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
Delayed Transfer of Care

Go to Better Care Exchange >>

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)

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** 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	
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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
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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 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.	**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.**
	Numerator	257	260		
	Denominator	46,625	47,301		

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.	**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.**
	Numerator	80	80		
	Denominator	100	100		

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			