do not apply to the amounts paid directly from Government to local authorities. The expectation remains that in any decisions around BCF Plans and funding, Ministers from both aforementioned departments will be consulted.

2.6 Allocations of improved Better Care Fund, Winter Pressures funding and Disabled Facilities Grant will be paid directly from Government to local authorities. Any future year's allocations will be decided through the 2019 Spending Review.

2.7 As in previous years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement (£300 million) and for the provision of carers' breaks (£130 million) also remains in the NHS contribution.

2.8 The local flexibility to pool more than the mandatory amount will remain.

2.9 Further details of the financial breakdown are set out in Table 1.

Table 1 – BCF funding contributions in 2019-20

BCF funding contribution	2019-20
Minimum NHS (Clinical Commissioning Groups) contribution	£3.840bn
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.505bn
Grant allocation for adult social care (improved Better Care Fund). Combined amounts were announced at Spending Review 2015 and Spring Budget 2017.	£1.837bn
Winter Pressures grant funding	£0.240bn
Total	£6.422bn

Disabled Facilities Grant (DFG)

2.10 Funding for the DFG in 2019-20 will be £505 million. This will be paid to local government via a section 31 grant. The DFG capital grant must be spent in accordance with an approved joint BCF plan, developed in keeping with this Policy Framework and Planning Requirements that will follow.

2.11 In two-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. Full details will be set out in the DFG Grant Determination Letter.

Winter Pressures funding

2.12 This money will be paid to local government, via a Local Government Act 2003 section 31 grant. Government will attach a set of conditions, requiring the funding

to be used to alleviate pressures on the NHS over winter, and to ensure it is pooled into the BCF. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care. The Grant Determination will be issued in April 2019. Reporting in relation to this funding will be managed through wider BCF reporting. Health and Wellbeing Boards will be required to confirm plans for the use of this funding in their BCF plans.

Improved Better Care Fund (iBCF) Funding

2.13 The iBCF grant will again be paid to local government, via a section 31 grant. The total allocation of the iBCF in 2019-20 will be £1.837 billion. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

2.14 The Government will attach a set of conditions to the section 31 grant to ensure it is pooled in the BCF at local level and spent on adult social care. The final conditions will be issued in April 2019. As part of our ambition to maintain continuity in 2019-20, the iBCF will not have any additional conditions of usage above what has previously been set out. The grant is to be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

National Conditions & Metrics for 2019-20

2.15 For 2019-20, there continue to be four National Conditions, in line with our vision for integrated care:

(i) Plans to be jointly agreed

(ii) NHS contribution to adult social care to be maintained in line with the uplift to CCG Minimum Contribution

(iii) Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care

(iv) **Managing Transfers of Care:** A clear plan for improved integrated services at the interface between health and social care that reduces

Delayed Transfers of Care (DToC), encompassing the High Impact Change Model for Managing Transfers of Care. As part of this all Health and Wellbeing Boards adopt the centrally-set expectations for reducing or maintaining rates of DToC during 2019-20 into their BCF plans.

2.16 Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance (for example by agreeing ambitious expectations across the metrics with plans setting out how the ambitions will be met) in the following four BCF 2019-20 metrics: **Delayed Transfers of Care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.**

2.17 Since June 2018, local health systems have been tasked with reducing the number of extended stays in hospital. This has required changes to the way that hospitals work but is also affected by what happens outside of acute hospital when patients are fit to go home. The BCF should continue to support the aim to reduce the number of patients who remain in acute hospitals for an extended period (21 days or more) by continuing ongoing work to implement and embed the High Impact Change Model for Managing Transfers of Care that support this ambition.

2.18 Across the country, areas have made strong progress in reducing Delayed Transfers of Care. From February 2017 to January 2019, there have been more than 2,280 fewer people delayed in an NHS bed per day. We believe that no-one should stay in a hospital bed longer than necessary as it removes people's dignity and can lead to poorer health and care outcomes. We want to continue to drive down Delayed Transfers of Care and for 2019-20 the national ambition will remain for no more than 4,000 delayed days per day (reported as 'DTOC beds').

The assurance and approval of local Better Care Fund plans for 2019-20

2.19 Plans will be developed locally in each Health and Wellbeing Board area by the relevant local authority and CCG(s). In order to reduce planning burdens we will collect narrative elements and confirmation of agreements through a set template, rather than freeform narrative. Areas should look to align with, and not duplicate, other strategic documents such as plans set out for local Strategic Transformation Partnerships/Integrated Care Systems. BCF plans will need to set out priorities for embedding implementation of the High Impact Change Model (National Condition four), and update their local visions and approaches to integration - see paragraph 3.1. Areas will need to submit full planning templates, confirming that the HWB has signed them off, in order for the National Conditions to be assured. Plans will be

assured and moderated regionally in line with the operational planning assurance process set out in the Better Care Fund Planning Requirements. As in 2017-19, there will be one round of assurance, after which plans deemed compliant by assurers at regional level will be put forward for approval.

2.20 Final decisions on plan approval and permission to spend from the CCG ringfenced contribution will be made by NHS England (as the Accountable Body for the BCF) having consulted the respective Secretaries of State for Health and Social Care, and Housing, Communities and Local Government.

2.21 The NHS Act 2006 allows NHS England to direct the use of the CCG elements of the fund where an area fails to meet one (or more) of the BCF conditions. This includes the requirement to develop an approved plan. If a local plan cannot be agreed or other National Conditions are not met, any proposal to direct use of the CCG elements of the Fund will be discussed and agreed with Ministers.

2.22 Local authorities are legally obliged to comply with section 31 grant conditions.

3. The Better Care Fund, Housing and Wider Integration Initiatives

3.1 The BCF offers a good opportunity to support the delivery of wider objectives and strategies around health and social care. In particular, every health and care system in England has agreed a Sustainability and Transformation Plan (STP) and formed a delivery partnership, providing the system-level framework within which organisations in local health and care economies can plan effectively and deliver a sustainable, transformed and integrated health and care service. Local areas should ensure the financial planning and overall approach to integrated care within BCF plans and local STP plans are fully aligned.

3.2 The Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, along with NHS England, the Local Government Association, and the Association of Directors of Adult Social Services are currently reviewing the BCF beyond 2020. We intend to provide an update on the future of the BCF shortly.

3.3 STPs and Integrated Care Systems (ICSs) will be required to agree new plans during the first half of 2019-20. We expect every STP and ICS plan to cover their work on Integrated Care; and for Health & Wellbeing Boards, and STP/ICS colleagues to engage proactively in producing this. Where these collaborative strategies exist, we will allow them to form the basis of integration narratives in planning for the BCF (or alternative programme, depending on the review of the BCF) for the following years. Graduation as previously set out has not been possible to date. As part of our review, Government will consider the use of graduation.

3.4 The Long Term Plan also sets out proposals on integration including investing in models of care that strengthen links between primary care networks and local care homes, such as the roll-out of Enhanced Health in Care Homes. The Government will encourage and support the NHS to use this as an opportunity to involve local government in the implementation of the Long Term Plan.

3.5 Building on previous work, a refreshed memorandum of understanding (MoU) 'Improving health and care through the home' was published by Public Health England in March 2018. This MoU, signed by over 25 stakeholders, emphasises the importance of housing in supporting people's health and sets out a shared commitment to joint action across Government and health, social care, and housing sectors in England.

3.6 There is an increasing range of material available to support local systems with the practical development of joint integration strategies and integrated services. The NHS England Integrating Better project recently produced a practical guide based on learning from 16 areas, which is available to health and care practitioners as part of the STP/ICS library of good practice (access requires a login). The Local Government Association also provide a range of support, tools and case studies, such as through a recently published evidence review and case studies of integrated care or the support provided through its Care and Health Improvement Programme.

3.7 Although the Disabled Facilities Grant (DFG) has been part of the BCF since 2015, it was last reviewed in 2008. Following calls from the sector and local authorities to ensure that it continues to provide help and meet users' needs as effectively as possible, the Government commissioned an independent review in February 2018. This was conducted by the University of the West of England in conjunction with several other partners, and both the main report and executive summary were published in December 2018. There are 45 recommendations and Government is carefully considering the detailed findings and will issue a response in due course.

Department of Health & Social Care

NHS

Better Care Fund Planning Requirements for 2019-20

Department of Health and Social Care, Ministry of Housing, Communities and Local Government, and NHS England

CONTENTS

Section 1 - Introduction 2

Section 2 - BCF Policy and planning requirements in 2019-20 3

Section 3 - Funding sources and expenditure plans 5

Section 4 - The Planning Template 9

Section 5 - National metrics 15

Section 6 - Local plan development, sign off and assurance 18

Section 7 - Intervention and escalation 19

Section 8 - Monitoring continued compliance with the conditions of the fund..... 20

Section 9 - Reporting in 2019-20..... 20

Section 10 - Timetable for planning and assurance 21

Appendix 1 - BCF planning requirements..... 22

Appendix 2 - Specification of Better Care Fund metrics 23

Appendix 3 - Support, escalation and intervention 27

Appendix 4 - Funding flows and accountability 30

PART 1 – THE BETTER CARE FUND

Section 1 - Introduction

1. The Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2019-20. This was developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England. The Framework forms part of the NHS mandate for 2019-20. The framework sets an objective for NHS England to issue these further detailed requirements to local areas on developing and implementing BCF plans for 2019-20.

2. The BCF provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

3. BCF planning and reporting will incorporate the separate processes for iBCF and Winter Pressures grants, removing duplication in collection and reducing the reporting burden overall. This will include:

    - Incorporation of narratives into a shorter single template.
    - Removal of the requirement to submit separate plans for Winter Pressures grant.
    - Removal of separate reporting on iBCF schemes and initiatives.
    - Single format for scheme level planning and reporting.

4. This document contains the BCF planning requirements which support the core NHS Operational Planning and Contracting Guidance for 2019-20. CCGs are therefore required to have regard to this guidance by Section 14Z11 of the NHS Act 2006. It is being published jointly with Departments to disseminate it directly to local government.

5. This document also incorporates the BCF Operating Guidance, which in the previous cycle was published in a separate document. All planning and operating guidance for the BCF in 2019-20 is therefore contained in this document.

6. The framework for the Fund derives from the government's mandate to the NHS for 2019-20, issued under Section 13A of the NHS Act 2006, which sets an objective for NHS England to ring fence £3.84 billion to form the NHS contribution to the BCF. These Planning Requirements set allocations for each CCG from this ring fence and apply conditions to their use. BCF plans and their delivery should comply with these conditions as part of the delivery of CCGs' duties under Sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006.

The BCF from 2020 and the NHS Long Term Plan

7. In June 2018, the government announced a review of the 'current functioning and structure of the Better Care Fund' to ensure it supports the integration of health and social care. There will be an update later this year.

8. The NHS has set out its priorities for transformation and integration through the NHS Long Term Plan, published on 7 January this year, including plans for investment in integrated community services and next steps to develop Integrated Care Systems. This includes a commitment for a new NHS offer of emergency response and recovery support through expanded multidisciplinary teams in primary care networks. This work will roll out from 2019-20. It is not a requirement that BCF funds are spent on this work, but it is expected that local areas will be considering how provision across health, local government, social care providers and the voluntary sector can support the shared aims of providing better care at or close to people's home and a clear focus on prevention and population health management.

9. The BCF in 2019-20 will continue to provide a mechanism for personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital. The continuation of the national conditions and requirements of the BCF from 2017-19 to 2019-20 provides opportunities for health and care partners to build on their plans from 2017 to embed joint working and integrated care further. This includes how to work collaboratively to bring together funding streams to maximise the impact on outcomes for communities and sustaining vital community provision.

Section 2 - BCF Policy and planning requirements in 2019-20

10. The Better Care Fund Policy Framework for 2019-20 provides continuity from the previous round of the programme.

11. The **four national conditions** set by the government in the Policy Framework are:

    i. That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grant determinations, must be signed off by the Health and Wellbeing Board (HWB), and by the constituent local authorities (LAs) and CCGs.

    ii. A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the uplift to the CCG's minimum contribution.

    iii. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, which may include seven day services and adult social care.

    iv. A clear plan on managing transfers of care, including implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all HWBs must adopt the centrally-set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans.

12. The Policy Framework also sets out the **four national metrics** for the fund:

    i. Non-elective admissions (Specific acute);
    ii. Admissions to residential and care homes;
    iii. Effectiveness of reablement; and
    iv. Delayed transfers of care (DToC).

13. All BCF plans must include ambitions for each of the four metrics and plans for achieving these are a condition of access to the fund. Expectations for reducing DToC will continue to be set centrally for each HWB area. The national ambition for reducing DToC is for the average daily number of people who are ready to go home, but still awaiting discharge to be less than 4,000. Local expectations set in the BCF Operating Guidance for 2018-19 have been retained. Areas that have not already achieved their local expectation should plan to achieve this as early as possible in 2019-20.

14. The main change in the BCF Planning Requirements from 2017-19 is that separate narrative plans will be replaced with a single template that will include short narrative sections covering:

    - the local approach to integration;
    - plans to achieve metrics; and
    - plans for ongoing implementation of the High Impact Change Model for Managing Transfers of Care.

Approval of agreed plans

15. BCF plans will be approved by NHS England following a joint NHS and local government assurance process at regional level. In addition to the national conditions and the condition to set the four national metrics, NHS England is also placing the following requirements for approval of BCF plans:

    - That all funding agreed as part of the BCF plan must be transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.
    - That all plans are approved by NHS England in consultation with DHSC and MHCLG.

16. NHS England will approve plans for spend from the CCG minimum in consultation with DHSC and MHCLG as part of overall approval of BCF plans.

17. The DFG, iBCF and Winter Pressures grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003.

Maintaining progress on former national conditions

18. BCF plans in 2017-19 were required to describe how partners would continue to build on progress against former BCF national conditions to:

    - Develop delivery of seven-day services across health and social care;

- Improve data sharing between health and social care; and
- Ensure a joint approach to assessments and care planning.

19. In 2019-20, areas should continue to make progress towards these goals.

Section 3 - Funding sources and expenditure plans

20. It will be a condition of the BCF that plans for spending all funding elements are jointly agreed by local authority and CCG partners. Plans will need to confirm that individual elements of the mandatory funding have been used in accordance with their purpose as set out in the BCF Policy Framework, relevant grant conditions and these requirements.

21. Scheme level spending details will need to include, where appropriate, an indication of the metric or metrics that a scheme is intended to improve. Where a planned scheme is an enabler for integration (for instance a workforce or digital integration scheme), then areas will be asked to indicate this on the spending plan (linked to the enablers identified in the Logic Model for Integrated Care) and are not required to indicate corresponding outcome metrics. Areas should also include short descriptions of schemes commissioned in the scheme level expenditure plan.

22. Areas can agree to pool additional funds into their BCF plan and associated Section 75 agreement(s). These additional contributions are not subject to the conditions of the BCF but should be recorded in the Planning Template. The mandatory contributions are set out below:

Table 1: BCF mandatory funding sources 2019-20

Minimum NHS ring-fenced from CCG allocation	£3,840 million
Disabled Facilities Grant (DFG)	£505 million
Improved Better Care Fund (iBCF)	£1,837 million
Winter Pressures grant	£240 million
Total	**£6,422** million

CCG minimum contribution

23. The mandate to NHS England for 2019-20 sets out an objective to ring-fence £3.84 billion in 2019-20 within its overall allocation to CCGs to be pooled into the BCF and subject to the conditions set out in the Policy Framework and these Operating Requirements.

24. NHS England has published allocations from this national ringfence for each CCG for 2019-20, on its website. The allocations for all mandatory funding sources are pre-populated in the Planning Template at an HWB level.

25. The allocation for each CCG includes funding to support local authority delivery of reablement, Carers Breaks and implementation of duties to fund carer support under the Care Act 2014.

26. Expenditure details in Planning Templates should set out the level of resource that will be dedicated to delivery of these activities. Reablement and other support to help people remain at home or return home from hospital with support, remain important outcomes for integration and the BCF, and are also priorities in the NHS Long Term Plan.

27. National conditions two and three apply only to the minimum funding allocation from CCGs.

National condition two: NHS contribution to social care is maintained

28. National condition two requires that, in each HWB area, the contribution to social care spending is maintained in line with the percentage uplifts for the CCGs that contribute to the BCF in that HWB. The uplift applies only to the CCG minimum contribution to social care and will be applied to the minimum expectation from 2018-19 for the HWB, rather than the assured contribution in 2018-19 (if this was higher than the minimum expectation). The purpose of this condition is to ensure that support from the NHS for social care services with a health benefit is maintained in line with the overall growth in the CCG minimum contribution to the BCF.

29. As in 2017-19, the minimum expectations will be confirmed in the BCF Planning Template. Any schemes where the spend type is 'social care' and the funding source is the CCG minimum will count towards this expectation. It is for local areas to agree the schemes that will be funded from this minimum. CCGs and councils can agree larger contributions, where this will deliver value to the system and is affordable.

National condition three: Agreement to invest in NHS-commissioned out-of-hospital services

30. A minimum of £1.091 billion of the CCG contribution to the BCF in 2019-20 is ring-fenced to deliver investment or equivalent savings to the NHS, while supporting local integration aims. Each CCG's share of this funding is set out in allocations and will need to be spent as set out in the national condition. This condition will be assured through the Planning Template, based on spend allocated to primary, community, social care or mental health care, that is commissioned by CCGs from the CCG allocation.

Grant Funding to local government to be pooled into BCF plans

31. The DFG, iBCF and Winter Pressures grant monies are paid directly to local authorities under Section 31 of the Local Government Act 2003, with specific grant conditions, including a requirement that the funding is pooled in the BCF. Allocations will be pre-populated in the Planning Template. The conditions for individual grants are set out below.

Improved Better Care Fund

32. The Grant Determination issued in April 2019 sets out that the purposes will replicate those from 2017-18 and 2018-19 – and therefore that the funding be used for:
    - meeting adult social care needs;
    - reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
    - ensuring that the local social care provider market is supported.
33. The grant conditions for the iBCF also require that the local authority pool the grant funding into the local BCF and report as required.

34. iBCF funding can be allocated across any or all of the three purposes of the grant in a way that local authorities, working with CCG(s) determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the three purposes. The funding does not need to be directed to funding the changes in the High Impact Change Model (HICM). This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

35. Since April 2018, reporting on the iBCF has been incorporated into the main BCF reports and this will continue for 2019-20.

Winter Pressures Funding

36. The Grant Determination for Winter Pressures funding was issued in April 2019. In 2019-20, the Grant Determination sets a condition that this funding must be pooled into BCF plans. The grant conditions also require that the grant is used to support the local health and care system to manage demand pressures on the NHS with particular reference to seasonal winter pressures. This includes interventions that support people to be discharged from hospital, who would otherwise be delayed, with the appropriate social care support in place, and which help promote people's independence. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

37. Each BCF plan should set out the agreed approach to use of the Winter Pressures grant, including how the funding will be utilised to ensure that capacity is available in Winter to support safe discharge and admissions avoidance. The BCF process will ensure that the use of this money has been agreed by plan signatories and the HWB, confirmed in the Planning Template.

38. Details of planned schemes and expenditure should be confirmed in the Planning Template. Reporting on the grant will be through the main BCF process.

Disabled Facilities Grant

39. The DFG continues to be allocated through the BCF. Areas should think strategically about the use of home adaptations, the use of technologies to support people to live independently in their own homes for longer, and to take a joined-up approach to improving outcomes across health, social care and housing. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans and strategic use of the DFG can support this.

40. Innovation in this area could include combining DFG and other funding sources to create fast-track delivery systems, alongside information and advice services about local housing options. Local housing authority representatives and DFG leads should have a clear role in developing and agreeing BCF plans, supporting closer integration of housing, social care and health services.

41. DFG will continue be paid to upper-tier authorities. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore, each area will need to ensure that sufficient funding is allocated from the DFG monies in the pooled budget to enable housing authorities to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

42. In two-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government must be passed down to the relevant housing authorities (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans.

43. During these discussions, it will be important to continue to ensure that local needs for aids and adaptations are met, while also considering how adaptation delivery systems can help meet wider objectives around integration. Where some DFG funding is retained by the upper tier authority, plans should be clear that:

    - The funding is included in one of the pooled funds as part of the BCF;
    - The funding supports a strategic approach to housing and adaptations that supports the aims of the BCF; and
    - The use of the funding in this way has been developed and agreed with relevant district housing authorities.

44. Since 2008-09, the scope for how DFG funding can be used includes to support any LA expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables local government to use specific DFG funding for wider purposes.

45. This discretionary use of the funding can help improve delivery and reduce the bureaucracy involved in the DFG application process, helping to speed up the process. For example, LAs could use an alternative means test, increase the maximum grant amount, or offer a service which rapidly deals with inaccessible housing and the need for quick discharge of people from hospital. The Care Act also requires LAs to establish and maintain an information and advice service in their area. The BCF plan should consider the contribution that can be made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues.

46. The government commissioned an independent review of the DFG in February 2018. The review was published in December 2018 and makes 45 detailed recommendations. The government is carefully considering the review and will respond to its findings in due course.

PART 2 – COMPLETING BCF PLANS

Section 4 - The Planning Template

47. BCF plans must meet all four national conditions of the Fund, as set out in the Policy Framework and operationalised by the conditions and requirements contained in this document. Under national condition one**,** local government and CCGs are required to agree a plan for use of the pooled funding in the BCF for 2019-20. Local NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans.

48. Local partners are required to develop a joint spending plan that meets the national conditions and planning requirements. In developing BCF plans for 2019-20, local partners will be required to develop, and agree, through the relevant HWB(s) a completed Planning Template, including:

    - A narrative on the approach to integration of health and social care, highlighting key changes from 2017-19;
    - Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
    - A scheme-level spending plan demonstrating how the fund will be spent and compliance with national conditions two and three;
    - A brief description of the overall approach to progressing the implementation of HICM along with the planned level of implementation for each of the changes; and
    - Quarterly plan figures for the national metrics on effectiveness of reablement and admissions to residential care. Metrics for non-elective admissions will be mapped directly from CCG operational plans. Areas will be expected to achieve and maintain DToC expectations agreed between NHS England and Departments, pre-populated in individual Planning Templates. Brief narratives describing how elements of the overall HWB plan will impact these metrics are required to accompany the plan figures set out on the template.

Completing the Planning Template

Narratives

49. BCF narrative plans for 2017-19 set out how CCGs and local government were making progress towards integration by 2020, both through BCF funded schemes and more widely. The agreed BCF narrative will be collected through the Planning Template for 2019-20 and it is expected that they will be shorter and focussed on updates to 2017-19 plans.

50. As in 2017-19, BCF plans should represent the joint plan for integration of health and social care locally, with clear governance through the HWB. The narrative sections of the template should confirm these arrangements, particularly highlighting how these have developed since 2017-19. Where a single narrative is agreed across two or more HWB areas, for instance to reflect jointly agreed approaches across a wider geography (for example, Sustainability and

Transformation Partnership (STP)/Integrated Care System (ICS)), this narrative can be submitted in the template of one of the HWBs. Separate Planning Templates will still need to be submitted for all HWBs, with completed expenditure, metrics and confirmations tabs, to enable assurance of the national conditions on behalf of NHSE and Departments.

51. All confirmations of compliance with the requirements will be collected nationally through the Planning Template. Guidance on completing these are included in the Planning Template.

52. Narratives will need to describe:

- The approach to joining up care around the person.
- Approaches to joint commissioning and delivery of health and social care at HWB level.
- How the BCF plan and relevant elements of the STP/ICS plan align, including any jointly owned outcomes.

Joining up care around the person

53. Plans should set out the approach locally to person centred care. This may include single assessments, personal budgets, and Integrated Personalised Commissioning (IPC). There is no specific requirement to fund particular types of activity through the BCF, but the agreed local approach and links to these agendas should be set out in the narrative section. Further information on IPC is set out below.

Integrated Personalised Commissioning

Building on the learning from IPC, NHS England published their vision for personalised care in January 2019. This includes a comprehensive model for personalised care that brings together 6 key components. The components are:-

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets.

There are currently 21 demonstrator sites including three integration accelerator sites (Lincolnshire, Nottinghamshire and Gloucestershire) who are implementing this model and learning will be shared as soon as available on NHS England website.

Some examples from the programme include:

- In Lincolnshire, Nottinghamshire, and Gloucestershire, the council and the NHS are introducing joined-up assessment and personalised

care and support planning for people who have health and social care needs.

- Tower Hamlets are working across health and social care to provide people with integrated provision of wheelchairs and home equipment
- Gloucestershire and Hampshire, the NHS and local government are working together to train staff to deliver personalised care.

Other parts of the country are encouraged to consider this approach and how they can plan to support the roll out of this comprehensive model including joint working to expand the use of joint assessments and care and support planning, integrated personal budgets and expand social prescribing schemes in partnership with primary care networks.

HWB level plans

54. Plans should set out the high-level approach to integrated care in the area. This could include:

- Approaches to joint commissioning
- Delivery of integrated care, preventative services and population health management.
- Approaches to integration with housing and other local services, including work with the local voluntary sector.

Links to system level plans

55. Narrative plans should set out the alignment locally between the BCF plan and the STP or STPs it overlaps.

56. The NHS Long Term Plan sets out how STPs and ICSs should work with local government to plan and commission health and care services at 'place' level – usually HWB level, including shared decisions on the use of resources. This will include production of five-year plans by each ICS and STP in 2019. The expectation is that local systems will align these geographies in a way that makes sense in relation to local authority and health boundaries. The Long Term Plan sets an expectation that all ICSs will have a partnership board that includes representation from local government and that ICSs and HWBs will work closely together. One key consideration should be how data and information will be made accessible and shared across sectors.

Continuing to address inequalities in BCF plans

57. Local partners should continue to consider how the activities in their BCF plan will address health inequalities in the area in line with duties in the Health and Social Care Act 2012, and reduce inequalities for people with protected characteristics under the Public Sector Equality Duty in the Equality Act 2010, building on approaches agreed in 2017-19 plans. Local strategies for reducing inequalities across the constituent organisations can be referenced where appropriate, but the narrative plan must include a short overview of any priorities and investment to address inequalities.

Implementation of the High Impact Change Model for Managing Transfers of Care

58. National condition four requires health and social care partners in all areas to work together to:

    - Agree a clear plan for managing transfers of care and improved integrated services at the interface of health and social care that reduces DToC, encompassing the HICM, and home based intermediate care (including reablement).
    - Continue to embed the HICM.

59. In the HICM section of the Planning Template, areas should set out the current state of implementation for each of the eight changes in the model and the planned level of implementation by March 2020. Areas should agree a narrative describing the priorities and actions for 2019-20 to embed the model, including:

    - Details of changes;
    - Anticipated improvements to care and discharge, minimising delays and ensuring that as many people as possible are discharged safely to their normal place of residence.

60. Areas were expected to implement the model during 2017-19 as part of the BCF planning and operational requirements, and should be able to confirm that each of the eight changes are at least established. If this is not the case for any of the changes, the plan should set out what is being done to ensure that the relevant change is implemented as soon as possible.

61. Where all parties in an area have implemented a variation on the model (for example if an existing, successful, approach would be duplicated by elements of the change model) the plan should briefly explain the rationale for this, that sets out how the aims of the specific change are met. All partners, including relevant A&E Delivery Boards, should be involved in agreeing the approach.

62. The LGA, Association of Directors of Adult Social Services (ADASS), NHS England and NHS Improvement and Government are reviewing the HICM and a new version will be published later in the year. For the purposes of the BCF in 2019-20, areas should set out their plans against the existing model.

Developing approaches to managing transfers of care

63. In 2017-18, the Better Care Support programme commissioned Newton, to work with nine HWBs in 14 health and care systems experiencing persistent challenges with levels of DToC. In addition to the specific diagnostic, planning and improvement work done in these systems, the findings have been brought together into a report '[People First, manage what matters]'.

64. The report makes several recommendations for all areas to consider:

    - Ensure that those making decisions about people's discharge from acute settings have robust, timely and accurate information about the flow and capacity within the entire system (enabled by interoperability, data and information sharing between health and social care).

- Question the outcomes achieved for people once discharged.
- Put rigorous systems of outcome measuring and monitoring in place.
- Assess the effectiveness of system-wide leadership.
- Ensure that the mechanisms of governance in place are aligned with the outcomes the system is seeking to achieve.
- Align resource allocation with achieving the best outcomes for people, rather than with current patterns of discharge decision-making.

65. Local areas are encouraged to take these recommendations into account in developing their ongoing implementation of the HICM.

Reablement and the NHS Long Term Plan

66. The Long Term Plan outlines how the NHS, over the next five years, will be implementing the commitments to invest in reablement, crisis response and intermediate care services, to increase their responsiveness and reduce delays in people receiving the right care in the right place. The NHS has set itself a target for services to be in place to support people within two days for reablement and two hours for crisis response. These targets are not BCF conditions, and areas are not required to implement any specific schemes or allocate BCF funds to their implementation in 2019-20. Local health systems will need to continue to work with social care colleagues to deliver these commitments over the coming years and agree the approach to commissioning and co-ordination to ensure that these services are in place and deliver the best outcomes for individuals who need them.

Further guidance

67. There is an increasing range of material available to support local systems with the practical development of joint integration strategies and integrated services. The NHS England Integrating Better project recently produced a practical guide based on learning from 16 areas, which is available to health and care practitioners as part of the STP/ICS library of good practice. The LGA also provide a range of support, tools and case studies, such as through the recently published evidence review and case studies of integrated care or the support provided through its Care and Health Improvement Programme. Further guidance includes:

- BCF ‘How to’ guides are available on the BCF pages of the NHS England Website;
- Guidance supporting the High Impact Change Model, which can be found on the LGA website;
- A series of ‘Quick guides’ from NHS England to support health and social care systems;
- The Logic Model for Integrated Care, developed by the Social Care Institute for Excellence on behalf of government.

Expenditure plans

68. The Planning Template will include the scheme-level spending plan for the use of the full value of the budgets pooled through the BCF. These plans will need to include:

    - area of spend;
    - scheme type;
    - commissioner type;
    - provider type;
    - funding source;
    - the metrics that the scheme is intended to influence;
    - total 2018-19 investment (if existing scheme);
    - total 2019-20 investment;
    - the anticipated number of beneficiaries (for certain schemes).

69. To understand and account for the impact of funding committed to the BCF, the Policy Framework makes a commitment that more information on the impact of the BCF will be collected, through the planning process. The BCF Planning Template for 2019-20 will collect this through:

    - Clear narratives on the four national metrics describing the activity that is being commissioned through the BCF to support achieving these ambitions, including preventative approaches.
    - Scheme level data to indicate the metric(s) or integration enablers that schemes are intended to impact on (where appropriate).
    - Planned outputs from certain scheme types (comprising significant spend areas that have easily definable outputs).

70. Detailed instructions on completing this are included in the guidance section of the Template.

71. Expenditure plans must include indicative outputs for the scheme types listed in Table 2.

Table 2: Output measures for selected BCF scheme types.

Service	Unit
Domiciliary care	Packages/hours of care
Reablement/rehabilitation	Packages/hours of care
Bed-based intermediate care Step up/step down	Number of beds
Residential placements	Placements
Personalised care at home	Packages

72. There will be an option to select the output unit that is relevant to the scheme – for instance for a domiciliary care scheme this might be total hours or number of packages planned. Plans will not need to show additional packages.

73. As the Planning Template is now collecting more information on the outputs expected from schemes, iBCF reporting will be significantly reduced. Local authority finance directors have still been asked to certify that the iBCF grant is being used exclusively on adult social care in 2019-20.

74. This information will not be used to make judgements on value for money or to make assurance decisions, but will be used to understand how the BCF is used and the levels of activity it supports. National partners recognise that further work is needed to improve measurements of the impact of integrated approaches through the BCF. They will work with local areas to develop models to inform future programmes.

75. CCGs should ensure that these returns mirror their operational planning returns for 2019-20, submitted through central UNIFY and finance return templates. This will include some of the same data, for example funding contributions and baseline Non-elective admission metrics agreed in the CCG operational plans. There will be a national reconciliation process to ensure the data provided matches in all cases.

Section 5 - National metrics

76. The BCF Policy Framework confirms that the existing four national metrics will continue as conditions for the fund. The metrics are:

    a. Non-elective admissions (Specific acute);
    b. Admissions to residential and care homes;
    c. Effectiveness of reablement; and
    d. Delayed transfers of care;

77. Information on all four metrics will continue to be collected nationally. The table below sets out a summary of the information required and where this will be collected. The detailed definitions of all metrics are set out in Appendix 2.

Table 3: National Metrics

Metric	Collection method	Data required
Non-elective admissions (Specific acute)	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Template	Quarterly HWB level activity plan figures for 2019-20.
Admissions to residential and care homes	• Collected through nationally developed high level Planning Template	Plans should confirm an annual metric for 2019-20
Effectiveness of reablement	• Collected through nationally developed high level Planning Template	Plans should confirm an annual metric for 2019-20

Metric	Collection method	Data required
Delayed transfers of care	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through the Planning Template	Local expectations will be set at HWB level and prepopulated in the metrics tab of each HWB Template.

Metric plans

78. BCF plans must include narratives that describe how the schemes and enabling activity for health and social care integration in the agreed BCF plan will support the delivery of each metric.

79. These narratives should include any significant changes from 2017-19 plans, including any schemes that have been decommissioned or planned new schemes.

Non-elective admissions (NEAs)

80. The detailed definition of the NEA metric is set out in the Planning Round Technical Definitions. Figures submitted in CCG operating plan returns have been pre-populated into the Template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for reducing NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.

Delayed transfers of care

81. The BCF Policy Framework for 2019-20 retains the centrally set expectation for reducing DToC nationally to below 4,000 delays per day across England. The expectations set for HWBs for 2018-19 in the BCF Operating Guidance 2017-19 have been retained and are pre-populated in each area's Planning Template. Where an area has not met their expectation, they should ensure that there are plans in place to do so as soon as possible. Where areas have already met these expectations, they should continue to implement joint plans to manage discharge and flow to minimise delays.

82. Progress in reducing DToC will continue to be monitored regularly by national partners. Support for areas experiencing significant challenges (and areas keen to further improve and innovate) will continue to be provided through the Better Care Support offer based on performance over time, taking into account the overall rate of delays as well as the distance from BCF plan expectations. This will include a review of progress prior to Winter.

83. Narratives for implementing the HICM and reducing DToC must set out how CCGs, LAs, NHS providers of acute, community and mental health bed-based services and providers of social care will work together to achieve the DToC expectation. Local plans should focus on system wide approaches to ensuring that people are discharged in a safe and timely way to the most appropriate setting, taking account of guidance referenced in Section 4 of this document.

84. Expectations for reducing DToC in 2019-20 are articulated as a single HWB ambition and have not been split into separate NHS and social care expectations. This is intended to support joint working and accountability at system level and BCF plans should describe how these ambitions will be met locally through integrated, collaborative approaches.

PART 3 - ASSURANCE, APPROVAL AND INTERVENTION

Section 6 - Local plan development, sign off and assurance

85. Plans will be assured and moderated regionally, which will be a joint NHS and local government process. Recommendations for approval of BCF plans will be made following cross regional calibration of outcomes to ensure consistent application of the requirements nationally. From April 2019, the NHS has moved to a new regional structure with integrated NHS England and NHS Improvement regional offices. Moderation of HWB BCF plans will be carried out at the new NHS regional footprint, with full involvement of local government.

86. The main Planning Requirements included in this document (summarised on Appendix 1) and a set of underpinning key lines of enquiry (KLOE) have been produced to support a consistent assurance process. These will be available to local areas on the planning requirements confirmations sheet within the Planning Template.

87. The Better Care Support team (BCST) will provide a range of resources to help local areas develop their plans, including signposting to support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice. Better Care Managers (BCMs) will provide practical support and advice during the planning process.

88. The assurance of plans will be a single stage, with an assessment of whether a plan should be approved or not approved. Plans should be submitted by 27 September 2019, having been approved or scheduled to be approved by the relevant HWB(s).

89. Areas are asked to send their Planning Template to their BCM, copied to england.bettercaresupport@nhs.net. The BCST will collate data from the Planning Template to assist regional assurance. If an agreed plan is not submitted by the deadline, the BCSt will work with the local BCM to agree appropriate support for the area to agree a plan promptly. Areas will be expected to take up this support. If it appears that a plan is unlikely to be agreed locally within a reasonable timeframe, formal escalation will be considered.

90. The assurance process, including reconciling any data issues, will be a joint NHS England and local government process. Local government has been funded to carry out assurance via regional local government leads. BCMs and the BCST will work with these teams to ensure they are fully briefed on the requirements of the BCF for 2019-20 and have capacity in place to participate in the process. The confirmations sheet in the Planning Template sets out the main planning requirements for the BCF and associated KLOEs. NHS regional finance teams will be involved in assurance, particularly in assuring that larger increases to social care from the CCG minimum contribution are affordable and present value to the NHS.

Calibration and plan approval

91. Following regional assurance and moderation, the BCST will co-ordinate a cross-regional calibration exercise with regional colleagues to provide assurance that plans have been assured in a consistent way across England. The BCST will

provide data on provisional assurance outcomes and facilitate the cross-regional discussion to agree a consistent approach to assurance outcomes across all regions. This may result in regions being asked to revisit recommendations from assurance panels where it is agreed that the requirements have not been applied consistently. Following this, recommendations and advice for approval will be provided to DHSC and MHCLG and then to NHS England for approval of spending plans from the CCG minimum contribution.

Table 4: BCF assurance categories

Category	Description
Approved	• Plan agreed by HWB. • Plan meets all national conditions. • Agreement on use of local authority grants (DFG, iBCF and Winter Pressures). • Metrics are set and plans agreed for delivery of these metrics. • No or only limited work needed to gather additional information on plan – where there is no impact on national conditions or metrics.

Not approved	• One or more of the following apply:
	  • Plan is not agreed.
	  • One or more national conditions not met.
	  • No local agreement on use of local authority grants (DFG, iBCF and Winter Pressures).
	  • Plans not agreed for delivery of metrics.

92. Formal approval of BCF plans and authorisation for CCGs to use the CCG minimum element of the BCF will be given by NHS England, following agreement with DHSC and MHCLG that all conditions are met. These decisions will be based on the advice of the assurance process set out above. Where plans are not initially approved, the BCST may implement a programme of support, with partners, to help areas to achieve approval as soon as possible or consider placing the area into formal escalation.

93. Following formal approval, CCG funding agreed within BCF plans must be transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.

Section 7 - Intervention and escalation

94. Escalation will be considered in the event that:
    - CCGs and local authority are not able to agree and submit a plan to their HWB; or
    - The HWB do not approve the final plan; or
    - Regional assurers rate a plan as ‘not approved’.

95. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. This will initially be a regional process. If regional escalation is not able to address the outstanding planning requirements, senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to a National Escalation Panel meeting to discuss concerns and identify a way forward.

96. If a plan is not approved, the area should not proceed with the signing of a Section 75 agreement in relation to NHS monies.

Section 8 - Monitoring continued compliance with the conditions of the fund

97. BCMs and the wider BCST will monitor continued compliance against the national conditions (including the metrics) through the BCF reporting process described below and their wider interactions with local areas.

98. If an area is not compliant with any of the conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan resulting in a risk to meeting the national conditions, or if performance against metrics is problematic, the BCST, in consultation with national partners, may make a recommendation to initiate an escalation process. Any intervention will be appropriate to the risk or issue identified.

99. It is recognised that owing to various circumstances, places may wish to amend plans in-year to:

- Modify or decommission schemes
- Increase investment or include new schemes.

100. In such instances, any changes to assured and approved BCF plans arising in-year must be jointly agreed between the LA and the CCGs and continue to meet the conditions and requirements of the BCF. A jointly agreed and HWB approved resubmission of an updated BCF Planning Template with an accompanying rationale will be required. If the need arises to amend BCF plans in-year please contact the relevant BCM in the first instance.

101. The intervention and escalation process (outlined in subsequent sections) ultimately leads to NHS England exercising its powers of intervention provided by NHS Act 2006, in consultation with DHSC and MHCLG, as the last resort.

Section 9 - Reporting in 2019-20

102. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

103. To serve these purposes, areas are required to provide quarterly reporting for the BCF over 2019-20 in relation to the CCG minimum contribution and the Winter Pressures grant.

104. These reports are discussed and signed-off by HWBs (or with appropriate delegation) as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into s.75 agreements. Monitoring will include confirmation that s.75 agreement is in place.

105. The reporting template will be made available to the local systems with associated guidance and timetables via the Better Care Exchange, an online platform that all Better Care leads are able to access.

Section 10 – Timetable for planning and assurance

106. The submission and assurance process will follow the timetable below:

Table 5: BCF Planning and assurance timetable

BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local government). All submissions will need to be sent to the local BCM, and copied to england.bettercaresupport@nhs.net	By 27 September
Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation	By 30 October
Regionally moderated assurance outcomes sent to BCST	By 30 October
Cross regional calibration	By 5 November
Assurance recommendations considered by Departments and NHSE	5 – 15 November
Approval letters issued giving formal permission to spend (CCG minimum)	Week commencing 18 November
All Section 75 agreements to be signed and in place	By 15 December

Appendix 1 - BCF planning requirements

Condition/Requirement	Collection method	Assurance approach
Jointly agreed plan including; • Confirmation of funding contributions • National conditions • Scheme level spending plan	Collected through single Planning Template, submitted to Better Care Managers and copied to england.bettercaresupport@nhs.net	Assured regionally by relevant NHS teams and local government assurers, with regional moderation involving the LGA and ADASS at NHS regional level, supported by collation and analysis of data on national conditions and expenditure plans carried out nationally.
National Metrics	Submitted through UNIFY (NEA) and through the Planning Template (Effectiveness of Reablement and Residential admissions)	Collated and analysed nationally, with feedback provided to relevant NHS teams and local government assurers for regional moderation and assurance process. Regional assurance will also confirm that the area has a coherent plan for achieving these metrics.

Appendix 2 - Specification of Better Care Fund metrics

Metric One: Total Non-elective spells (specific acute) per 100,000 population

Outcome sought	A reduction in the number of unplanned acute admissions to hospital.
Rationale	Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings.
Definition	**Description**: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population. Numerator: Number of specific acute non-elective spells in the period. Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider. Number of specific acute hospital provider spells for which: • Der_Management_Type is 'EM' and 'NE' **Where** 'EM' = Emergency and 'NE' = Non-Elective Please refer the Joint Technical definitions for Performance and Activity (2019-20) and see Appendix A- SUS Methodology for details of derivations and Appendix B for full list of Treatment Function Code categorisation. **Denominator:** ONS mid-year population estimate for all ages (mid-year projection for population
Source	Secondary Uses Service NCDR(SEM) – SUS+ NCDRis derived from SUS+ (SEM) and not the SUS+ PbR Mart. Adjustments are made to the data to correct for improbably high or low data points and ensure a consistent time series; this is in line with monthly activity reporting within NHS England. For more details see Joint Technical definitions for Performance and Activity (2019-20). Population statistics (ONS)
Reporting schedule for data source	Collection frequency: Numerator collected monthly (aggregated to quarters for monitoring). Denominator is annual. Timing of availability: data is available approximately 6 weeks after the period end.
Historic	From 2017-18, total number of specific acute non elective spells replaces non elective (general and acute) episodes metric

Metric Two: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Outcome sought	Overarching measure: Delaying and reducing the need for care and support.
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
Definition	**Description**: Annual rate of older people whose long term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by NHS Digital **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework: NHS Digital (SALT) Population statistics (ONS)
Reporting schedule for data source	Collection frequency: Annual (collected Apr-March) Timing of availability: data typically available 6 months after year end.
Historic	Data first collected 2014-15 following a change to the data source.

Metric Three: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Outcome sought	Delaying and reducing the need for care and support When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence.
Rationale	There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services. This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from SALT collected by NHS Digital. **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December. This data is taken from SALT collected by NHS Digital Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework
Reporting schedule for data source	Collection frequency: Annual (although based on 2x3 months data – see definition above) Timing of availability: data typically available 6 months after year end.
Historic	Data first collected 2011-12 (currently five years data final available (2011-12, 2012-13, 2013-14, 2014-15 and 2015-16)

Metric Four: Delayed transfers of care from hospital per 100,000 population

Outcome sought	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.
Definition	Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate (mid-year projection for 18+ population) *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month.
Source	DToCs (NHS England) Population statistics (ONS)
Reporting schedule for data source	Collection Frequency: Numerator collected monthly (aggregated to quarters for monitoring). Denominator is annual. Timing: data is published approximately 6 weeks after the period end.
Historic	Data first collected Aug 2010

Appendix 3 - Support, escalation and intervention

Where performance issues or concerns over compliance with the requirements of the BCF are identified, the BCST and BCM will take steps to return the area to compliance. Broadly this will involve the following steps:

1. **Trigger** – a. Concern during planning process that a compliant plan will not be agreed b. BCF plan not submitted c. BCF plan submitted does not meet one or more planning requirement	The BCM and regional partners in consultation with the BCST will consider whether to recommend specific support or if the area should be recommended for escalation. Initially support may be appropriate or a defined timescale set for the issue to be rectified.
2. Informal support	If appropriate, the BCM will work with the area to advise on the issue and consider, with local leaders, what further support may be provided. This may include support through regional NHS or local government structures. Alternatively, it may be decided that it is appropriate to move straight to formal support or a formal regional meeting.
3. Formal Support	The BCM will work with the BCST to agree provision of support.
4. Formal regional meeting	Areas will be invited to a formal meeting with regional NHS and local government representatives and the BCST to discuss the concerns, plans to address these and a timescale for addressing the issues identified.
5. **Commencing Escalation** as part of non-compliance	If, following the regional meeting, a solution is not found or issues are not addressed in the timescale agreed, escalation to national partners will be considered. If escalation is recommended, BCF national partners will be consulted on next steps. To commence escalation, a formal letter will be sent, setting out the reasons for escalation, consequences of non-compliance and informing the parties of next steps, including date and time of the Escalation Panel.

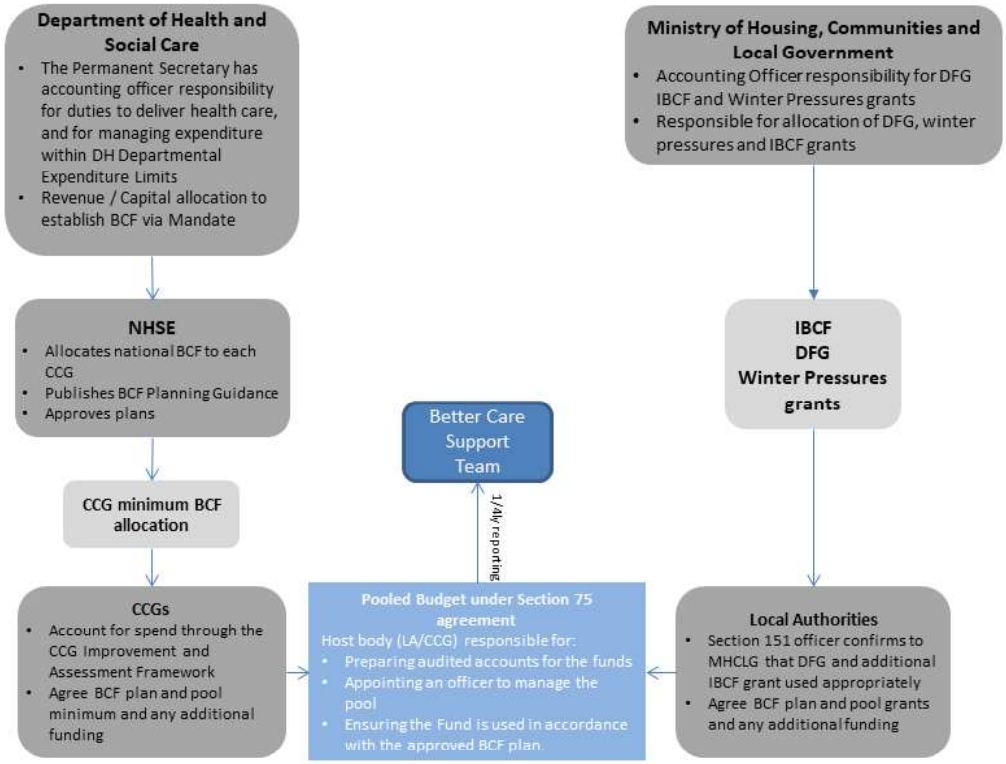
6. The **Escalation Panel**	The Escalation Panel will be jointly chaired by MHCLG and DHSC senior officials, supported by the BCST, with representation from: • NHS England • LGA Representation from the local area needs to include the: • Health and Wellbeing Board Chair • Accountable Officers from the relevant CCG(s) • Senior officer(s) from LA
7. **Formal letter and clarification** of agreed actions	The local area representatives will be issued with a letter, summarising the Escalation Panel meeting and clarifying the next steps and timescales for submitting a compliant plan. If support was requested by local partners or recommended by the Escalation Panel, an update on what support will be made available will be included.
8. **Confirmation** of agreed actions	The BCM will track progress against the actions agreed and ensure that the issues are addressed within the agreed timescale. Any changes to the timescale must be formally agreed with the BCST.
9. Consideration of **further action**	If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include: • Agreement that the Escalation Panel will work with the local parties to agree a plan. • Appointment of an independent expert to make recommendations on specific issues and support the development of a plan to address the issues – this might be used if the local parties cannot reach an agreement on elements of the plan. • Appointment of an advisor to develop a compliant plan, where the Escalation Panel does not have confidence that the area can deliver a compliant plan. • Appointment of an advisor or support to address performance issues, including progress towards agreed DToC metrics. • Withholding BCF payments that are due to be made.

	• Directing the CCG as to how the minimum BCF allocation should be spent. The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off.

NHS England has the ability to direct the use of the CCG funds where an area fails to meet one of the BCF conditions and NHS England considers that the CCG(s) in question is failing, has failed or is at significant risk of failing to discharge any of its functions. This includes the duties under Sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006. If a CCG fails to develop a plan that can be approved by NHS England or if a local plan cannot be agreed, any proposal to direct use of the fund and/or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DHSC and MHCLG ministers. The final decision will then be taken by NHS England. Once a decision has been taken any directions would be made under Section 14Z21 of the NHS Act 2006.

The Escalation Panel may make recommendations that an area should amend plans that relate to spending of the DFG, Winter Pressures or iBCF. This money is not subject to NHS England powers to direct. A BCF plan will not be approved, however, if there is not agreement between health and local government partners on the use of these grants (a requirement of national condition one). Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

Appendix 4 – Funding flows and accountability



This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by the Better Care Support Team, Operations and Information Directorate.

If you have any queries about this document, please contact the Better Care Support Team at: england.bettercaresupport@nhs.net

For further information on the Better Care Fund, please go to: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Published to GOV.UK in pdf format only.

Community and Social Care Group/Care and Transformation Directorate/Commissioning, Integration and Transformation Unit

www.gov.uk/dhsc

Herefordshire Council

Meeting:	**Health and wellbeing board**
Meeting date:	**Monday 14 October 2019**
Title of report:	**Integrated Care System and One Herefordshire**
Report by:	**Director of adults and communities** **Director of strategy and transformation (NHS Herefordshire Clinical Commissioning Group and One Herefordshire)**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose and summary

To provide an update and overview of the developing Integrated Care System and One Herefordshire. National Health Service England (NHSE) requires that this plan must involve and ideally be agreed with community providers, primary care providers, and the new Clinical Directors of Primary Care Networks. It should also be subject to dedicated discussion at all health and wellbeing boards.

Recommendation(s)

That:

(a) the health and wellbeing board determine its own role in taking forward the priorities; and

(b) the board identify any items for inclusion in its future work-programme.

Further information on the subject of this report is available from
John Coleman, Tel: 01432 260382, email: John.Coleman@herefordshire.gov.uk

Alternative options

1. The health and wellbeing board may identify additional and alternative approaches to delivering the desired outcomes or may make recommendations to relevant bodies regarding actions to improve integration.

Key considerations

2. This paper and the attached background presentation provides an overview of the current plans for the Herefordshire and Worcestershire Sustainability Transformation Partnership (STP), One Herefordshire and the Integration plan delivered by the Better Care Fund Plan (BCF).

3. The evolving landscape of STPs and integration has been cemented by the NHS Long Term Plan (www.england.nhs.uk/long-term-plan/) where the key five themes include:

    - a new service model for the 21st Century;
    - people will get more control over their own health and personalised care when they need it;
    - local NHS organisations will increasingly focus on population health and fulfilling their duties in reducing health inequalities whilst moving to Integrated Care Systems everywhere;
    - digitally-enabled primary and outpatient care will go mainstream across the NHS; and
    - reducing pressure on emergency hospital services

4. The new service model for the 21st Century describes a change for General Practice (GP), moving to Primary Care Networks (PCNs) to deliver care to populations of 30-50k. In Herefordshire this would result in five PCNs across four localities (two PCNs in Hereford city). The plan commits funding to the networks for additional resources to support the vision to improve population health, support self-care and reduce the length of stay in hospitals by providing more support in locality areas.

5. STPs have been evolving over the past few years, and developed across Herefordshire and Worcestershire based on an NHS Clinical Commissioning Group (CCG) footprint area. The next step is STPs transitioning into Integrated Care Systems (ICS) across the country by April 2021. This will involve a shift of decision making to a partnership approach across commissioners and providers of health and social care to drive integrated care delivery, better utilise resources, improve population health and reduce inequalities.

6. Key changes are also emerging for CCGs, to streamline commissioning arrangements which could typically involve a single CCG for each ICS/STP area. CCGs will become leaner and more strategic, and will support providers to partner with councils and other organisation on population health, inequalities and service redesign.

7. The priorities in the NHS Long Term Plan are areas are being worked upon, both within the Herefordshire and Worcestershire STP and the work of One Herefordshire. As a minimum, system plans should focus on four things:

    - meeting the new funding guarantees for primary medical and community health services;
    - supporting the development of their Primary Care Networks (PCN);

- improving the responsiveness of community health crisis response services to deliver the services within two hours of referral, and reablement care within two days of referral; and
- creating a phased plan of the specific service improvements and impacts they will enable primary and community services to achieve, year by year, taking account of the national phasing of the new five-year GP contract.

8. During 2019/20 the Herefordshire and Worcestershire STP will be transitioning into the new ways of working, and developing to absorb NHSE/NHSI responsibilities as these are devolved. This includes developing partnership forums that enable us to work through a partnership approach whilst recognising that accountability and responsibility of individual organisations won't change.

9. As part of the development of STPs into ICSs the local 'place' will need to be developed, as the NHS seeks to engage in a meaningful manner with the council and local communities to address wider wellbeing, population outcomes and inequalities. This concept of 'place' is best described as being coterminous with health and wellbeing board boundaries, making One Herefordshire our local vehicle to drive this forward. This will include supporting the development of PCNs at more local level, as well as working with the council and local communities to address wider wellbeing.

10. One Herefordshire is our place based partnership, and we are currently developing our five year integration plan. Our vision is for Herefordshire to be a county of healthy individuals living within healthy communities:
    - Herefordshire residents will be supported and enabled to keep themselves well at home;
    - when needed they will have joined up care and support, underpinned by specialist expertise, delivered in the best place by the most appropriate people; and
    - our services will be clinically and financially sustainable, working in partnership to make best use of the 'Herefordshire pound' within the Herefordshire and Worcestershire Integrated Care System (ICS).

11. There are a number of priority areas that are being developed within One Herefordshire for the next two years and these are:

    Year 1 Priorities

    - Community resilience
    - Integrated primary, community and mental health services
    - Urgent care, including frailty, dementia and end of life
    - Elective care: musculoskeletal, ophthalmology, dermatology and outpatient redesign
    - Digital and population health management

    Year 2 Priorities

    - Prevention
    - Psychological interventions
    - Complex mental health needs
    - Back office and infrastructure

- Estates

12. The Better Care Fund (BCF) and Integration plan is an integral part to the delivery of the One Herefordshire programme. The plan was refreshed last year to provide an overview of the key areas of focus for partners. The BCF plan has been agreed with the CCG for 2019/20 and that BCF, IBCF and Winter Pressures funding for 2020/21 was confirmed in the budget.

13. The quarterly performance report for BCF shows that delayed transfers of care (DToC) and the urgent care system remains a challenge for health and social care, this includes providing the appropriate level of support to keep people at home and admissions into care homes.

Community impact

14. The changes described are aligned and integral to delivering the NHS Long Term Plan and by providing services at a locality level also supports the council's corporate objective to 'enable residents to live safe, healthy and independent lives.'

15. The plans are intended to move our health and social care system to a new service model in which patients get more options, better support and properly joined up care at the right time in the optimal care setting will support communities to remain within their own homes and reduce the need for hospitalisation and long term care. This will support our objectives of building community resilience and tackling health inequalities.

16. One Herefordshire recognises 'Talk Community', the community plan that the adults and communities directorate, as a critical underpinning component of One Herefordshire and its 5 year strategy. It will support One Herefordshire partners in improving wider wellbeing and population outcomes, as well as addressing their statutory duties around health inequalities. Citizens have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by councils, to take steps to improve the health of the local community.

Equality duty

17. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows: A public authority must, in the exercise of its functions, have due regard to the need to -

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

18. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. The STP is developing a more joined up approach to its equality duties, and has an STP equality work stream which is developing a robust and uniform approach to equality impact assessment across Herefordshire and Worcestershire.

19. The council and CCG are committed to equality and diversity using the public sector equality duty (Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. All equality considerations are taken into account.

20. It is not envisaged that the recommendations in this report will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender, reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

21. The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the act. This is through improving the health and wellbeing of people in Herefordshire by enabling them to take greater control over their own homes and communities. There are no negative impacts for looked after children or with respect to the council's corporate parenting role.

Resource implications

22. The One Herefordshire five year 'integration' plan is currently in development, and will demonstrate how we will work collectively to use our resources more efficiently.

23. The BCF is considered within this programme of work. As noted above, the BCF plan has been agreed with the CCG for 2019/20 and that BCF, IBCF and Winter Pressures funding for 2020/21 was confirmed in the budget. The BCF has clear national conditions and metrics on the funding and allocations of the budget.

24. Additional funding has been committed by the Department of Health to support the development of the PCNs, increasing resources across the networks for a number of professional roles.

Legal implications

25. Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. Specifically functions of the board relevant to this report are to: encourage those who arrange the provision of any health or social care services in Herefordshire to work in an integrated manner for the purpose of advancing the health and wellbeing of the people of Herefordshire:

    - encourage those who arrange for the provision of any health related services in Herefordshire to work closely with the health and wellbeing board;
    - encourage the close working of those providing health or social care services with those who arrange for the provision of health related services in Herefordshire; and
    - review whether the commissioning plans and arrangements for the NHS, public health and social care (including Better Care Fund submissions) are in line with and have given due regard to the health and wellbeing strategy.

26. There are no specific legal implications in the recommendations of the report.

Risk management

27. There are a number of risks associated with the changes described and these will be managed through the One Herefordshire executive body (the One Herefordshire Health

and Care Partnership), the Integrated Care Alliance Board and within the council via the directorate and/or corporate risk register.

Risk / opportunity	Mitigation
STP and NHS undertaking timely and appropriate engagement with stakeholders and key partners on key issues. Often due to conflicting priorities this can result in limited time for consultation/engagement on key issues.	Where possible the local transformational programme and timescales is being carefully scoped to ensure full engagement/consultation is undertaken.
The STP focusses on a Herefordshire and Worcestershire integrated care system model rather than placed based solutions.	Development of the place based model through One Herefordshire will ensure that local people continue to receive the appropriate level of care. It will also ensure care is more joined up for service users, and that we are supporting prevention and wider wellbeing.
Unable to recruit to the planned posts to deliver the PCN model, in the context of local and national workforce challenges.	Recruitment campaign is underway and this will continue until posts are filled. Portfolio careers and shared roles across organisations will support recruitment.
Planning guidance for the BCF is delayed further resulting in lack of assurance of future funding and uncertainty of the future programme and funding for BCF	Council officers continue to work with local health partners to develop a local health and social care integration plan to mitigate where possible.

Consultees

28. There is a national requirement to engage with the public and stakeholders on the NHS Long Term Plan (LTP). The engagement process is set out to seek views and comments on the local priority areas in the LTP. Engagement activity, face-to-face and through online survey is ongoing and is being undertaken by Healthwatch Herefordshire (on behalf of Healthwatch Herefordshire and Worcestershire) and STP engagement teams. Feedback from this engagement was published on the STP website in July/August 2019 and Herefordshire council's adults and wellbeing scrutiny committee will be considering this plan in October.

29. There has not been a need to undertake consultation on this paper as there are no specific service change proposals to be consulted on. Any changes resulting from implementation of specific areas of the presentation will be consulted on fully with the Council and other key stakeholders.

Appendices

Appendix 1 Integrated Care Systems and One Herefordshire presentation (agenda page 143)

Background papers

None

Integrated Care Systems and One Herefordshire

Integrated Primary and Community Services

Herefordshire Health and Wellbeing Board

October 2019

The NHS Long Term Plan

Main themes -

1. ‘Local NHS organisations will increasingly focus on population health and reduction of inequalities, moving to Integrated Care Systems everywhere’

2. ‘People will get more control over their own health and personalised care when they need it’

3. ‘Digitally-enabled primary and outpatient care will go mainstream across the NHS’ – avoiding a third of face to face outpatient appts within 5 years

4. ‘A new service model for the 21st Century’ – breaking down the divide between primary and community services and reducing pressure on emergency hospital services’

5. Changes for General Practice - Primary Care Networks (PCNs) for 30-50k population – working with other providers at locality level

NHS Action on Prevention

- ‘the NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+’
- New targeted NHS funded smoking cessation offer
- ‘hospitals with the highest rate of alcohol dependence-related admissions will be supported to establish Alcohol Care Teams’
- Reduce the NHS carbon footprint by 20% with less travelling
- Mental health ambulance transport vehicles that reduce inappropriate conveyance

Integrated Care Systems (ICSs)

- Evolution of STPs - ICSs to cover the whole country by April 2021

  'Commissioners will make shared decisions with providers on how to use resources, design services and improve population health'

- Streamlined commissioning arrangements:

  - typically involving a single CCG for each ICS/STP area
  - CCGs will become leaner, more strategic organisation
  - CCGs will support providers to partner with local government and other organisations on population health, inequalities and service redesign.

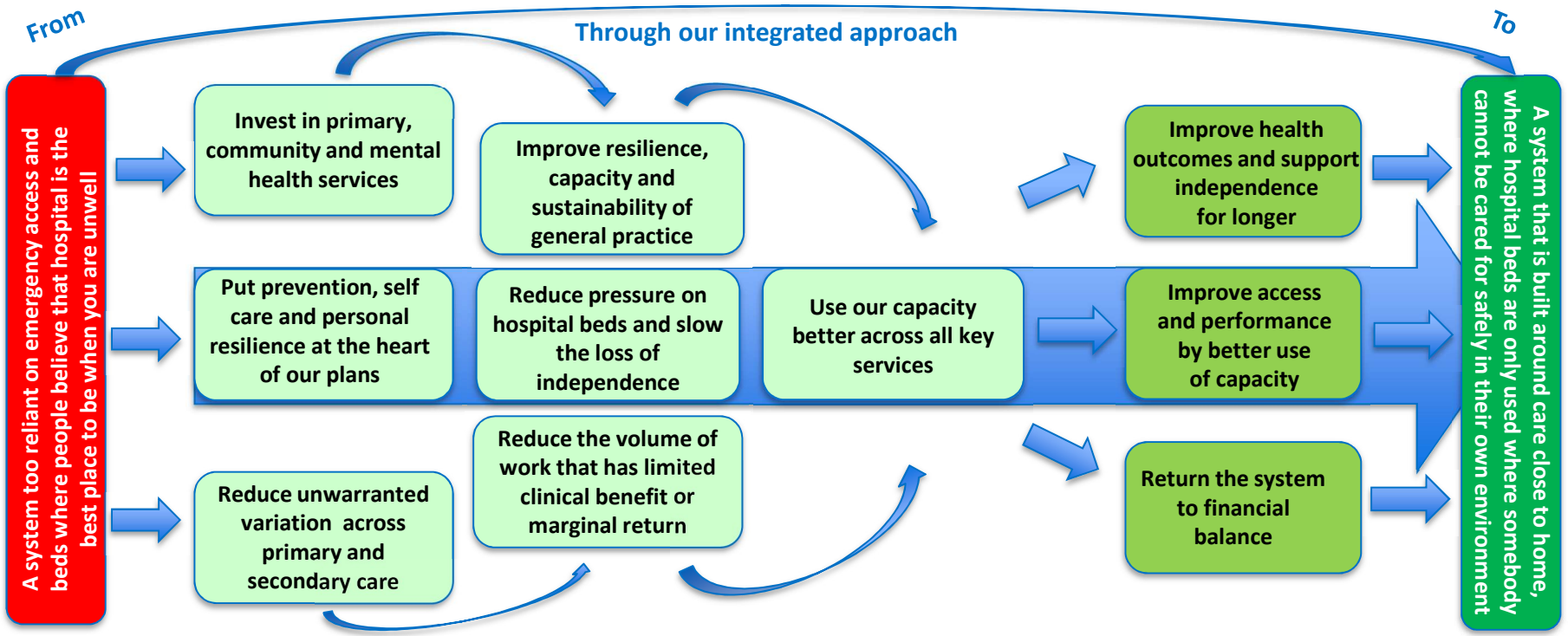
- Funding flows and contract reform will support the move to ICSs

  - Local alliance contracts or giving one provider lead responsibility

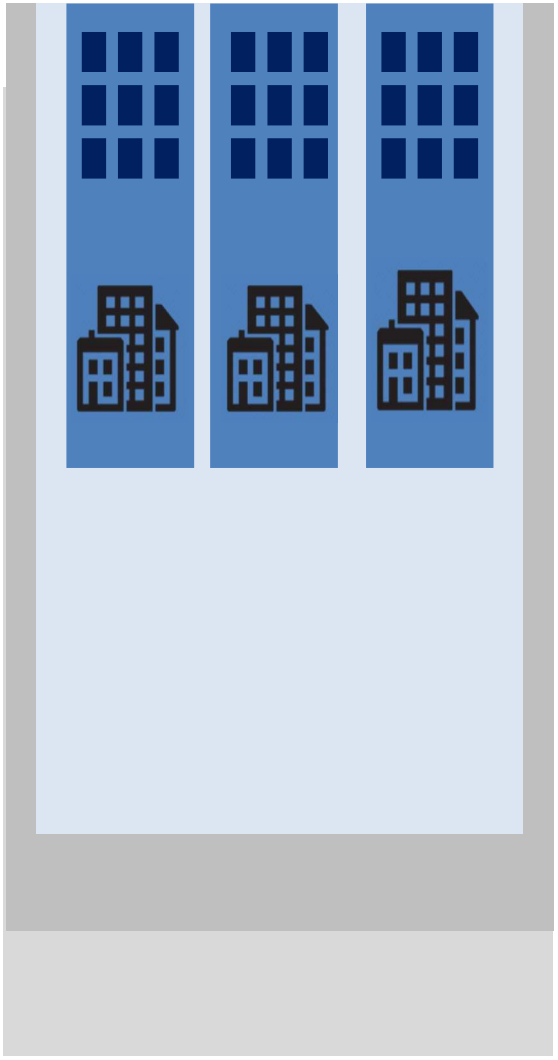
- Full review of the Better Care Fund concluding in early 2019

H&W STP Vision

"Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people"



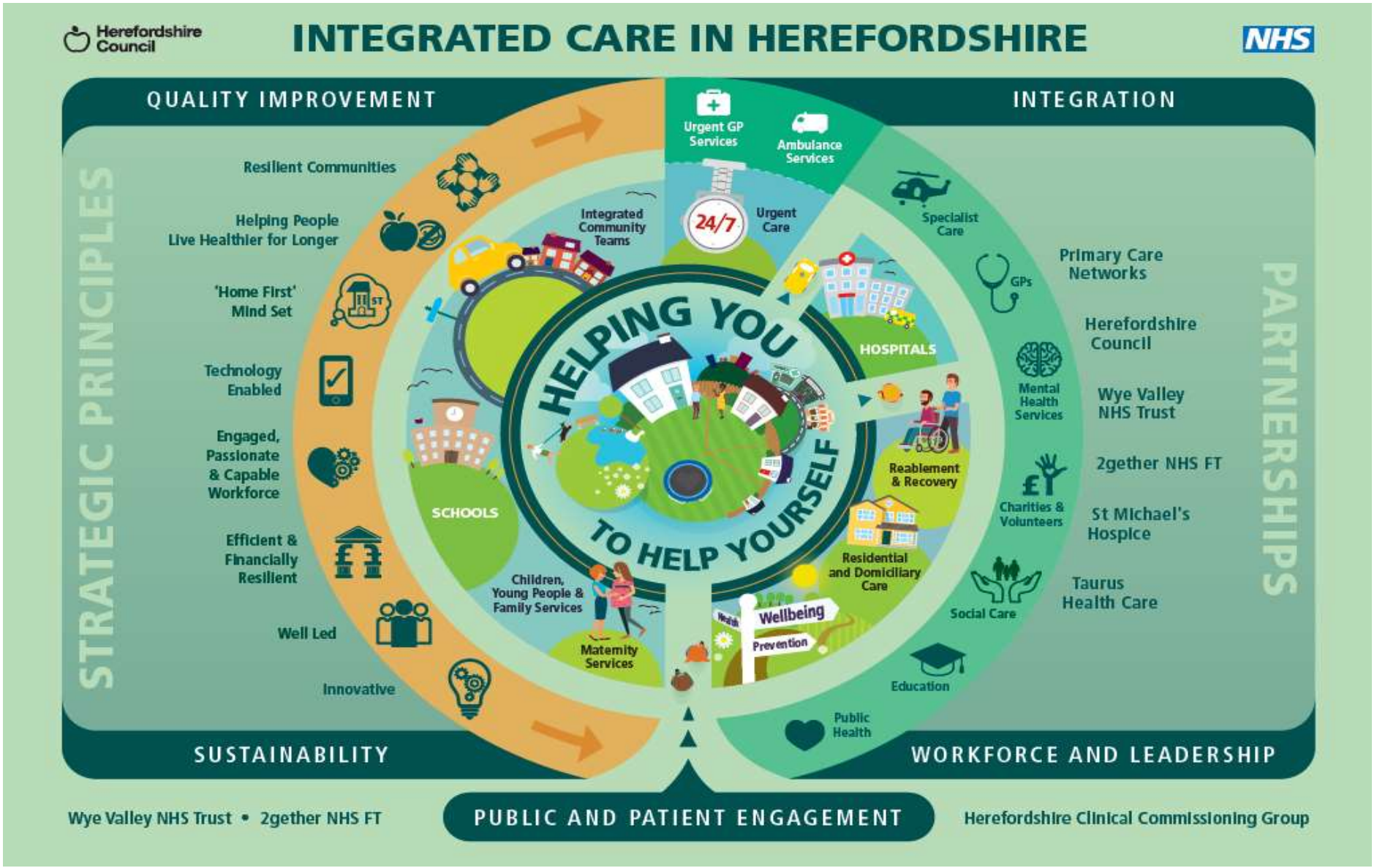
(Work In Progress)
The Tiers in an ICS



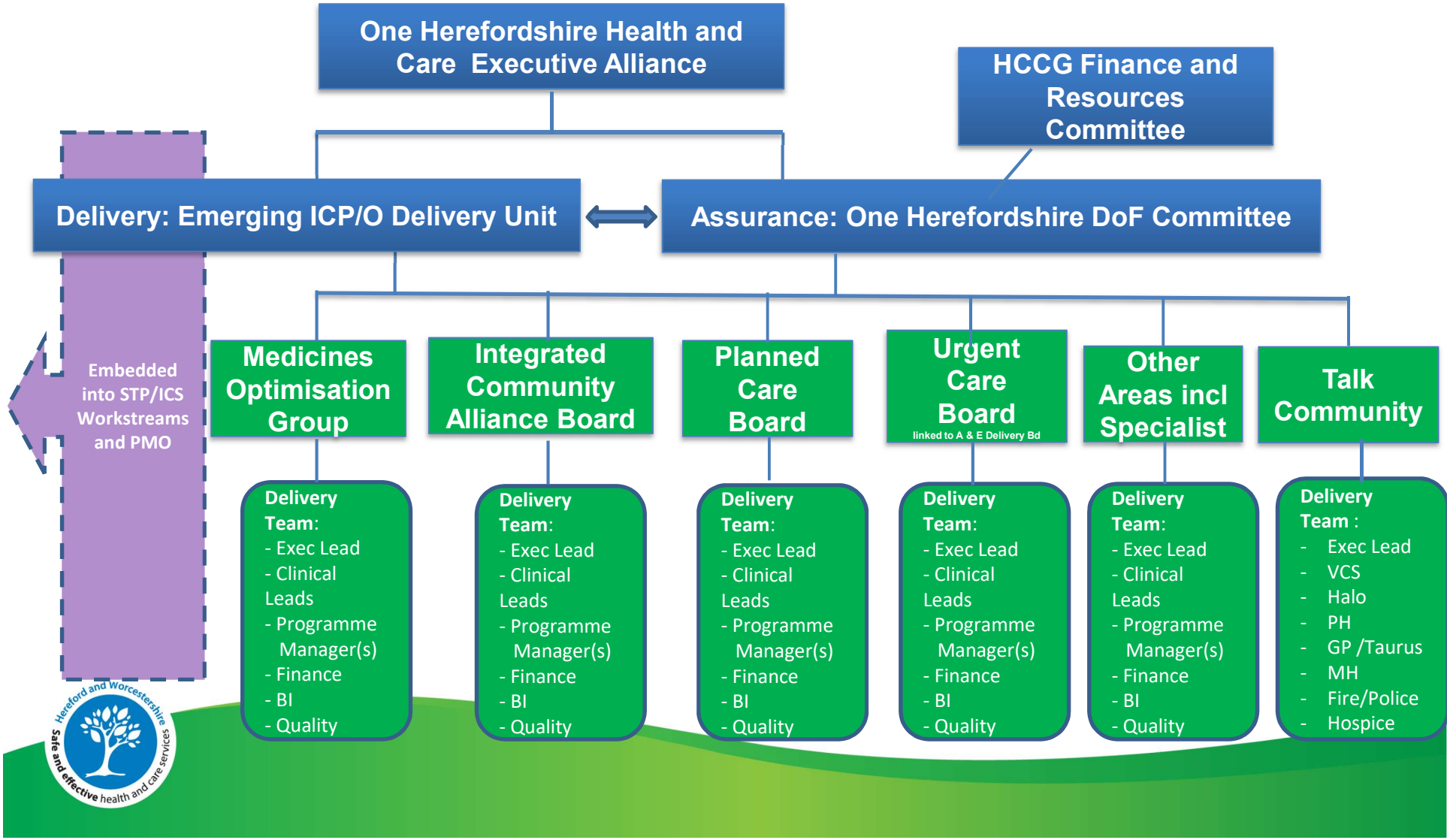
Neighbourhood (PCN) **~50k**	• Integrated multi-disciplinary teams • Strengthened primary care through PCNs – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).
Place **~250k**	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out of hospital care around specialties and for hospital discharge and admission avoidance
System-wide **~1m**	• System strategy & planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system; to reduce unwarranted variation in care / outcomes

One Herefordshire

- Our ‘Place Based’ Integration Plan – within the Herefordshire and Worcestershire ICS
- Herefordshire Partners ‘Whole System Plan’
- Functional Integration:
  - Integrating at the point of delivery
  - Looking for shared efficiencies
  - Not about Shifting Risk
- This is a 5 Year Plan


Herefordshire Council
INTEGRATED CARE IN HEREFORDSHIRE
NHS
QUALITY IMPROVEMENT
INTEGRATION
STRATEGIC PRINCIPLES
PARTNERSHIPS
Resilient Communities
Helping People Live Healthier for Longer
'Home First' Mind Set
Technology Enabled
Engaged, Passionate & Capable Workforce
Efficient & Financially Resilient
Well Led
Innovative
Urgent GP Services
Ambulance Services
24/7
Urgent Care
Integrated Community Teams
HELPING YOU TO HELP YOURSELF
HOSPITALS
SCHOOLS
Children, Young People & Family Services
Maternity Services
Reablement & Recovery
Residential and Domiciliary Care
Health
Wellbeing
Prevention
Specialist Care
GPs
Primary Care Networks
Herefordshire Council
Mental Health Services
Wye Valley NHS Trust
Charities & Volunteers
2gether NHS FT
St Michael's Hospice
Social Care
Taurus Health Care
Education
Public Health
SUSTAINABILITY
WORKFORCE AND LEADERSHIP
Wye Valley NHS Trust • 2gether NHS FT
PUBLIC AND PATIENT ENGAGEMENT
Herefordshire Clinical Commissioning Group

2019/20 Delivery and Assurance



Focus Session

A focus on the work of:

- *Talk Community*
- *Integrated primary and community services*

Talk Community Key Programmes

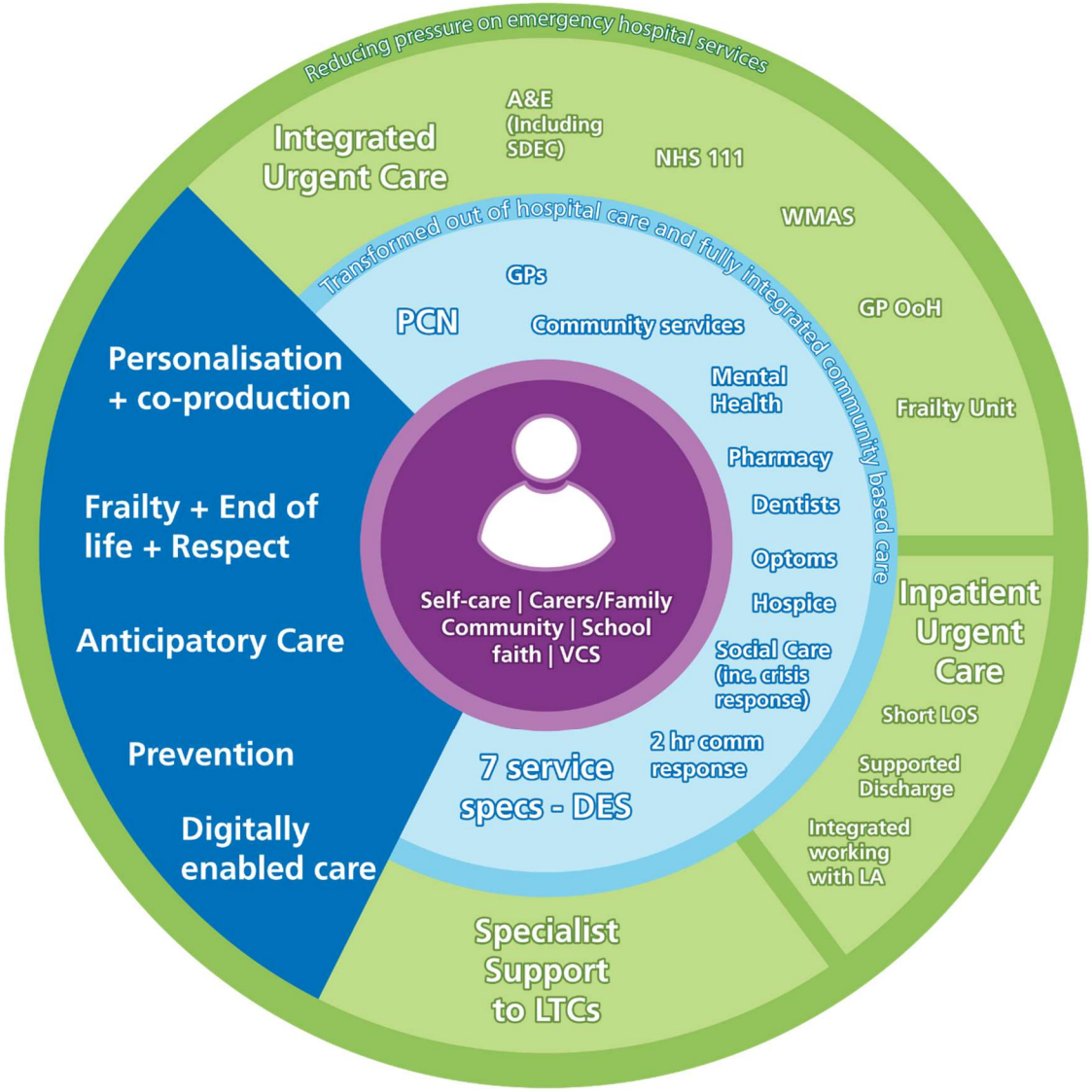
Talk Community will be implemented through detailed plans in six key areas;

- ❑ Talk Community Hubs
- ❑ The Commissioning approach
- ❑ Talk Community Business
- ❑ Talk Community Safety & Cohesion
- ❑ Talk Community public health
- ❑ Operational developments

Integrated Care Alliance Board Work Plan

Project	Lead Organisation
Development of locality Management Teams	Taurus/WVT
Development Support	Taurus
Primary Care Network Development	Taurus
Integrated HF team	Herefordshire Council
Integrated Out of Hours	WVT/Taurus
Integrated Discharge team	Herefordshire Council
High Intensity User	System approach
End of Life dementia pathway	CCG
Discharge to assess	Herefordshire Council
Integrated Psychological therapies	CCG
Community bed right sizing	CCG
BI and KPI	Taurus and system approach

To Deliver the Vision of Our STP Long Term Plan Submission



Delivering Our Commitment to Transform Out of Hospital Care and Fully Integrated Community Based Care, Reducing Pressure on Emergency Care

Our system commitment to	Outcomes we will deliver
Support people to age well by delivering integrated end to end pathways focused on anticipatory care to keep people well in their own home focusing on supporting frail and/or older people and those at the end of life	Functional integration with acute services and VCS Implementation of ReSPECT Delivery of ICOPE Strategy (Worcs) and replicate into H'fordshire
Increase the use of population health management to develop anticipatory care for targeted population cohorts	Reduce inequalities in access and reduce unwarranted variation Proactive care planning ensuring timely interventions
Deliver digitally enabled care and self care using a shared care record and information	Enhance the ability for individuals to take control of their care Facilitate rapid decision making to reduce acute admission
Delivery of a comprehensive high quality systemwide approach to frailty	Improved decision making for patients living with frailty Consistent approach in use of Rockwood Frailty Scoring tool
Delivering improved crisis response in the community within 2 hours and reablement care within 2 days	Reduction in emergency attendances and admissions Care closer to home
Delivering personalisation of care for patients with long term conditions empowering self-care by providing timely access to primary and secondary support in times of crisis	Improved access to services and delivery of right care at the right time. People feel better able to self-care and are supported to do so
Support for people living in care homes	Delivery of the 'Enhanced health in care homes'
Offering simplified access to healthcare providing alternatives to A&E	The public will have a better understanding of services available and when to access.
Focussing on rehabilitating the patients in the community and avoiding readmission supporting patients on discharge from hospital	Reduction in hospital re-admissions; patients feeling supported post discharge.
Give carers greater recognition and support	Identification of care status by primary care , Adoption of carers passports , Identification of carers and carers need in anticipatory care plans
Increase the provision of care in peoples homes	More people cared for in their place of residence
Support early discharge from hospital	Cross organisational working between system partners
Building capacity and workforce to deliver	Greater retention of staff and less reliance of agency

General Practice and PCN Development

By 2024 General Practice will:

Sustainable and comprehensive general practice through the commissioning of PCNs as the building block of integrated care will have become a proven platform for further local NHS investment. PCNs will systematically have delivered new services to implement the Long Term Plan and achieved clear, positive and quantified impacts for people, patients and the wider NHS. Our delivery model to achieve this is set out in our 5 year Primary Care Strategy .

Priorities:

- Sustainable general practice practices, working collectively within PCNs and through them with partners across health and care and the voluntary and community sector
- Implementation of the PCN DES 7 specifications by building on work already taking place
- PCNs to have formed clear and agreed multi-disciplinary teams with community provider partners and wider stakeholders
- Workforce & leadership development within and across PCNs, for clinical & non-clinical staff
- Improve quality, reduce unwarranted variation across the STP
- Ensure consistent, equitable, high quality services to patients and the public
- Remove the historic divide between Primary and Community Services
- Continued investment in general practice through local funding streams aligned to the PCN.
- Digital solutions to support the future model of care
- Consistent approach to development of Estate
- Consistent approaches to commissioning across the STP, equity of investment, supporting quality improvement as well as sustainability and efficiency

Provider and Commissioner Commitments:

There has been a collaborative approach to developing delivery plans across the STP working with the Local Medical Committee, GP federations, practices, patients and the public to ensure how we transform primary care services to meet the health needs of the population we serve. The establishment of a STP GP Provider Board will enhance these on-going conversations as the Strategy develops.

Unwarranted Variation and health inequalities:

- High numbers of older people living in poor health
- Premature mortality rates vary significantly between the two counties
- Men and women in contact with mental health services have a lower life expectancy than the rest of the population
- Addressing unwarranted variation in relation to referrals to acute care, prescribing, dementia diagnosis rate

Prevention:

- Commitment to radically scaling up prevention activities across all our health and care interactions with the population

PCNs will be key delivery mechanisms for:

- Immunisation and vaccination
- Identification, case finding and management of CVD risk factors
- Identification and case finding for National Diabetes Prevention programme
- Identification and case finding for smoking cessation and pulmonary rehabilitation
- Maintaining low-levels of antimicrobial prescribing in line with national targets

Workforce requirements:

Having access to a skilled workforce is the biggest challenge we face. To address this we will:

- Redesign the primary care workforce, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity
- Deliver STP workforce plan across 4 themes:
  - Developing a sufficient supply of highly skilled staff
  - Enabling up-skilling of the current workforce
  - Developing and promoting new roles
- Supporting pharmacy staff to take on increased patient facing roles
  - Developing and promoting new ways of working

Investment: £19.651m
Targeted Investment: £5.399m

Financial Recovery:

- Reducing pressure on secondary care through a reduction in non-elective admissions
- Reducing variation in referral rates and primary care prescribing

Personalised Care:

Shared decision making embedded within anticipatory care planning and roll out of RESPECT tool

Self management plans for people with Long Term Conditions

Digital:

- Delivery of on-line consultation offer in each practice by April 2020
- Delivery of a video consultation offer to all patients by April 2021
- Uptake of NHS App
- Offering all patients access to the Electronic Prescribing Service

General Practice and PCN Development

Timeline:								
Milestone	**Expected outcomes (LTP headline metrics included where available)**	**How we will achieve this**	**Delivery expected (Quarter)**				
			19/20	20/21	21/22	22/23	23/24
Meeting the new funding guarantees for primary medical services and community health services;	Delivery of outcomes set out in the Primary Care Strategy	Commissioning the 7 new national service specifications		x			
Creating a phased plan of the specific service improvements and impacts they will enable primary and community services to achieve, year by year, taking into account of the national phasing of the new 5-year GP contract	Delivery of outcomes set out in the Primary Care Strategy	Through delivery of the service improvements set out in the Primary Care Strategy and the GP contract framework	x	x	x	x	x
Support provided for PCN development		Funding released to ICS/STPs	x				
		Funding parameters agreed. National PCN development prospectus shared	x				
		ICS/STPs support PCNs in self assessment, identifying areas of initial focus and potential support needs, focus on service improvement area i.e. new national services	x				
		ICS/STPs collate support needs and put together system plan for PCN development - General Practice Transformation Board via PCN Development Sub Group	x				
		Systems and CCGs support PCNs to review progress against PCN priorities	x				
Delivery of: i) on-line consultation offer in each practice by April 2020 ii) a video consultation offer to all patients by April 2021 iii) Electronic prescribing service (EPS) and Electronic repeat dispensing eRD)	On-line consultations available in each practice by April 2020. Video consultation to all patients by April 2021 All practices to offer EPS and eRD from April 2019	Single GP on-line consultations programme in place across H&W	x				
		Evaluation of on-line consultations pilots	x				
		Testing and trialling of NHS App	x				
		H&W Wellbeing platforms enhanced		x			
		Common framework for Technology Enabled Care Services and pilot plan			x		

Integrated Primary and Community Services

Delivering our Vision

Priorities:
Work in partnership with General Practice to develop our PCNs to deliver integrated primary and community (health and mental health) services, with functionally aligned social care. This will embed:

- Personalisation and support for self-care
- Anticipatory care – for frail and/or older people and those at the end of life
- Enhanced health in care homes
- A 2 hour crisis response and reablement within 2 days
- Cross organisational working to support early discharge
- Population health management to drive service improvements and a shift to anticipatory care for targeted population cohorts
- Digitally enabled care and self-care, including shared records and information
- Improved Long Term Condition management, including self-management
- In partnership with general practice deliver the 7 service specifications from April 2020.
- Community service redesign to ensure service delivery at or close to home.
- Develop specifications to meet integrated care needs.
- Parity of esteem

Functionally integrating with acute services and the VCS as part of end to end pathways focused on anticipatory care and domiciliary based provision to keep people well in their own home, focused on:

- Frail and/or older people
- Those at the end of life

Redesigning bed based services to support people in their own homes whenever possible

Provider and Commissioner Commitments:

- To deliver the funding guarantee
- Support to PCN development – including alignment of community resources to PCNs and delegated decision making
- Acute support/out-reach to PCNs, underpinned by education, communication and shared information

Performance & metrics:

- Percentage of NHS revenue spent on primary and community services
- PCN access measure, to include access to online/telephone GP appointments
- GP workforce measures
- Impact on UEC system – A&E attendances and NEL admissions
- Reduced elective referrals
- Awaited national health inequalities measures by PCN
- Proportion of people who report being supported to manage their own condition
- Healthy life expectancy

Unwarranted Variation:
We will utilise our PHM approach to address unwarranted variation across PCNs in:

- NEL admissions and A&E rates
- Diagnostic use
- Referrals into secondary care
- Dementia diagnoses rates
- IAPT access
- Prescribing practice Frailty Diagnosis Rates - Advance Care Planning and Anticipatory Prescribing

Prevention:
PCNs and associated services will be key delivery mechanisms for:

- Immunisation and vaccination
- Identification, case finding and management of CVD risk factors
- Identification and case finding for National Diabetes Prevention programme
- Identification and case finding for smoking cessation and pulmonary rehabilitation
- Focus on High intensity users and carer identification
- Ageing Well Agenda - to prevent reduce or delay the onset of frailty

Workforce requirements:
GP Forward View delivery
Provider input – to be confirmed through templates based on capacity modelling
Carter report recommendations:
E-rostering, mobile working, dynamic scheduling
Impact on staff re. personalised care agenda
Address the vacancy gap in primary/community providers

Ageing Well investment over the 5-year period: £8.616m

Financial Recovery:
Finance to confirm – based on:

- impact on A&E and non-elective admissions
- Community bed redesign in Herefordshire

Personalised Care:

- Shared decision making embedded within anticipatory care planning and roll out of ReSPECT tool
- Self management plans for people with Long Term Conditions
- A frailty-sensitive approach to care

Digital:

- NHS app
- GP practice telephone/online consultations
- Shared records and information
- Data sharing to enable full delivery of Population Health Management approach

The Four Strategic Priorities for Integrated Primary and Community Services

Deliverable	Expected outcomes	Milestones (How we will achieve this)	Timeline				
			19/20	20/21	21/22	22/23	23/24
Delivery of an improved crisis response within two hours, and reablement care within two days	1. Reduced conveyance by Ambulance to Acute Care 2. Reduced A&E attendances and NEL admissions 3. Improved outcomes for patients – with reduced Hospital Acquired Functional Decline (HAFD)	**Baseline and Planning** Map existing provision across health, mental health and reablement services Specification for new service agreed – including acceptance/exclusion criteria, outcomes, KPIs Demand and capacity modelling for new service – linked to community bed redesign Operational planning including skill mix, competency and workforce development	X				
		PDSA Test and learn cycles to refine clinical model and pathway, and understand impact and risks Commences end of 2019/early 2020 linked to community bed redesign	X	X			
		Full Implementation – and Ongoing Refinement Service in place across the STP Ongoing evaluation and refinement of the model			X	X	
Delivery of the new national Anticipatory Care service in conjunction with PCNs providing 'anticipatory care' jointly with primary care (joint enterprise with GP practices as part of PCN delivery), to the following cohorts: • those living with moderate and severe frailty • those recognised as approaching the end of their lives	1. Reduced inappropriate conveyance by Ambulance to Acute Care 2. Reduced inappropriate A&E attendances and NEL admissions 3. Improved outcomes for patients – with reduced NEL admissions resulting in reduced Hospital Acquired Functional Decline (HAFD) 4. Increased achievement of death in preferred place of death	**Identification and management of frailty** using the Rockwood tool : • In 2019/20 by PCNs through local GP contracting arrangements (Primary care Excellence) • Anticipated to be in national PCN service specification in 2020 onwards • Use of CGA in proactive assessment with patient preferences guiding reactive response	X	X			
		MDT working between PCNs, community services (health and mental health) and social care, to identify and support • In 2019/20 through local GP contracting arrangements (Primary care Excellence) • Anticipated to be in national PCN service specification in 2020 onwards • Supported by regional PHM support offer • Identify other resources to support (e.g. housing)	X	X			
		Roll out of RESPECT tool: • Across PCNs and community services 2019 • Across acute providers – 2019 in Herefordshire, 2020 Worcestershire • Supported by training of General Practice, community services, care home providers, WMAS, acute providers and social care	X	X			
		Support PCNs to deliver **National Service Specification** • Understand requirements of national service specification • Engage with PCNs to agree operational delivery model • Develop implementation plan • Commence from 2020	X	X			
Supporting PCNs in the delivery of the new Enhanced Health in Care Homes	1. Reduced conveyance by Ambulance to Acute Care 2. Reduced A&E attendances and NEL admissions 3. Improved outcomes for patients – with reduced Hospital Acquired Functional Decline (HAFD)	**Baseline and Planning** • Care home engagement • Mapping of care homes to PCNs • Mapping of existing initiatives • Mapping of care home development needs against existing initiatives and national PCN service specification • Agree operational model incorporating national PCN specification– including co-ordination with local authority care home oversight	X				
		Implementation • Develop workforce plan • Develop implementation plans • Run test and learn cycles and review impacts, share best practice and grow impact		X			
		Final model in place • Implementation			X		

The Four Strategic Priorities for Integrated Primary and Community Services

Timeline:							
Deliverable	**Expected outcomes (LTP headline metrics included where available)**	**How we will achieve this**	**Delivery expected (Quarter)**				
			19/20	**20/21**	**21/22**	**22/23**	**23/24**
(iv) building capacity and workforce to do these three things, including by implementing the Carter report and using digital innovation	1. Increased recruitment 2. Increased retention 3. Resilient and upskilled workforce – able to deliver LTP requirements 4. Improved productivity	**STP Peoples Strategy** • Draft strategy in place – to be updated following publication of national strategy with clear delivery plans by programme (cross-organisational) • Detailing new roles, competency frameworks and cross-organisation approaches to recruitment, retention and staff development	X				
		Develop New Workforce model and culture • Generate baseline of current work force – capacity and competencies against new service requirements • Consider new roles and competencies to release other time or fill hard to recruit roles • Understand linkages to PCN (GP) workforce development • Develop OD plan – including cross organisational posts and training/education requirements • Commence recruitment	X				
		Implementation • Back office approaches to employment, training, supervision, staff development, recruitment and retention. • Commence test cycles for new ways of recruiting and employing staff.		X			
		Implement Carter Report • Digitally supported mobile working in place • Shared records and information across primary are and community services – in place from November 2019 • E-rostering – to be implemented in 2020	X	X			
		Training and Education in Frailty • Development of training modules Tier 1 2 and 3 of Core Capabilities framework – WhIN and university of Worcester					

Questions?