Herefordshire Council

Supplement to the agenda for

Health and wellbeing board

Monday 26 September 2022

3.30 pm

Plough Lane

Herefordshire Pharmaceutical Needs Assessment 2022

26th September 2022

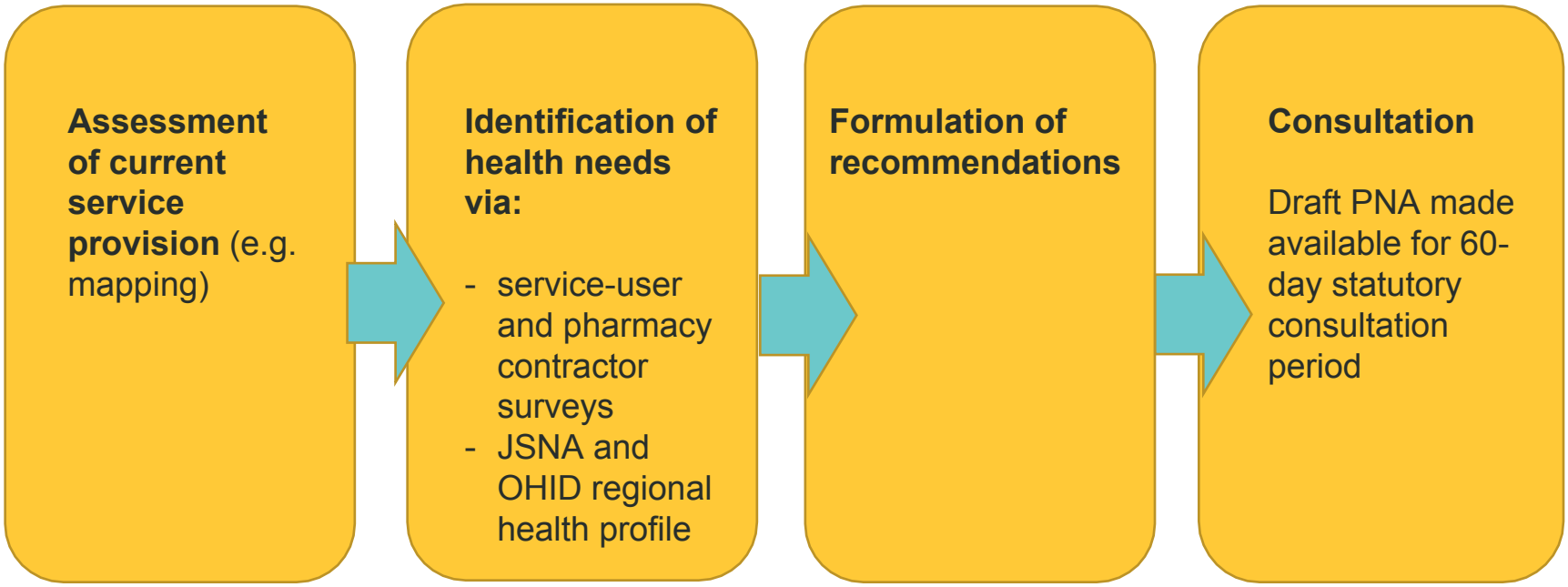
What is a PNA?

- The PNA provides an assessment of the current provision of pharmaceutical services across Herefordshire and whether this meets the needs of the population, identifying any potential gaps in service delivery

- The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 state that HWBs must produce PNAs every 3 years

- The HWB has delegated responsibility for the development of the PNA to a working group

What is the PNA process?



- The statutory 60-day consultation period for this PNA ends on 29th September 2022 (Thursday)
- The publication deadline is 1st October 2022

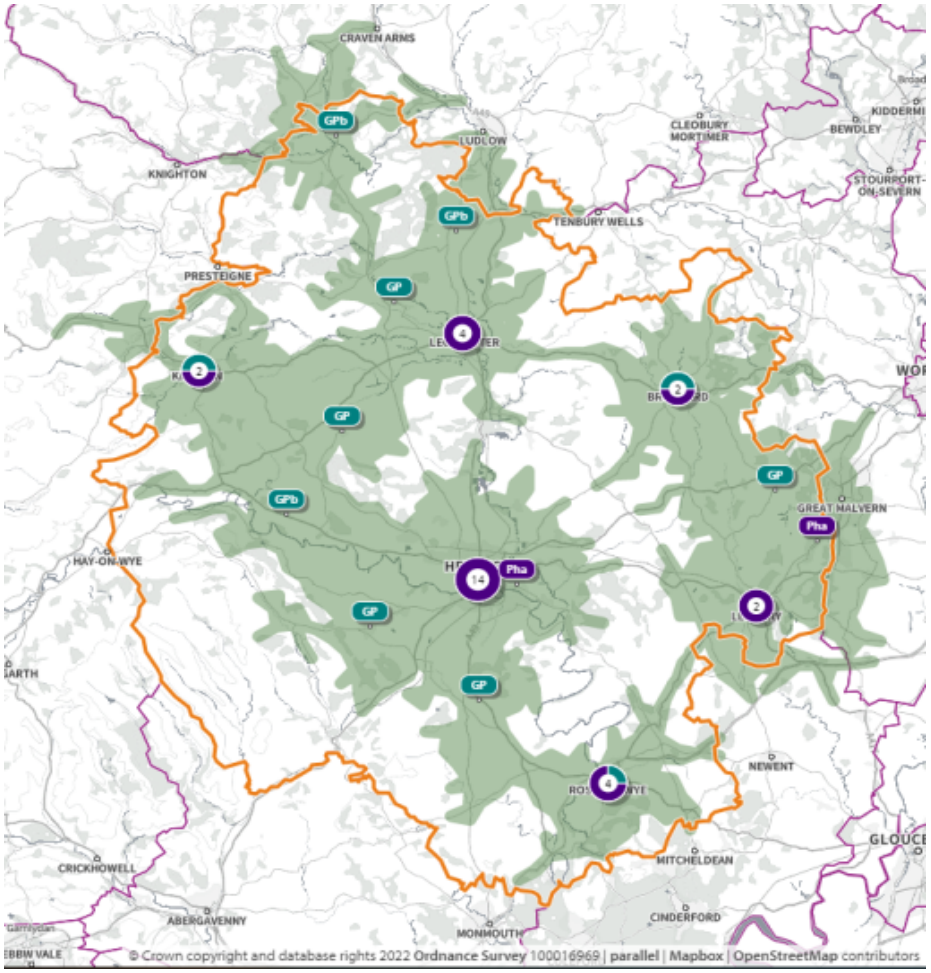
Assessment of current service provision

- The locations of pharmacies and contractors were mapped, along with the services provided by pharmacies in each PCN area

				2020 Mid-Year Estimates	
Primary Care Network	Pharmacies	Dispensing Practices	Total Contractors	Population per pharmacy (England=5056)	Population per contractor (England=4605)
East	4	2	6	7,461	4,974
Hereford City	15		15	5,438	5,438
North and West	5	4	9	8,391	4,662
South and West	3	4	7	13,413	5,748
Total	**27**	**10**	**37**	7,171	5,233

- Travel time analysis indicates good access to services by car **(the entire population lives within a 20-minute car journey to a pharmacy or GP dispensing practice)**
- Around 64% of the total population of Herefordshire live within a 30 minute walking distance of a pharmacy of GP dispensing practice
- 64% of the population can access a community pharmacy or dispensing practice within 30 minutes by public transport on a weekday morning
- On Sundays 7 of the 27 pharmacies in the county are open

10 minute travel time (car) to pharmacies/dispensing practices within Herefordshire (91% of population)



Assessment of services continued…

- Community pharmacies provide pharmaceutical services under the NHS Community Pharmacy Contractual Framework in three categories:

  - Essential Services
  - Advanced Services
  - Locally Commissioned and Enhanced Services

- Pharmacies must provide all Essential Services, but they can choose whether or not they wish to provide Advanced and Enhanced services

- Where possible the provision of services offered was assessed at a PCN level

- **Analysis indicates adequate provision of most services across the county**

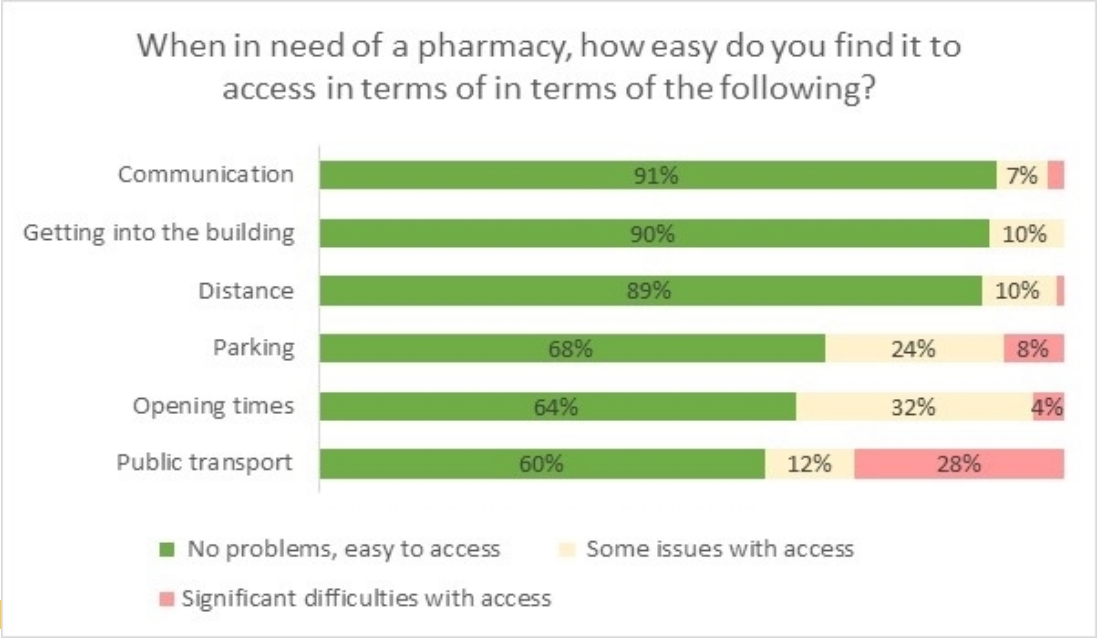
- There are some areas currently under development or consideration, including:

- hypertension case-finding (currently not available in North and West PCN)
- needle and syringe exchange (only one pharmacy is providing this in Hereford City)
- sharps disposal (not currently commissioned in Herefordshire)

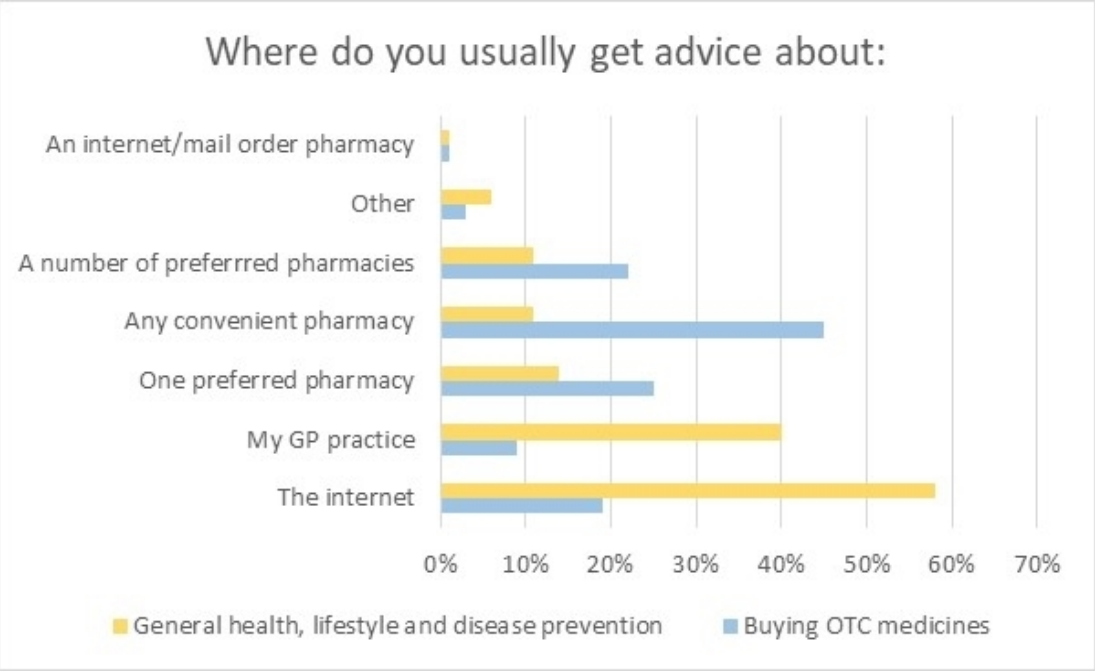
Identification of health needs - Public Survey

- The Pharmacy Services Public Questionnaire was published online (10th November 2021-31st January 2022) and asked about service-user experience – promoted widely
- 181 responses received – a small self-selected sample - not representative
- Survey asked questions about access, opening times and levels of satisfaction with the advice and information they receive
- A large majority found accessing pharmacy services was easy in terms of communication, accessibility of building and distance. Some respondents noted 'some issues' or 'significant difficulties' with access in terms of:

- Parking (32%)
- Opening times (36%)
- Public transport (40%)



- 72% were very satisfied or fairly satisfied with the amount of information that they normally received about medication from their community pharmacy or dispensing practice
- Most respondents used pharmacies to obtain advice on buying OTC medicines. However, they reported that they usually get advice about health, lifestyle and disease prevention from the internet or GP practice, despite 83% being aware that pharmacists can provide this.



Pharmacy Contractor Survey

- Community pharmacies and dispensing practices also completed questionnaires about accessibility, the services they provide and those they would be willing to provide if commissioned
- Responses were received from 17 out of 27 community pharmacies and 6 out of 10 dispensing practices within Herefordshire
- Gaps in data on services provided were filled manually using data held by NHSE
- All responding contractors said that the door to the pharmacy is accessible to all customers, including those who use pushchairs, wheelchairs and walking frames. There is disabled parking available outside most pharmacies and all dispensing practices
- Almost all community pharmacies reported willingness to provide a wide range of additional services if they were to be commissioned

Identification of health needs - JSNA & OHID regional health profile

- Health and well-being needs of the Herefordshire population were identified using the JSNA and OHID regional health profile, focussing on issues where there is opportunity for community pharmacies to meet needs

- Over half of the population live in areas defined as ‘rural’

- The county has a relatively older age structure compared with nationally with a quarter of the population aged 65 or over

- Herefordshire has on average, relatively low levels of overall multiple deprivation. The most deprived IMD domains are the indoor living environment and geographical barriers to services

JSNA Level	Indicator	Issue
Protecting the vulnerable	Multiple Complex Vulnerabilities	150 individuals with MCVs identified at the start of the pandemic - increased risk of chaotic lifestyles and dying prematurely
	Domestic Abuse	An estimated 4,900 women and 2,400 men were victims of domestic abuse 2019-2020
Housing	Fuel Poverty	In 2019, 17% (14,000) households suffered fuel poverty. 27.7% more deaths occurring in the winter months than the non-winter months
Getting a good start	Smoking in pregnancy	11.5% of mothers are smokers at the time of delivery
	Child overweight & obesity	In 2019/20 26% of Reception children and 34% of Year 6 were overweight. Obesity twice as likely in most deprived compared to least deprived
	Child oral health	Child oral health is significantly worse than across England - a third of 5 year-olds showed visible signs of decay in 2018/19
Healthy Lifestyles	Adult overweight & obesity	67% adults overweight/obese
	Adult smoking	Smoking prevalence in routine and manual occupations is 28.6%. Higher than the regional and national rates (23.3% and 24.5% respectively)
	Diabetes diagnosis	The diabetes diagnosis rate in Herefordshire is 70.1%. Lower than the regional and national rates (86.3% and 78.0% respectively)
	Dementia diagnosis	The estimated dementia diagnosis rate in Herefordshire is 51.0%. This is lower than the regional and national rates (58.1% and 61.6% respectively)

Recommendation	Who?
Pharmacies should work with partners in the system to reduce vaccine inequalities, promoting the flu vaccine offer, particularly in deprived communities. Pharmacies should also contribute to other vaccination programmes.	Pharmacies PCNs Taurus Healthcare Local Authority Public Health Team
Flexibility around opening hours should be considered, including the option of extending existing contractors' opening hours on a locally commissioned rota basis.	Pharmacies Pharmacy Commissioning Lead
Encourage secondary care based pharmacy colleagues to begin to incorporate DMS into their discharge processes. The focus should be on discharges for frail patients, those on high risk medicines and those whose primary diagnosis is shown to be a frequent cause of readmission before 30 days.	ICB/ICS and system partners
Pharmacies in areas of deprivation should be particularly encouraged to implement and promote blood pressure checks.	Pharmacies
Formation of a network of pharmacy Health Champions should be explored, in partnership with the local public health team. This could be utilised to achieve improved and consistent practice to maximise the health promoting role of community pharmacies.	Local Authority Public Health Team Integrated Care System (ICS) Pharmacy Lead for Herefordshire Local Pharmaceutical Committee
Clear pathways need to be established for the disposal of all sharps and waste medicines as part of a redefined service.	Pharmacy Commissioning Lead

Recommendation	Who?
Volunteer efforts initiated during COVID-19 lockdowns, to facilitate pharmacy access for those living in rural communities should continue where possible under the responsibility and discretion of the pharmacist/pharmacy.	Talk Community Local Authority Public Health Team
Ensure that pharmacies have access to up-to-date information about non-medical service directories, for example, social prescribing. Pharmacies should also be aware of key local issues such as fuel poverty, domestic violence and mental health.	Local Authority Public Health Team Health Champions Network
If child oral health is not identified as a national priority, local resource should be provided to enable pharmacies to give this support and advice on a voluntary basis.	Local Authority Public Health Team Health Champions Network
Consider increasing the availability of commissioned services such as: • weight management • pharmacotherapy and behavioural support for smoking cessation • NHS Health checks • Diabetes Prevention	Commissioners across the system
Consider and further explore the availability and use of translation services in pharmacies. NHSE do not currently commission translation services for pharmacies to access.	PNA Working Group

Consultation

- The statutory 60-day consultation period for this PNA ends on 29th September 2022 (Thursday)

- 12 responses have been received from 3 contributors (LPC, practice manager and an NHS contracts manager)

- All comments have been worked through, all except one were actioned and changes can be seen in the most recent version

- Amendments are broadly in the following categories:
  - Clarification of data, e.g. rurality classifications and no. of PCN dispensing practices (2)
  - Updated opening hours (1)
  - Clarity of wording (7)
  - Formatting (1)

Conclusions

- This PNA has found that the level of access to pharmaceutical services currently commissioned across Herefordshire generally meets the needs of the population

- the role of community pharmacies in preventing ill-health and supporting self-care could be strengthened through the existing pharmacy contractor base

- Recommendations were made using data from public and contractor surveys, the JSNA, OHID regional health profile and the 2018 PNA

- We suggest that the Health and Wellbeing Board review progress annually, and that a Herefordshire PNA Working Group is set up to progress the recommendations. This working group will work closely with a proposed Worcestershire PNA Working Group

Herefordshire Council

Title of report: Herefordshire's Better Care Fund (BCF) Integration plan 2022-23

Meeting: Health and wellbeing board

Meeting date: Monday 26 September 2022

Report by: Integrated Systems Lead, All Age Commissioning

Classification
Open

Decision type

This is not an executive decision

Wards affected
(All Wards);

Purpose

To update Health and Wellbeing Board members on Herefordshire's Better Care Fund (BCF) Integration Plan for 2022-23 and seek formal Health and Wellbeing Board approval.

Recommendation(s)
That:

a) **the Herefordshire Better Care Fund narrative plan, planning template and capacity and demand template be approved; and**

b) **note work ongoing to support integrated health and care provision that is funded via the BCF.**

Alternative options

1. The board could decline to approve the submission. It is a national condition that the plan is approved by the Health and Wellbeing Board (HWBB). If it is not approved then the national BCF escalation process, as detailed within the planning requirements will be implemented to support and ensure compliance.

Further information on the subject of this report is available from
Marie Gallagher, Tel: 01432 260435, email: Marie.Gallagher1@herefordshire.gov.ukl

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 BCF provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Herefordshire & Worcestershire Integrated Care Board (HWICB) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), and the improved Better Care Fund (iBCF).

4. The BCF in 2022-23 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 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, the County Plan, Health and Wellbeing Strategy, Talk Community Plan and the NHS Long Term Plan.

6. The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) published the policy framework for the implementation of the Better Care Fund 2022-23 in July 2022. BCF plans are required to be submitted by 26 September 2022.

7. For 2022/23 submissions consist of:

   i A BCF narrative plan (**Appendix 1**)

   ii A BCF planning template including planned expenditure, confirmation that national conditions are met, ambitions for national metrics and additional contributions to BCF section 75 agreements. (**Appendix 2**)

   iii An intermediate care capacity and demand plan (this will not be subject to assurance). (**Appendix 3**)

8. The Better Care Fund planning requirements **(Appendix 4**) indicates the national conditions that BCF plans must meet:

   i. A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.
   ii. NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
   iii. Invest in NHS commissioned out-of-hospital services.
   iv. Implementing the BCF policy objectives.

9. The BCF policy framework sets out the national metrics for the BCF 2022-23, as follows:

Avoidable admissions to hospital	Unplanned admissions for chronic ambulatory care sensitive conditions
Admissions to residential / nursing care homes	Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population

Effectiveness of reablement	Proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation
Discharge destination	Improving the proportion of people discharged home based on data on discharge to their usual place of residence

10. Herefordshire's BCF submission 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 changes between the previous plan and the 2022-23 plan are minimal. Partners across the system are continuing to work together towards their shared vision.

11. As per the requirements for the national programme, this plan will be submitted on the national deadline of 26 September 2022, following approval from the board. A regional assurance process will then be undertaken by 24 October 2022 and approval letters should be received week commencing 28 November 2022.

12. The existing governance arrangements for the BCF will remain in place for 2022-23, where the HWBB is responsible for agreeing the BCF plan and for overseeing delivery through quarterly reports. The BCF plan and the programmes of integration work that are within the BCF and plan are reported to a number of council, system and HWICBs.

Community impact

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

14. Talk Community brings together community, third sector and statutory services to connect with peers and share ideas and experiences within the local PCN areas - working with communities to identify and address issues that affect them, increase sustainability of communities by facilitating the development of partnerships and collaborative approaches and helping identify any gaps in provision.

Environmental Impact

15. Herefordshire Council provides and purchases a wide range of services for the people of Herefordshire. Together with partner organisations in the private, public and voluntary sectors we share a strong commitment to improving our environmental sustainability, achieving carbon neutrality and to protect and enhance Herefordshire's outstanding natural environment.

16. Whilst this is a decision on back office functions and will have minimal environmental impacts, consideration has been made to minimise waste and resource use in line with the Council's Environmental Policy.

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 council and HWICB 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. 27. 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.

19. 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.

20. 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 Sustainability and Transformation Partnership (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 which the BCF will be included.

21. 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

22. The Herefordshire BCF plan 2022-23 maintains the key schemes identified in the 2021-22 submission. These include operational social work, NHS community services, Talk Community, Home First, Hospital at Home, brokerage, support for carers, discharge to assess, trusted assessors and falls response and prevention.

23. 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.

24. 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. Since 2020-21, funding that was previously paid as a separate grant for managing winter pressures has been included as part of the iBCF grant, but is not ringfenced for use in winter.

25. Herefordshire Better Care Fund Summary 2022/23

Pool 1- Minimum Mandatory Contributions	**2021/22 £**	**2022/23 £**	***Change Between Years***
Planned Social Care Expenditure	6,157,462	6,505,974	*5.66%*
NHS Commissioned Out of Hospital Care	8,163,907	8,625,984	*5.66%*
Total Minimum Mandatory Contribution from CCG	**14,321,369**	**15,131,959**	***5.66%***
Disabled Facilities Grant (Capital)	2,268,653	2,268,653	*0.00%*
Total Pool 1	**16,590,022**	**17,400,612**	***4.89%***

Pool 3- Improved Better Care Fund	**2021/22 £**	**2022/23 £**	***Change Between Years***
IBCF Grant	6,583,421	6,782,841	*3.03%*
Total Pool 3	**6,583,421**	**6,782,841**	***3.03%***

Please note that there is intentionally no pool 2, as it is for additional voluntary contributions to the BCF, of which there are none from either partner.

26. Where any procurement activities arise from the plan they will be procured in line with the council's contract procedure rules.

Legal implications

27. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. 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.

28. Health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.

29. Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.

30. Overseeing the deployment of BCF resources locally is a key part of their remit. BCF plans have to be signed off by the health and wellbeing board as well as the HWICB, which represents the NHS side of the equation

31. 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.

32. The iBCF is paid directly to the council via a Section 31 grant from the Department of Levelling Up, Housing and Communities (DLUHC). 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

33. Monitoring the delivery of the Herefordshire BCF Plan is undertaken by the council and HWICB. The Integrated Systems Lead monitors any risks, which are managed through the community and wellbeing directorate risk register where necessary.

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/national assurance process	The council and HWICB have worked through the national guidance and requirements to ensure a robust response and a comprehensive, detailed plan is submitted.
Failure to achieve national metric ambitions	A robust process form monitoring activity on a monthly basis is in place and will be monitored through the joint strategic commissioning partnership group.

Consultees

34. Views were sought from key stakeholders from across the health and social care system prior to submission. These views have generally reinforced the commitment to integrated working across the local system and the importance of continued funding of core essential services in social care and community health which support that integration and dellver best outcomes for local people.

Appendices

Appendix 1 – Herefordshire's BCF narrative plan 2022-23
Appendix 2 – BCF planning template (planned expenditure)
Appendix 3 – Intermediate care capacity and demand plan
Appendix 4 – Better Care fund planning requirements 2022-23

Background papers

None identified

Report Reviewers Used for appraising this report:

Governance	Matthew Evans	Date 21/09/2022
Finance	Kim Wratten	Date 18/09/2022
Legal	S Evans	Date 20/09/2022
Communications	Luenne Featherstone	Date 18/09/2022
Equality Duty	Carol Trachonitis	Date 18/09/2022
Procurement	Lee Robertson	Date 20/09/2022
Risk	Jo Needs	Date 20/09/2022

Approved by	Hilary Hall	Date 22/09/2022

BCF	Better Care Fund
iBCF	Improved Better Care Fund
HWICB	Herefordshire & Worcestershire Integrated Care Board
HICM	High Impact Change Model
HWBB	Health and Wellbeing Board
DFG	Disabled Facilities Grant
D2A	Discharge to Assess
DHSC	Department of Health and Social Care
DLUHC	Department of Levelling Up, Housing and Communities

Herefordshire Better Care Fund Plan 2022/23

Herefordshire Health and Wellbeing Board

September 2022

Contents

1. Executive summary

The Better Care Fund (BCF) programme aims to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people, and their families and carers. A key principle of the BCF is to use a pooled budget approach in order for health and social care to work more closely together. As the population ages, the need for integrated care to improve people's experience of health and social care, the outcomes achieved and the efficient use of resources has never been greater.

Our priorities for 2022-23

Herefordshire's Better Care Fund (BCF) Plan for 2022/23 will continue to support our long-term vision, and build on previous system priorities and strengthen what has been achieved so far. Our plan sets out the work we need to do to further develop the way we work together on our shared priorities to deliver key outcomes for local people. Priorities for the BCF 2022-23 include:

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

Herefordshire's BCF funding continues to be used for several key core social care and NHS community services - operational social work, brokerage, integrated discharge, community health and care services, Deprivation of Liberty Safeguards **(**DoLS), short-term and long-term placements in home care and care homes, and discharge to assess; it is central to the delivery of health and social care in the community.

Herefordshire continues to invest in services which improve the health and wellbeing of people in Herefordshire, by enabling people to take greater control over their own health and the health of their families, and helping them to remain independent within their own homes and communities.

System partners are working together to ensure that robust metrics are in place.

Metric	Detail
Avoidable admissions	Unplanned Admissions for chronic ambulatory care sensitive conditions (NHS OF 2.3i)
Residential care admissions	Annual rate of older people whose long term support needs are best met by admission to residential and nursing care homes. (ASCOF 2A part 2)
Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement (ASCOF 2B part 1)
Discharge destination	Percentage of discharges to a person's usual place of residence (SUS data)

Detailed information regarding spend allocation for the BCF 2022-23 is available in the planning template. The table below provides a high level summary which highlights key focus areas of spend including community based schemes, integrated care planning and navigation and reablement in a person's own home.

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£4,300,073
Planned spend	£8,625,984

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£6,505,975
Planned spend	£6,505,974

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£1,292,021	(5.3%)
Carers Services	£483,220	(2.0%)
Community Based Schemes	£8,315,321	(34.4%)
DFG Related Schemes	£2,268,653	(9.4%)
Enablers for Integration	£658,557	(2.7%)
High Impact Change Model for Managing Transfe	£1,321,985	(5.5%)
Home Care or Domiciliary Care	£298,523	(1.2%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£4,066,891	(16.8%)
Bed based intermediate Care Services	£796,657	(3.3%)
Reablement in a persons own home	£3,081,270	(12.7%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£445,511	(1.8%)
Residential Placements	£1,154,843	(4.8%)
Other	£0	(0.0%)
Total	**£24,183,452**	

Key changes since our previous plan

Since our previous BCF plan, our focus has increasingly been on the way we can further integrate our services to support people, and focus on broader engagement and links with primary care and the voluntary sector.

Several key 'place' level challenges are understood and partners are working together to address, for example, recruitment and retention of staff across care sector and cost of living care in a rural community. There are many opportunities for further joined up working and the BCF continues to support the delivery of Herefordshire's HWBB and Integrated Place Strategy and Priorities.

New ways of thinking and models of delivery that require a collaborative and flexible approach to deploying our resources, including our workforce, to meet system wide pressures, not only in hospitals, but also in social care, primary care, mental health and community-based services are continually being explored.

We are applying health inequalities considerations to our work in the BCF, in terms of how the activities are supporting people that are more likely to experience adverse outcomes and ensuring a culturally sensitive approach.

2. Background and context

Herefordshire is a predominantly rural county, with the fourth lowest population density in England. The city of Hereford, in the middle of the county, is the centre for most facilities; other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington. 95 per cent of the land is classified as rural, with 53 per cent of the county's population living in rural areas.

The Joint Strategic Needs Assessment, published by Herefordshire Council, is the main source that has informed the population assumptions; in addition, the Older People Needs Assessment (2018) has qualified levels of frailty and dementia across our population. Further local data can be found at: Home - Understanding Herefordshire. The main challenges for Herefordshire are rurality, sparsity of population, and ageing population. The BCF metrics bear this out, as older adults are more likely to have longer lengths of stay in hospital and are less likely to be discharged home. The BCF plan aims to address these challenges through improved integrated discharge, integrated and expanded community services, increased reablement through discharge to assess, upstream interventions to reduce hospital admissions and by strengthening community resilience through Talk Community.

All partners continue to be committed to equality and diversity using the scope of the Equality Act 2010 and demonstrate that we are paying 'due regard' in our decision making in the design and delivery of services. It is fundamental that individuals are at the heart of all activities and services. All partners continue to work to enable all people to access services, and ensuring those people requiring additional support due to, for example, a learning disability and/or autism, have equal access to services and are supported to be as independent as possible in the community wherever possible.

The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the act. This is through improving the health and wellbeing of people in Herefordshire by enabling them to take greater control over their own homes and communities. Where appropriate, an Equality Impact Assessment (EIA) is undertaken for separate schemes and services that are within the BCF. Where large changes are planned via the BCF an EIA will be completed. It is not envisaged that the content of this plan will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender reassignment, marriage and civil partnerships (in employment only), pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The council has worked across all directorates to support businesses, residents and communities throughout the pandemic to remain as safe as possible and to prevent and reduce spread of infection and protect those most vulnerable in our society. The focus now moves towards recovery. To support the recovery a Recovery Plan is currently being delivered, which focusses upon the local economy, community wellbeing and organisation. The recovery plan also focuses on the immediate actions needed in the short term and priorities include:

Through the partnerships with Public Health, Voluntary Community Social Enterprise (VCSE) and trusted local voices, we can connect with our communities to improve relationships with those who experience the greatest health inequalities. Organisational development is required to build awareness, knowledge, skills and clearly set out the relevance to everyone's role on how they can reduce health inequalities.

3. Planning Requirement (PR1)
A jointly developed and agreed plan /involving stakeholders

Ongoing, system wide discussions and meetings have enabled a range of key stakeholders to be involved in the preparation and review of proposals that sit within the Better Care Fund (BCF) plan 2022/23.

Engagement and involvement has been through a variety of system and internal meetings, including the One Herefordshire Partnership, which brings partners together at Place level as part of the Integrated Care System in Herefordshire and Worcestershire, and through the sharing of data and wider documentation.

Ongoing engagement and collaboration via Talk Community has enabled the VCSE sector to contribute to priorities and ongoing developments highlighted in the plan. At a strategic level housing colleagues continue to input into priorities and developments associated with the BCF plan including representation at appropriate board meetings.

Key stakeholders involved include:

Herefordshire Council internal stakeholders (including Cabinet Member), One Herefordshire Partnership, Wye Valley NHS Trust (WVT), Herefordshire and Worcestershire Health Integrated Care Board (HWICB), Primary Care Networks, Taurus Healthcare, Clinical Practitioners Forum, Joint Strategic Commissioning Executive Group, Herefordshire Health Watch and voluntary and community organisations.

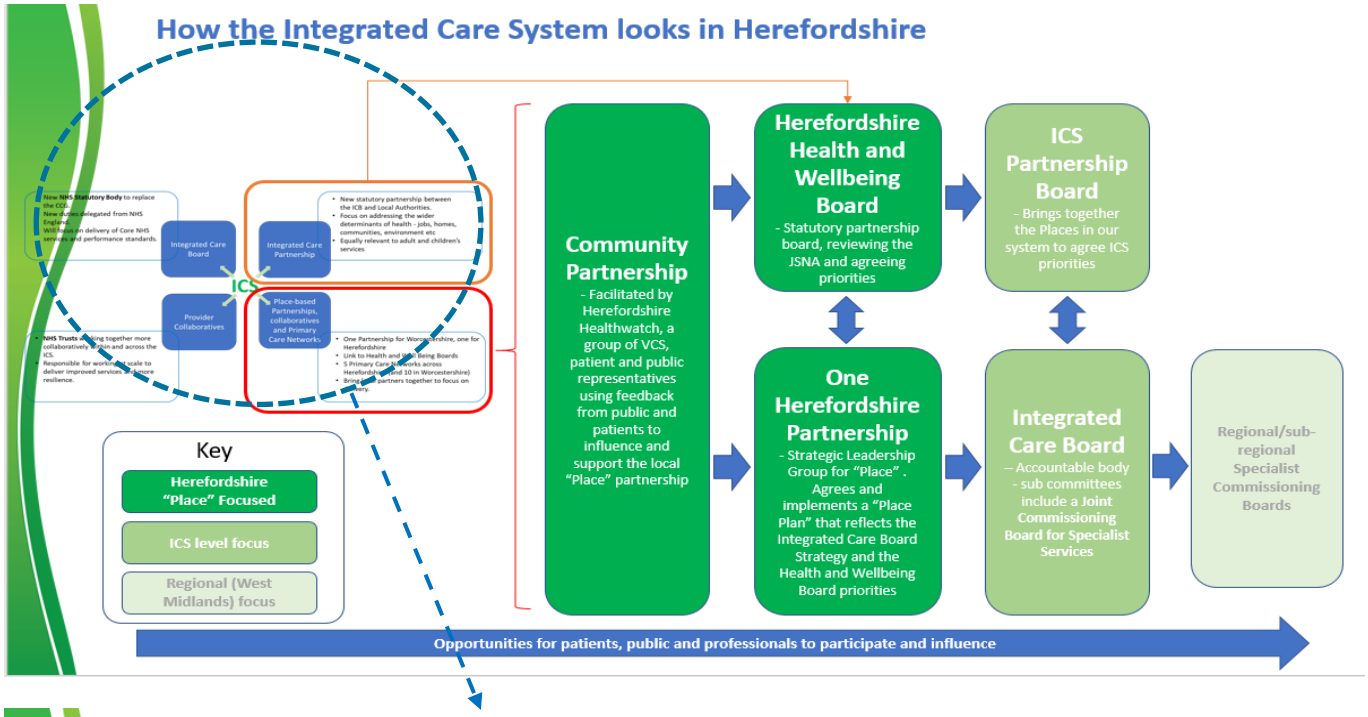
Governance

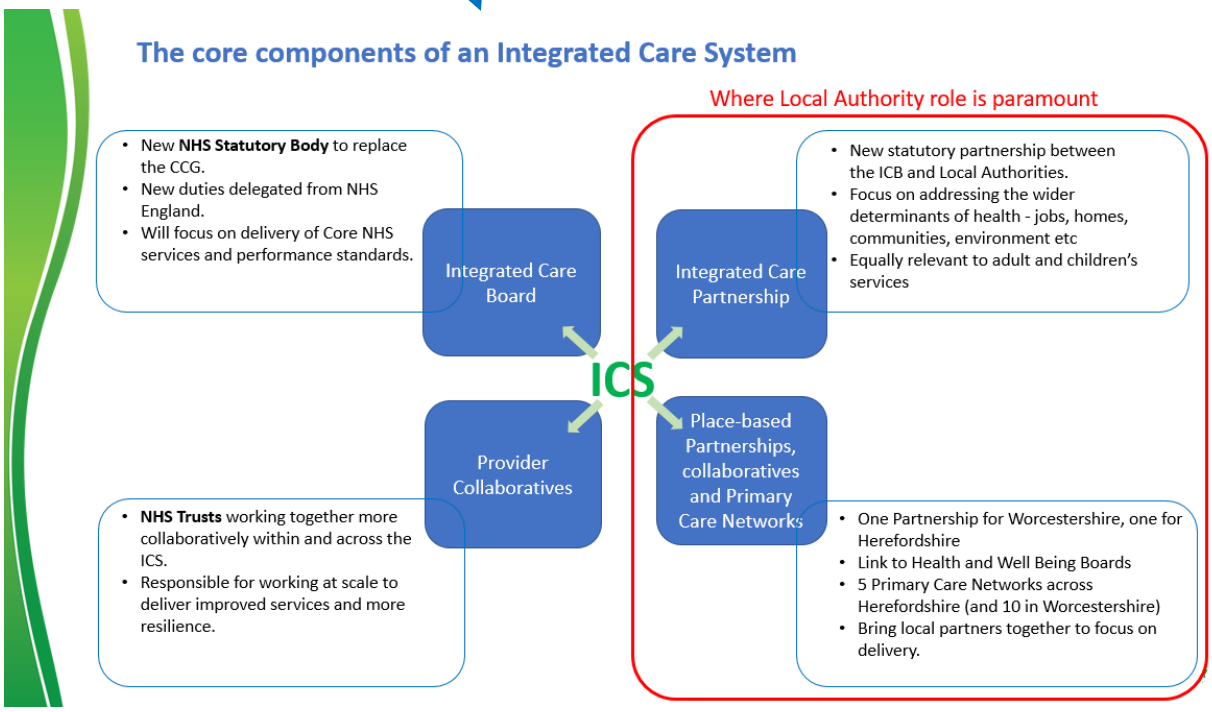
The Herefordshire Health and Wellbeing Board is responsible for agreeing the BCF plans and for overseeing delivery through quarterly reporting.

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

With the new ICB, further governance arrangements (as illustrated below) are in place including reporting to various strategic commissioning groups with updates on delivery and reviewing next steps and intentions.

These groups link into the One Herefordshire Partnership to ensure that we continue to build an ambitious approach to integration.





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

The **One Herefordshire Partnership (1HP)** board is the vehicle by which Herefordshire Place partners work together at a strategic level and is a key enabler of the BCF plan delivery.

The Herefordshire Place partners are:

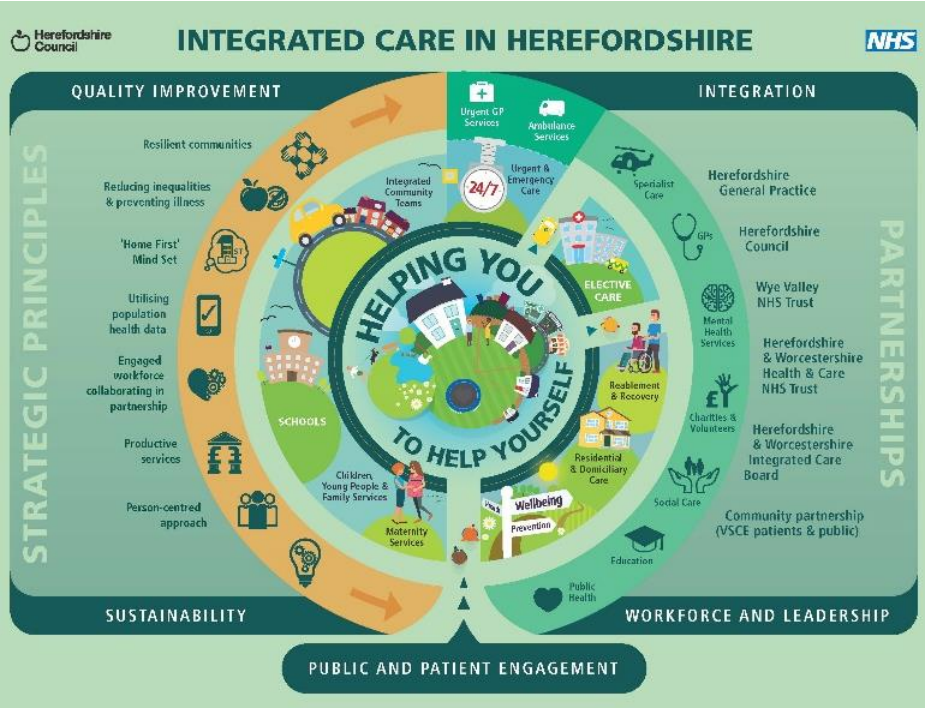
Herefordshire Council	Herefordshire General Practice	Herefordshire and Worcestershire Health and Care NHS Trust
Wye Valley NHS Trust	Herefordshire and Worcestershire ICB	

The primary purposes of the 1HP are to:

- set the strategy for Herefordshire's health and care services;
- approve priorities, programmes, plans and objectives;
- receive updates on progress against the objectives and performance of integrated services; and
- ensure that appropriate engagement with the public, service users and staff has taken place.

4. Planning Requirement (PR2)
A clear narrative for the integration of health and social care

Integrated working across health and care provides the opportunity to deliver the best possible outcomes for local people and achieve the best use of our collective resources. By working collaboratively and having a clear focus (as illustrated in the diagram below), we can ensure that the priorities are representative of the needs of our local population. The BCF is a critical element of delivering 'place' plans as it provides the joint funding to support schemes that deliver on our local priorities.



For people who need both health and social care services, the aim is that they receive the right care, in the right place, at the right time. There is particular focus on addressing health inequalities and in achieving improved health outcomes for all by targeted use of the funds available.

Joint priorities

- Tackling health inequalities.
- Digital innovation.
- Improving urgent care services.
- Supporting our workforce.
- Ensuring the delivery of high quality services.
- Developing our approach to population health management.

A **Joint Health and Wellbeing Strategy** is currently in development and with the establishment of a new Integrated Care System for Herefordshire and Worcestershire it brings a timely opportunity for the new strategy to inform and deliver action at both the system and place level.

The coronavirus pandemic had a profound impact on our health and wellbeing, affecting outcomes across the life course. It has shone a light on some of the health and wider inequalities that persist in our society. A new strategy therefore presents an opportunity to include our aspirations and priorities for tackling inequalities as part of our recovery recognising that many of the causes of ill-health are deep rooted in society.

Indicative timescales for the development of the strategy are summarised below with the aim to publish the final strategy in March 2023 for implementation in April 2023, under the following guiding principles:

- The priorities in the strategy will be based on need, supported by actions based on evidence of effectiveness.
- Prevention (in all its forms) will be at the heart of all we do
- A 'proportionate universalist' approach – something for everyone and more for those who need it the most
- The strategy will focus on areas where partnership action adds value and there is commitment across the system
- Narrowing health inequalities as a core aim

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

How is our plan contributing to reducing health inequalities in Herefordshire?

The BCF Plan is a platform for articulating how we will use system, county and place level collaborations to strengthen health inequality in strategic and operational planning.

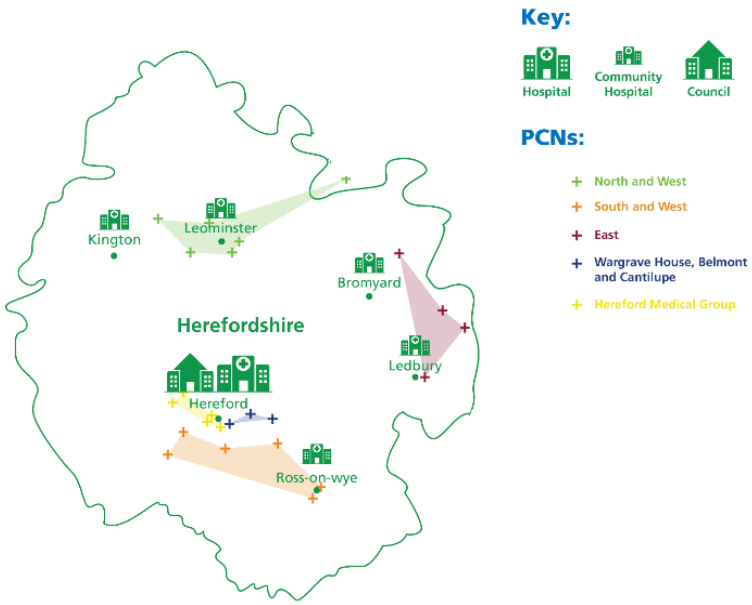
All of the PCNs have oversight through the Herefordshire Health Inequalities Group and feed into the ICS Health Inequalities and Prevention Collaboration along with discussions at Community Partnership meetings.

Herefordshire's PCN Approach includes:

- Partnership working – people, statutory bodies, VCSE and business.
- Views of people with lived experience.

- PCNs working collaboratively with Public Health and the Herefordshire Health Inequality Group for advice, guidance and expertise on how to approach developing plans.
- Innovation & transformation.
- Cohesive approach – data sharing, monitoring and evaluating impact.

By the end of September 2022, PCNs and commissioners will jointly work with stakeholders and council commissioners, VCSE partners and local clinical leaders, to design, agree and put in place a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs.



Herefordshire and Worcestershire ICB serves a population of over 800,000 people across two diverse counties where there is variation in health outcomes across communities, and differences can be seen when considered by ethnicity, deprivation and rurality. The factors which drive this variation can be complex and Herefordshire & Worcestershire ICB and system partners are committed to understanding these reasons and working in partnership with people and communities to break down barriers and enable everyone to feel they can access health services when they need to, allowing timely support and treatment.

Partners across the system are coming together at the Herefordshire and Worcestershire Integrated Care Partnership Assembly to develop and agree an Integrated Care Plan which will share the vision for integrated care, improved health and care outcomes and a reduction in unwarranted variation in outcomes. Underpinning this strategy are the joint strategic needs assessment (JSNA) which provides an assessment of the health needs of the population and focused work to reduce unwarranted variation in outcomes. In Herefordshire & Worcestershire, health provision is working to **CORE20PLUS5**, an approach to reducing health inequalities and unwarranted variation developed and used across the NHS in England. This focuses efforts to increase tailored support to those living in the most deprived 20% of the national population (CORE 20) and locally define groups including unregistered populations and those experiencing barriers due to health literacy. The key clinical areas of variation are Maternity, Severe Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis and Hypertension.

In order to address variation in outcomes in these 5 clinical areas, Herefordshire & Worcestershire ICB has invested over £4.3m within Primary Care Networks (PCNs) to deliver improved outcomes. All PCNs have worked with councils, voluntary sector and communities, implementing initiatives which support people to access services, go through relevant health checks and ultimately, where clinically appropriate, enter treatment. For every person who enters treatment earlier than they would have done, their opportunity for an improved outcome increases and we will help to reduce the health inequalities we see in our counties. Interventions include both medical and non-medical, covering accessing support groups, tackling loneliness and supporting people to understand the implications of a diagnosis and importantly how they can take simple steps in their day to day lives to improve their health and wellbeing. The system will measure on and report on the ambition to improve outcomes over the next 5 years.

The **Tackling Health Inequalities Board** (Herefordshire and Worcestershire) continues to work collaboratively.

- A review of a specialist dental pathway is underway.
- Lifestyle advisor teams are supporting improvements in management of weight for those with Learning Disabilities following outcomes of LeDeR reviews.
- We are increasing awareness of use of Respect (Recommended summary plan for emergency care and treatment) for people with LD.
- We are raising awareness of MCA and its place in identification and recognition of health needs and to improve outcomes
- HW LeDeR Strategy 2022 to 2025 has been produced (herefordshireandworcestershireccg.nhs.uk).

A review of the joint Herefordshire and Worcestershire Autism Strategy should be published in April 2023 and will be a 3 year strategy. This focuses on 7 priority areas which mirror the priority areas within the National Strategy for Autistic Children, Young People and Adults 2021 to 2026. It focuses on the following:

- Improving understanding and acceptance of Autism within Society.
- Supporting more autistic children into employment.
- Tackling health and care inequalities for Autistic people.
- Building the right support in the community.
- Improving support within the criminal and youth justice systems.
- Keeping safe – This is a Herefordshire place based priority.

5. Planning Requirement (PR3)
A strategic, joined up plan for Disabled Facilities Grant Spending

Our approach to bringing together housing, health and care is to work collaboratively across partner organisations, including the voluntary and community sector, to support people and continue to work to deliver the goal of maximising independence and people living well at home.

Disabled Facilities Grant

The DFG is a capital grant pooled into the BCF to promote joined-up approaches to meeting people's needs to help support more people of all ages to live in suitable housing so they can stay

independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care and strategic use of the DFG can support this.

Under the Care Act there is a requirement for closer cooperation of services that support the health and wellbeing of those who may be in need of care and support. An emphasis is placed on greater integration between health and social services to deliver more person-centred outcomes. The strategic direction for DFG is to continue to work to deliver the goal of maximising independence and people living well at home. Working with the councils' Housing services we look to use DFG to help increase the amount of suitable available housing in Herefordshire to enable more people to remain at home, living well for longer.

The DFG aims to support vulnerable, disabled and older people to be independent, enabling carers to continue their role safely, preventing accidents and helping people to return from hospital. It therefore crosses the boundaries between housing, health and social care and reflects the increasing national focus on the integration of housing with health and social care services.

This year, Herefordshire Council's allocation is £2,268m. Our target is to complete 200 mandatory DFG grants and 20 discretionary DFG or assistance grants in the financial year.

Adaptations costing £1,000 or less are referred to as minor adaptations and as such are procured outside of this budget under the council's duties within the Care Act or via social landlords. However within the flexibilities offered under the council's Home Adaptations and Assistance policy, a free rapid response minor adaptations service to prevent delayed discharge from hospital is provided plus a small Handyperson's service to assist people living in their own homes with small repairs, maintenance and improvements, at subsidised cost. These two schemes are funded via the DFG capital budget.

Under the new government flexibilities on the use of DFG funding particular emphasis will be placed on supporting housing strategy to prevent and relieve homelessness, including a contribution of £250k towards 6 properties specifically acquired to prevent homelessness, and a contribution of £500k to enable continued partnership working between Strategic Housing, Prevention Services, private and social registered landlords and external agencies ensuring funds are available for accessible housing schemes and adaptations within such properties. This is in line with government guidance on use of DFG to support capital projects that benefit social care.

As in previous years, the DFG will be used to support the delivery of community equipment services, including technology enabled living. Community equipment covers a wide range of equipment for home nursing usually provided by the NHS, such as pressure relief mattresses and commodes, and equipment for daily living such as shower chairs and raised toilet seats,. It also includes, but is not limited to:

- Minor adaptations such as grab rails
- Ancillary equipment for people with sensory impairments
- Telecare equipment such as fall alarms

Community equipment plays a vital role in enabling disabled people of all ages, including children, to maintain their health and independence, and to prevent inappropriate hospital admissions. Modernisation of community equipment services therefore supports policy initiatives such as:

promoting independence for disabled people; intermediate care services; the reduction of falls by older people, and support for carers.

The use of DFG funding is designed to meet the challenges presented in the to offer practical help to the residents of Herefordshire to live independently at home including the provision of adaptations, technology enabled living and community equipment, preventing, delaying or reducing the need for care and support. In practical terms this includes, but is not limited to:

- Adaptations to aid independent living for older persons in their own homes rather than moving to care homes.
- Reducing the need for, and scale of care packages.
- Assisting with hospital discharge to return home.
- Efficient delivery of nursing at home services.
- Reducing hospital admissions.
- Improving housing safety and security.
- Reducing the risk of falls at home.
- Preventing and relieving Homelessness.
- Linking with other agencies to help reduce fuel poverty.

Our current Regulatory Reform Order (RRO) offers include:

- An emergency repayable grant which offers a means tested grant to help to remedy serious risks to health and safety caused by structural or environmental defects in a person's own home. The service has received an increasing number of referrals for this support from social care colleagues and is working jointly with those colleagues to help find solutions and rectify these hazards to ensure the vulnerable person's greater safety and enable them to remain living in their home.
- The service also liaises quarterly with housing association colleagues to discuss and agree actions plans to resolve any relevant issues that have come to light with regards to adaptations, repairs or other housing support required for their vulnerable residents.
- The minor adaptations service run by the Home Improvement Agency (HIA) includes a rapid response option to facilitate hospital discharge, and a small handyperson's service.
- A fast-track option for some major adaptations is also available for specific circumstances such as hospital discharge or other urgent situations.
- The Independent Living Services work jointly with Strategic Housing colleagues to look at design requirements or adaptations required when accessible new build properties are being built for disabled adults/children whose needs cannot be met via the accessible homes register.

Options for emergency and transitional accommodation for older, and disabled people are being scoped. The scoping exercise also seeks to identify the supply of adapted and accessible properties with reference to demand, particularly with respect to any regional imbalances between demand and supply. There is also the matter of accessible and adapted housing required for people whose history of rough sleeping has led to physical disabilities and mental ill health.

The council has a new supported living scheme for people with mental health needs, utilising affordable housing quotas as part of the planning process for a new development. Similarly, we are seeing a new 80 unit extra care scheme as part of another affordable housing development for older people, where there will be collaboration with local DN team/s.

6. Planning Requirement (PR6)
An agreed approach to implementing the BCF Policy objectives, including a capacity and demand plan for intermediate care services (National Condition 4 - Implementing the BCF Policy Objectives)

Partners in Herefordshire are committed to meeting the BCF policy objectives, to:

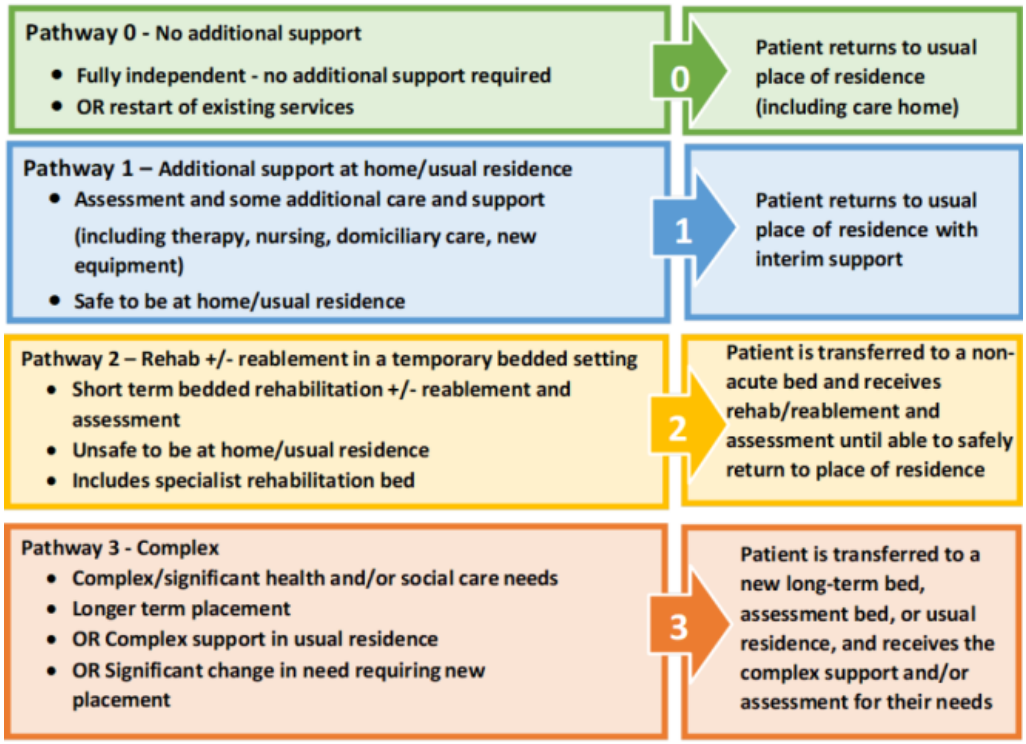
- Enable people to stay well, safe and independent at home for longer; and
- Provide the right care in the right place at the right time.

As part of our improvements to ensure as a system we are 'providing the right care in the right place at the right time' a review of demand and capacity modelling has been undertaken in line with planning requirements, which is located at Appendix 2.

6.1 Discharge to Assess, Integrated Discharge Team, Community Integrated Response Hub and Home First

Discharge to Assess (D2A) model

Discharge to Assess (D2A) is based on four pathways for discharges from acute hospital beds, Pathway 1 (Home) being the optimum pathway for patients who need additional support:



For the Herefordshire system, a number of services make up D2A provision for pathways one, two and three, including reablement services, block home care provision and bed based provision. National funding via DHSC ended on 31st March 2022 and from 1st April 2022 discharge pathways have been funded locally. Current discharge pathways have not changed and are funded via the BCF. This funding source is sufficient to sustain the current model for most of this financial year, but after that point an agreed, affordable, recurrently funded solution must be in place.

Increased use of BCF funding has been invested in Wye Valley Therapy Support and a new Care

Act Assessment Team & new posts in Social Care Complex Care. The ICS Point of Prevalence audit is being undertaken on 21 September 2022, which, along with the demand and capacity template (located at appendix 2) will inform future modelling.

Teams across Herefordshire, including WVT, Herefordshire Council and General practice information leads are combining data sets to provide a greater understanding of the current Discharge to Access pathway. This looks to demonstrate patients being accessed by the integrated discharge team and then the onward journey of the patient, split by discharged home (pathway 0) and referrals onto pathways 1, 2 or 3.

Integrated Discharge Team

The Integrated Discharge Team are responsible for supporting Complex Discharges across Wye Valley Trust Acute and Community Hospitals. The ethos of the integrated team, which is made up of NHS and adult social care staff, is to identify patients at ward level, working with patients, families and ward staff whilst patients are not medically stable by planning discharge arrangements and discharging patients as soon as possible once medically stable.

Integrated Discharge Coordinators have been employed to support wards ensuring that effective discharge processes are undertaken thus improving patient flow. The innovative team consists of Health and Social care colleagues, working together, to ensure the safe and timely discharge of patients following the Discharge to Assess model of working. The coordinators work closely with ward staff, attend twice daily ward MDT meetings using the ethos of 'Why not Home, Why not Today' and communicating with patients, relatives and other community services to provide a proactive and continuous process of discharge planning, avoiding delays and thereby improving patient experience.

The discharge dashboard will graphically present numbers of patients sitting with the Integrated Discharge Team (IDT), numbers referred to specific pathways and a high-level drill down to understand caseloads better. This overlaid with capacity of services will provide an operational insight into patient activity currently in the system. Starting with daily refreshes with the view to move to more real-time.

Community Integrated Response Hub

System partners work in collaboration to the 'Home is Best' principle.

The Community Integrated Response Hub (CIRH) provides the function of an urgent community response and consists of five responding assets:

- Hospital at Home Therapy – (Wye Valley NHS Trust) Joint/interdisciplinary working with nurses, support workers and therapists is commonplace for patients requiring both routine monitoring and 2-hour response interventions.
- Hospital at Home Nursing - (Wye Valley NHS Trust).
- Home First.
- Virtual GP (vGP) - (Taurus Healthcare).
- Community Advanced Clinical Practitioners (ACPs) - (Wye Valley NHS Trust).

Work is being undertaken to expand the CIRH to become a single point of access for a variety of health pathways. The current offer will continue but will include additional pathways such as Patient Initiated Follow up (PIFU), care homes and long-term conditions.

The Single Point of Access (SPA) will be developed to respond to the increasing need for new models and service developments coming on-line. Central hubs for transfer, Virtual Ward, early

supportive discharge support receive escalation calls from primary, secondary care, the council and NHS111 and there will be a response from the SPA.

Home First

The Home First Service provides a short term, reablement offer to support people to retain or regain their independence and work to get someone back as close to their previous level of independence as possible, which is our enabling approach. The service promotes the health, wellbeing, independence, dignity and social inclusion of the people who use the service. The enablement ethos is fundamental to the delivery of this service.

Home First responds and works quickly, flexibly and efficiently as possible to stop someone from losing their independence, to facilitate the most positive outcome for individuals. This involves ensuring that care planning is focussed on people's strengths and abilities, how these can be built upon and how people can be assisted on their journey to independence. As well as managing risk and safety with the right level of intervention.

Throughout 2022/23, system partners will continue to invest in the growth of the Home First service (via the BCF) in order to support multi pathways, including hospital discharge. The Home First service transferred from Herefordshire Council in July 2022 and is now delivered by Hoople Care.

6.2 Talk Community

Talk Community (Talk Community Directory) continues to be one of the council's strategic and primary approaches to demand management and admission prevention. Talk Community is bringing Herefordshire together to encourage residents, businesses, community leaders and our Council to play their part in making Herefordshire a better place to live and work.

The Customer Service Team acts as a single point of contact, maximising the use of the Talk Community web-site as a primary tool for the provision of information and signposting with the aim of assisting customers to get the right support, when they need it within their communities. The Talk Community web-site provides a platform to connect the people of Herefordshire to community groups, events, hubs and information to help them stay happy and healthy. It is a one stop shop for online national and local information, advice and guidance for the whole of Herefordshire across all ages, which supports our early help and prevention agenda. Evidence from key performance data indicates that the web-site is reaching those people that require help and support. The number of users has increased from 6.6k to 9.1k since April 22 to July 22, with page views increasing from 18.6k to 26.8k and number of hits increasing form 8.7k to 13.9k for the same period.

Growth of the Talk Community hubs continues, with a network of 67 hubs across Herefordshire, creating local, accessible, safe places for people to connect to their community and find out about support, services, groups and activities that can help them stay independent, happy and healthy at home. Wye Valley NHS Trust (WVT) has launched a pilot, volunteer-led Talk Community Hub, at the County Hospital (acute) site. The main emphasis of the model is information and signposting and is available to anyone visiting the County hospital including patients, carers, visitors and staff. This will link into existing support services at the County Hospital including the Eye Care Liaison Officer (ECLO), Defence Medical Welfare Service (DMWS) and Macmillan Information & Support service. The model will also work alongside discharge coordinator roles to support patients, carers and families during admission and prior to discharge. Talk Community brings together community, third sector and statutory services to connect with peers and share ideas and experiences within the

local PCN areas - working with communities to identify and address issues that affect them, increase sustainability of communities by facilitating the development of partnerships and collaborative approaches and helping identify any gaps in provision.

Other support being offered/undertaken by Talk Community include, but are not limited to:

Mental Health Support	Mental health awareness training provided to 150 people and mental health first aid training to 50 people enhancing mental health support within communities. Offer QWELL online support tool enabling residents to access online support 24/7.
Financial Support	Money on your Mind toolkit to support residents to access local and up to date financial support information. 7 voluntary organisations funded to be debt & financial management centres with 34 volunteers trained.
Community Broker Team	A person-centred approach to care planning. Recognising individuals are more likely to live happier and healthier lives when supported to retain their independence and access their local communities for as long as possible; the team has mapped in detail the community services across Herefordshire.
Healthy Lifestyle Service	Healthy Lifestyles team offer a wide range of healthy lifestyle information, advice and support to help residents make changes in their lives to improve health & wellbeing. Structured one to one and group support to stop smoking, get more active, eat better, drink less, lose weight, lower blood pressure and cholesterol

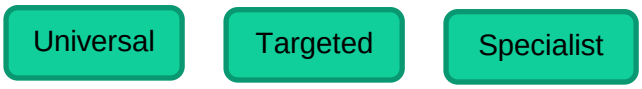
6.3 Integrated approach to commissioning - Falls

Herefordshire Council are working collaboratively with commissioning partners across the system in order to further develop integrated approaches to commissioning. A current example of this is the system wide review and development of an integrated falls pathway, as detailed below.

Business as usual services funded and delivered through the BCF/iBCF which '***enable people to stay well, safe and independent at home for longer***' include several Falls Prevention services. In Herefordshire there are 3 key services currently commissioned to deliver support for people identified as moderate and high risk of falls. These are:

- Falls Prevention Service.
- Falls Responder Service.
- Falls Care Navigator Service.

A falls review is being scoped collaboratively for the future blueprint of Falls Prevention support and services in Herefordshire is divided into 3 key areas of service delivery:



The **Universal** offer is designed to be accessible to all residents, carers, and professionals across Herefordshire. It is proposed that this single, streamlined, multiagency developed offer will be

accessible through the Talk Community online directory and will contain information, advice and guidance which is tailored to be suitable for all patient profiles (from LOW through to SEVERE). A vast communication/engagement plan will be developed in order to ensure all stakeholders are made aware of the Universal provision available and a small working group will be established to work together to develop the content. A 'no wrong door' concept will be adopted, where professionals from across the health and social care sector will be encouraged to refer customers / patients to the Universal offer as soon as possible. This provides an opportunity to ensure the messaging is consistent across statutory and community services.

The **targeted** provision will be further developed and available to those in the MEDIUM / HIGH cohorts. The training proposed for the health and social care workforce will aim to support professionals to increase their knowledge regarding Falls Prevention and ensure awareness of the Universal offer and ability to work with individuals to complete the self-assessments and checklists available. Herefordshire's Public Health is supporting a review of the falls prevention model, in order to strengthen the upstream, preventative part of the proposed new falls pathway.

It is proposed that the **specialist** commissioned services will introduce an eligibility criteria which enables them to focus services upon those who are at HIGH and SEVERE risk of falls. These specialist services will provide specialist physiotherapy and OT assessment and support, specialist service to provide outreach to repeat fallers, respond to falls and provide training and assist with developing the Universal offer.

- Talk Community Customer Services also support the falls prevention agenda by sending out falls leaflets, postcards and A4 posters to a number of stakeholders.
- Through the Talk Community Directory - Falls prevention - Talk Community Directory

Further work is planned to ensure that this pathway is an alternative to ambulance attendances, through introducing support to care homes on falls and to ensure that the NHS111 is able to refer to the falls service.

Herefordshire council will be taking forward the recommissioning of services within the pathway during 2023. This will lead to a new partnership between NHS providers, local communities and the council's Talk Community and public health programmes, to reduce avoidable falls and the consequential impact on health services and social care.

6.4 High Impact Change Model (HICM)

The **HICM** is designed to support local system partners to improve health and wellbeing, minimise unnecessary hospital stays and encourage the consideration of new interventions. The table below provides an overview of Herefordshire's local, joint self-assessment.

High Impact change Model - Herefordshire self assessment and improvement plan
August 2022

https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high/about

High Impact Change Area	Self Assessment Where are we now?	Summary of current position
Change 1: Early Discharge Planning	**Plans in place**	Herefordshire's Integrated Discharge Team continues to facilitate discharge planning. Plans in place to look at the elective pathway from pre-op through to discharge. The Red Bag Scheme is currently not active.
Change 2: Monitoring and responding to system demand and capacity	**Established**	System partners continue to work together to monitor and respond to system demands. A Point of Prevalence audit is planned to take place in September and a demand and capacity dashboard is currently being developed.
Change 3: Multi-disciplinary working	**Mature**	The Integrated Discharge Team is developed and embedded. Partners work closely together throughout the Urgent Care Pathway including daily huddle meetings, where patient trackers and progress are discussed.
Change 4: Home First D2A	**Mature**	Wherever possible, people are supported to be assessed in their usual place of residence. The council has introduced the CAAST team, who complete Care Act assessments once people have been discharged.
Change 5: Flexible working patterns	**Mature**	Demand and capacity is currently being mapped across the system, which will inform if seven-day working patterns are required/suitable. Seven-day services in place where required.
Change 6: Trusted Assessment	**Mature**	Trusted Assessors are in place and available for Care Home assessments. People are safe and having assessments in a timely way.
Change 7: Engagement and Choice	**Established**	Admission advice and information leaflets are readily available, including web based information. Alternative languages and accessibility options are currently being explored. The local authority has a range of information available to support individuals and families to make decisions regarding care. The Talk Community Directory is available to all and provides a rich source of advice and information. In addition to this there are currently 67 Talk Commuhity Hubs in Herefordshire which offer up to date health and wellbeing information and help bring residents together by connecting people to services, groups and activities within their local community or across the county.
Change 8: Improved discharge to care homes	**Established**	System partners meet with Care Home providers on a 4 weekly basis, to discuss a range of topics and issues. In addition, information, best practice, policy and guidance documents are distributed to Care Homes on a regular basis. Care Homes are encouraged to access clinical support via the Community Integrated Response Hub. Care Home Clinical Practitioners continue to work to identify individual provider needs to inform day to day activity; enhance individual care through collaborative working, to broaden knowledge and skills to ensure the successful delivery of clinical support and advice to Residential and Nursing Homes across Herefordshire.
Change 9: Housing and related services	**Mature**	Referral pathways to Home adaptations, equipment and telecare services are well established and services are delivered promptly. The impact of homelessness and housing issues are fully understood and the local authorities' housing solutions team is available 24/7. A dedicated Housing Solutions Officer is in place to specifically support discharge.

7. Key areas of progress and developments (PR7)
(Planning Requirement – BCF Pool matched funding)

Hoople Care has been established in order to assume the management of adult social care services that have been in-sourced by the council. The council has recognised that some services cannot be provided in social care markets with the appropriate consistency of quality and value for money. It has therefore taken decisions to in-source or create new services over recent years.

The transfer of registration will help to implement objectives within Herefordshire's market position statement 2020/2025. This underlines the council's willingness to consider its role in markets where the market cannot meet demand challenges and needs of individuals. Transferring the services to Hoople Care will ensure consistency in regulated service delivery.

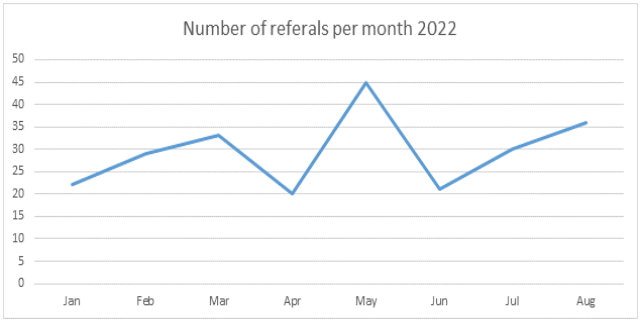
- The vision is for Hoople Care to become a leading care provider and have a strong presence in the market.
- The establishment of Hoople Care over time is expected to support resilience and stability in the care and support market in Herefordshire.
- It is proposed to enhance the Hoople Care model building on the successful insourcing of the residential services for learning disabled people.
- There will be further opportunity to combine the council's recruitment and training provider (Hoople) with its care provision to improve and sustain the quality of in-house services.
- There is an opportunity to aligning to the council's Talk Community's approach and Hoople connecting people into communities on a strengths based model.
- Hoople Care will contribute to, support and develop the health, family support and social care workforce.
- There is potential for collaborative working between the Hoople Care provision and the wider NHS services and the Integrated Care System (ICS).

The **Clinical Care Home Practitioners** continue to be funded via iBCF with the team employed by WVT (Integrated Care Division). The team have continued to work to identify individual provider needs to inform day to day activity; enhance individual care through collaborative working using gold standard evidence based education as a resource to broaden knowledge and skills to ensure the successful delivery of clinical support and advice to Residential and Nursing Homes across Herefordshire.

Outcomes

1. To increase education and confidence in recognising deterioration and enable the resident to stay within their own home environment.
2. To provide a more consistent access to education and support and to ensure that all care home staff are able to deliver safe, high quality, compassionate care.
3. To ensure that all nurses undertake the necessary clinical education or training with competency assessment in practice to support development of their knowledge, skills and expertise.
4. To reduce hospital admissions within our community and acute hospital sites.

The **Trusted Assessor** model was implemented in Herefordshire during 2018-19, and continues to be a valued resource in helping to reduce the number of delayed discharges, supporting individuals to be discharged to the appropriate care home or Discharge to Assess location, along with increasing time efficiency for care home managers. So far in 2022 the TA's have had 236 patients referred which shows an increase on previous years (2021 was 227 and 2020 was 131 by August).



Home First wage increase - Agreement with partners to increase hourly rate of Reablement Workers and Assessment and Review Officers to boost recruitment and retention. Home First provides an essential reablement service that facilitates early discharge from hospital and a return home for patients. It is known that the longer a person remains in hospital the more likely it is that they will experience reduced confidence and mobility and worse outcomes overall. Having a full complement of staff available within Home First would reduce delays for people ready to leave hospital.

Delays in providing this service not only impact on the individual patient but bed space issues for the hospital which in turns creates capacity issues across the whole health and care system The increase proposed to make employment in reablement work and the wider social care sector more attractive for people in the local employment market, providing pay above the living wage having a positive impact for the local economy and support an important function in reducing pressure on hospitals and enabling patients to return home without any unnecessary delays.

Workforce, Recruitment and Retention - An element of iBCF funding has been allocated to the redesign and marketing of the Herefordshire Cares website (www.herefordshirecares.co.uk) and social media campaign.

Herefordshire Cares engages both potential and existing care workers as the Herefordshire 'go to place' for news, information, opportunities, support and developments at national, regional and local level. The new approach is aiming to improve local recruitment and entrants to the local care sector.

Care Home providers and home care providers can advertise vacancies for free on the Herefordshire Cares website. In October and November, with provider engagement we are undertaking some filming for the website with care workers in their work place to highlight the sector. The team are also linking with Skills for Care, local colleges and ICS on system workforce training and requirements.

Supporting unpaid carers

Unpaid family carers are central to the delivery of high quality and integrated health and care services in Herefordshire. Both the council and NHS partners have given significant focus to their strategic work relating to carers and are now bringing forward a joint co-ordinated approach to strategy and engagement. Herefordshire council conducted comprehensive consultation and engagement with unpaid carers in 2021 in reviewing its existing carer's strategy and developing the new strategy. The content and focus of that strategy is entirely the product of that carer and stakeholder engagement. Across the ICB footprint, multiple agencies have collaborated to develop

a carer's charter approach with a focus on access to and participation in services. The Herefordshire strategy and ICB approach are now fully aligned and will shortly be adopted formally by the place based board for Herefordshire. The joint approach is focused on the rights of carers, their access to health and care services for themselves and their participation in the delivery of services to those they care for, promoting independence and prioritising take up of upstream, preventative services. Partners are now reviewing overall resourcing of services to unpaid carers in the light of adult social care reforms.

BCF funds the provision of carers respite placements with Acorns Childrens Hospice and St. Michael's Hospice Carers Support (£293,499K). The ICB continue to support carer's breaks through the Better Care Fund including the NHS provision for people with life-limiting conditions, providing respite care in appropriate clinical environments. Furthermore, the NHS minimum contribution will continue to support implementation of the Care Act through the provision of assessment, advice and support to carers. Within the strengths-based approach in reablement, the engagement and support to carers is an integral part, ensuring that carers are well-informed and supported. This includes access to equipment and aids. We also recognise that social isolation, fuel poverty and the wellbeing of carers is paramount. This is promoted through Talk Community throughout Herefordshire.

Implementing Care Act Responsibilities

Similar to previous years our Care Act responsibilities are met by the Carers Support Contracts (£225K). The council has also invested in a new Care Act Assessment Team (CAAST) part-funded by BCF (£229K).

The Care Act Assessment team (CAAST) is a bespoke team established within Adult social care delivery. Team members have the requisite qualifications and skill base to undertake a holistic assessment under the Care Act 2014 of individuals at their most optimum point of their recovery and reablement after a discharge from hospital. Assessment practitioners complete the assessment with individuals and carers using the Strength based model and currently undertake the assessments within the D2A model time frame of up to six weeks. This team has been specifically trained to assess and identify that individuals and their carers have maximised their independence and ensure that all opportunities are explored to promote further independence and wellbeing. For example by facilitating therapy assessments and interventions, grants for improved housing conditions and equipment, have been sign posted to ensure connections to their community and universal services. The plan is for all of the team to be trained to prescribe a range of aids (technology and equipment) or identify where more complex assessments are needed by OT's.

CAAST has responsibility for running the urgent care discharge spreadsheet (shortly to become the hospital to home digital pathway) which maps the individuals journey from hospital bed to final destination. Performance indicators show that individuals are now assessed well within the expected time frames. The feedback from partners, locality teams and clients and stakeholders has been very positive. For most discharges there is now one team to liaise with regarding someone who has been discharged rather than the five teams previously. CAAST is solely focused on the hospital discharges and does not have to navigate the other priorities of locality teams and so responsiveness to timeframes has vastly improved.

BCF Planning Template 2022-23

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 blue 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 sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. 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 the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.

6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these 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 NHS 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 text 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 a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

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 in tab 5b.
- 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. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS 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.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of 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.
8. 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. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. 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 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- 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)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement 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 expected 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.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and 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 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs 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.

Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM 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 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Herefordshire, County of
Completed by:	Marie Gallagher and Adrian Griffiths
E-mail:	Marie.Gallagher1@herefordshire.gov.uk
Contact number:	01432 260435
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	
If using a delegated authority, please state who is signing off the BCF plan:	Paul Walker/Simon Trickett

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Herefordshire Council Chief Executive /HWICB Chief Executive
Name:	Paul Walker/Simon Trickett

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Pauline	Crockett	Pauline.Crockett3@herefordshire.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Simon	Trickett	simon.trickett@nhs.net
	Additional ICB(s) contacts if relevant	Mrs	Jade	Brooks	jadebrooks@nhs.net
	Local Authority Chief Executive	Mr	Paul	Walker	Paul.Walker@herefordshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mrs	Hilary	Hall	hilary.hall@herefordshire.gov.uk
	Better Care Fund Lead Official	Mr	Adrian	Griffiths	Adrian.Griffiths2@herefordshire.gov.uk
	LA Section 151 Officer	Mr	Andrew	Lovegrove	Andrew.Lovegrove@herefordshire.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	Chief Finance Officer (HWICB)	Mr	Mark	Dutton	mark.dutton@nhs.net

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Herefordshire, County of

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,268,653	£2,268,653	£0
Minimum NHS Contribution	£15,131,958	£15,131,958	£0
iBCF	£6,782,841	£6,782,841	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£24,183,452**	**£24,183,452**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£4,300,073
Planned spend	£8,625,984

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£6,505,975
Planned spend	£6,505,974

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£1,292,021	(5.3%)
Carers Services	£483,220	(2.0%)
Community Based Schemes	£8,315,321	(34.4%)
DFG Related Schemes	£2,268,653	(9.4%)
Enablers for Integration	£658,557	(2.7%)
High Impact Change Model for Managing Transfer of (	£1,321,985	(5.5%)
Home Care or Domiciliary Care	£298,523	(1.2%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£4,066,891	(16.8%)
Bed based intermediate Care Services	£796,657	(3.3%)
Reablement in a persons own home	£3,081,270	(12.7%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£445,511	(1.8%)
Residential Placements	£1,154,843	(4.8%)
Other	£0	(0.0%)
Total	**£24,183,452**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	0.0	0.0	0.0

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.0%	92.0%	91.4%

Residential Admissions

		2020-21 Actual	2022-23 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	417	493

Reablement

		2022-23 Plan
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%

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: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Herefordshire, County of

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Herefordshire, County of	£2,268,653
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,268,653**

iBCF Contribution	Contribution
Herefordshire, County of	£6,782,841
Total iBCF Contribution	**£6,782,841**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

NHS Minimum Contribution	Contribution
NHS Herefordshire and Worcestershire ICB	£15,131,958
Total NHS Minimum Contribution	**£15,131,958**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£15,131,958**	

	2021-22
Total BCF Pooled Budget	**£24,183,452**

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

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Herefordshire, County of

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,268,653	£2,268,653	£0
Minimum NHS Contribution	£15,131,958	£15,131,958	£0
iBCF	£6,782,841	£6,782,841	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	**£24,183,452**	**£24,183,452**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,300,073	£8,625,984	£0
Adult Social Care services spend from the minimum ICB allocations	£6,505,975	£6,505,974	£1

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	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	Falls Prevention & Responder	Social Care		LA			Private Sector	Minimum NHS Contribution	£42,124	Existing
51	Community Resilience & Prevention	Community Commissioning	Prevention / Early Intervention	Other	Commissioning & contracting for community-	Social Care		LA			Local Authority	Minimum NHS Contribution	£219,753	Existing
52	Support for Hospital Discharge	Integrated Discharge Lead	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			NHS Acute Provider	Minimum NHS Contribution	£33,240	Existing
52	Support for Hospital Discharge	Home First	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Private Sector	Minimum NHS Contribution	£2,389,255	Existing
52	Support for Hospital Discharge	Discharge to Assess-unfunded services due to end of HDP	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Private Sector	Minimum NHS Contribution	£102,209	New
52	Support for Hospital Discharge	Discharge to Assess-unfunded services due to end of HDP	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£193,561	New
52	Support for Hospital Discharge	Discharge to Assess-unfunded services due to end of HDP	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£9,873	New

52	Support for Hospital Discharge	Care Act Assessment Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum NHS Contribution	£298,772	New
52	Support for Hospital Discharge	Short-term Residential Care	Bed based intermediate Care Services	Step up		Social Care		LA			Private Sector	Minimum NHS Contribution	£200,000	Existing
52	Support for Hospital Discharge	Housing Hospital Discharge	High Impact Change Model for Managing Transfer	Housing and related services		Social Care		LA			Local Authority	Minimum NHS Contribution	£80,407	Existing
52	Support for Hospital Discharge	Brokerage	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Social Care		LA			Local Authority	Minimum NHS Contribution	£224,212	Existing
52	Support for Hospital Discharge	Social Care Urgent Care	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£792,889	Existing
53	Partnerships & Integration	Partnerships & Integration Staffing	Enablers for Integration	Programme management		Social Care		LA			Local Authority	Minimum NHS Contribution	£351,362	Existing
54	Social Care Complex Needs	DoLs / AMHPs	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum NHS Contribution	£852,021	Existing
54	Social Care Complex Needs	Social Care Complex Needs Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum NHS Contribution	£491,296	Existing
57	Carers Support	Carers Support Contracts	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£225,000	Existing
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder	Community Health		CCG			Private Sector	Minimum NHS Contribution	£124,634	Existing
52	Support for Hospital Discharge	Discharge to Assess at LICU	Residential Placements	Discharge from hospital (with reablement) to		Community Health		CCG			Private Sector	Minimum NHS Contribution	£891,700	Existing
52	Support for Hospital Discharge	Home First	Reablement in a persons own home	Reablement service accepting community and		Community Health		CCG			Private Sector	Minimum NHS Contribution	£500,000	New
52	Support for Hospital Discharge	Discharge to Assess-unfunded services due to end of HDP	Reablement in a persons own home	Reablement to support discharge - step down		Community Health		CCG			Private Sector	Minimum NHS Contribution	£19,014	New
52	Support for Hospital Discharge	Discharge to Assess-unfunded services due to end of HDP	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum NHS Contribution	£36,007	New
52	Support for Hospital Discharge	Discharge to Assess-unfunded services due to end of HDP	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,837	New
57	Carers Support	Acorns Children's Hospice	Carers Services	Respite services		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£32,154	Existing
57	Carers Support	St Michael's Hospice Carer's Support	Carers Services	Respite services		Community Health		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£261,345	Existing
60	Community Health Services	Integrated Community Care	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£6,638,833	Existing
60	Community Health Services	Additional Community Services	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£29,390	Existing

60	Community Health Services	Head of Integrated Care Services	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£91,070	Existing
33	Disabled Facilities Grant	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£2,268,653	Existing
151	Community Resilience & Prevention	Talk Community	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	iBCF	£1,556,027	Existing
151	Community Resilience & Prevention	Care Navigator Frequent Fallers	Prevention / Early Intervention	Other	Falls Prevention & Responder	Social Care		LA			Local Authority	iBCF	£44,000	Existing
151	Community Resilience & Prevention	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	iBCF	£215,000	Existing
151	Community Resilience & Prevention	Trusted Assessors	High Impact Change Model for Managing Transfer	Trusted Assessment		Social Care		LA			Local Authority	iBCF	£79,866	Existing
152	Support for Hospital Discharge	Additional Costs of D2A beds (Ledbury ICU)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	iBCF	£233,026	Existing
152	Support for Hospital Discharge	Discharge to Assess-unfunded services due to end of HDP	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	iBCF	£70,791	New
152	Support for Hospital Discharge	Discharge to Assess-unfunded services due to end of HDP	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	iBCF	£134,063	New
152	Support for Hospital Discharge	Discharge to Assess-unfunded services due to end of HDP	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	iBCF	£6,838	New
154	Social Care Services	Locality Social Work Teams	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	iBCF	£3,276,823	Existing
154	Social Care Services	Social Care Business Delivery & Practice Improvements	Enablers for Integration	Workforce development		Social Care		LA			Local Authority	iBCF	£297,195	Existing
154	Social Care Services	Shared Lives	Residential Placements	Other	Shared Lives	Social Care		LA			Local Authority	iBCF	£143,238	Existing
156	Care Market Development	Care Home Practitioners	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Social Care		LA			NHS Community Provider	iBCF	£92,824	Existing
156	Care Market Development	Minor Investments Fund	Prevention / Early Intervention	Other	Miscellaneous small grants and payments to aid	Social Care		LA			Private Sector	iBCF	£15,000	Existing
156	Care Market Development	Herefordshire Cares Website	Enablers for Integration	Employment services		Social Care		LA			Private Sector	iBCF	£10,000	New
401	Social Care Demand	Block Nursing Home Beds (Leominster)	Residential Placements	Nursing home		Social Care		LA			Private Sector	iBCF	£119,906	Existing
401	Social Care Demand	Hard to place Home Care	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£298,523	Existing
401	Social Care Demand	Additional short-term respite placements	Carers Services	Respite services		Social Care		LA			Private Sector	iBCF	£189,721	Existing

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.

4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	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/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	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. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing 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.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	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, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	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.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	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 such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. 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 related specifically to discharge, 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.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	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.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	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.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	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.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	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.

18	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 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Rate per 100,000	82.8	84.2	83.2	62.1	Target set to match 21/22 levels	Herefordshire's BCF priorities for 22-23 as detailed in narrative plan have been identified as key areas to ensure Herefordshires residents remain at home and maintain independence for as long as possible; therefore assisting in achieving this target.
	Indicator value	160.2	163.0	161.0	120.3		
	Denominator	193,600	193,600	193,600	193,600		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value	0.0008264	0.0008419	0.0008316	0.000625		
	Indicator value	160	163	161	121		
	Denominator	193,600	193,600	193,600	193,600		

>> link to NHS Digital webpage (for more detailed guidance)

Percentage of hospital episodes, for inpatients aged	Denominator	0	0	0	0	N/A	N/A

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	92.0%	92.0%	91.4%	91.1%	Maintaining 2021-22 figures based on continuing to improve performance to match the national average.	Better data capture will lead to some improvement, as will understanding the relationship between this target and D2A. Practical improvements will stem from integrated discharge teams and strength-based assessment
	Numerator	3,477	3,460	3,365	3,193		
	Denominator	3,781	3,761	3,682	3,504		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	92.0%	92.0%	91.4%	39.8%		
	Numerator	3,477	3,460	3,365	1,393		
	Denominator	3,781	3,761	3,682	3,504		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
	Annual Rate	416.9	407.7	484.5	493.3	Maintaining 2021-22 figures because underlying demand and acuity from	Increasing capacity in Home First and Hospital at Home teams as part of

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Numerator	202	202	240	249	Herefordshire and community has not reduced. Herefordshire providers continue to face workforce challenges which are impacting upon the capacity available in the community.	discharge to assess continues to help increase reablement and reduce permanent admission to residential care homes.
	Denominator	48,458	49,541	49,541	50,481		

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 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	70.9%	80.0%	65.6%	80.0%	82.50% year-end report - maintaining previous year's performance. Some difficulties in moving clients on from Home First into the external domiciliary care market, but also an influx of level 1 (i.e. non-reablement) clients into the Home First Service, showed a drop is numbers, especially in the first quarter of 2021-22. The number of Homefirst staff available to provide reablement also reduced which has meant that Homefirst capacity to take on clients also reduced.	Increasing capacity in Home First and Hospital at Home teams will continue to maintain current good performance. Talk Community projects will strengthen and support community resilience.
	Numerator	122	320	42	320		
	Denominator	172	400	64	400		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. 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)	Confirmed through	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 ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? 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? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Page 6/7 How integrated system looks in Herefordshire infographic One Herefordshire (1HP) place partners infographic		
	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 describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	Page 8 Blueprint infographic Core20PLUS5		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (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 DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Page 12		
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	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 NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	PR6	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes	Page 15 HICM self assessment Talk Community - falls prevention hyperlink		

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?**	• Do 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? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			

Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans, useful definitions and where to go for further support. This sheet provides further guidance on using the Capacity and Demand Template.

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed off by the HWB as part of the wider BCF plan for 2022-23.

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to record demand

- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
Data for capacity and demand should be provided on a month by month basis for the third and fourth quarters of 2022-23 (October to March)

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as defined in appendix 4 of the BCF Planning Requirements.

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

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

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

2. Cover

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.bettercarefundteam@nhs.net
(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via your BCM.
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance -
https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest level of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services at a given time.

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:
- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

HM Government

NHS

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Herefordshire, County of
Completed by:	Adrian Griffiths
E-mail:	adrian.griffiths2@herefordshire.gov.uk
Contact number:	01432 383809
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Corporate Director Community Wellbeing & HWICB Chief Executiv
Name:	Hilary Hall and Simon Trickett

How could this template be improved?	

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

[<< Link to the Guidance sheet]

[^^ Link back to top]

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Herefordshire, County of

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	2302	2228	2302	2302	2079	2302
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	85	83	85	85	77	85
2: Step down beds (D2A pathway 2)	9	9	9	9	8	9
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	34	33	34	34	31	34

Any assumptions made:	Discharge demand is based on average daily discharges from Wye Valley NHS Trust (WVT). WVT is a combined acute and community providers and discharge data includes discharges from acute and community hospital beds

!!Click on the filter box below to select Trust first!!

Demand - Discharge							
Trust Referral Source (Select as many as you need)	Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
WYE VALLEY NHS TRUST	0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector	1104	1068	1104	1104	997	1104
WYE VALLEY NHS TRUST	1: Reablement in a persons own home to support discharge (D2A Pathway 1)	85	83	85	85	77	85
WYE VALLEY NHS TRUST	2: Step down beds (D2A pathway 2)	9	9	9	9	8	9
WYE VALLEY NHS TRUST	3: Discharge from hospital (with reablement) to long term residential care (Discharge to	34	33	34	34	31	34

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Herefordshire, County of

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	

Demand - Intermediate Care						
Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services						
Urgent community response						
Reablement/support someone to remain at home						
Bed based intermediate care (Step up)						

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Herefordshire, County of

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	

Capacity - Hospital Discharge							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
VCS services to support discharge	Monthly capacity. Number of new clients.	0	0	0	0	0	0
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.						
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	56	56	56	56	56	56
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	30	30	30	30	30	30
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	54	54	54	54	54	54

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: Herefordshire, County of

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	

Capacity - Community							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.						
Urgent Community Response	Monthly capacity. Number of new clients.						
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	24	24	24	24	24	24
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	0	0	0	0	0	0

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board: Herefordshire, County of

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	£7,224,568
BCF related spend	£4,588,174
Comments if applicable	The Herefordshire system is currently investing a mix of recurrent BCF funds and non-recurrent resources from local authority reserves to maintain the capacity put in place during the pandemic that otherwise would've been lost at the end of

Classification: Official

Publication approval reference: PAR1296

Better Care Fund planning requirements 2022-23

19 July 2022

Contents

Introduction

1. The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2022-23. The framework forms part of the NHS mandate for 2022-23.

2. The use of BCF mandatory funding streams (NHS minimum contribution, Improved Better Care Fund grant (iBCF) and Disabled Facilities Grant (DFG) must be jointly agreed by integrated care boards (ICBs) and local authorities to reflect local health and care priorities, with plans signed off by health and wellbeing boards (HWBs). BCF plans should include stretching ambitions for improving outcomes against the national metrics for the fund. No new metrics have been introduced for 2022-23.

3. One of the findings from the 2018 BCF review was to provide clearer and more focused objectives for the BCF that address wider system and prevention outcomes through co-ordination of services. The two objectives for 2022-23 BCF are:

   i. Enable people to stay well, safe and independent at home for longer.

   ii. Provide the right care in the right place at the right time.

4. National condition four of the BCF has been amended to reflect these two objectives and now requires HWB areas (referred to as areas in this document) to agree an approach within their BCF plan to make progress against these objectives in 2022-23.

5. BCF plans must be submitted by 26 September 2022. Draft plans can be submitted to Better Care Managers (BCMs) by 19 August for feedback, and areas are strongly encouraged to do this. Assurance will be carried out on final plans.

6. As in previous years, this guidance forms part of the core NHS Operational Planning and Contracting Guidance. ICBs are required to have regard to this guidance, which is issued using NHS England's powers under the NHS Act 2006.

   These planning requirements are being published jointly with the Local Government Association and will be disseminated directly to local government.

7. The iBCF and DFG continue to be paid to local authorities with a condition that they are pooled locally into the BCF and spent on specific purposes set out in the grant determinations and conditions.

8. For 2022-23, BCF plans will consist of:

- a completed narrative template
- a completed BCF planning template, including:
  - planned expenditure from BCF sources
  - confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
  - ambitions and plans for performance against BCF national metrics
  - any additional contributions to BCF section 75 agreements.
- A completed intermediate care capacity and demand plan submitted alongside the BCF plan. (These will not be subject to assurance.)

Legal framework

9. The government's mandate to the NHS for 2022-23, issued under section 13A of the NHS Act 2006, sets an objective for NHS England to ringfence funding to form the NHS contribution to the BCF. The Policy Framework confirms that this ringfence is £4.504 billion in 2022-23.

10. These planning requirements set allocations (published on the NHS website) from this ringfence to ICBs, and in turn from ICBs to their HWB areas, and apply conditions and requirements to their use.

11. BCF plans and their delivery should comply with these conditions as part of the delivery of ICB duties relating to the promotion of integration, acting effectively and efficiently, the improvement of the quality of services and the reduction of health inequalities under the NHS Act 2006.

Mandatory funding sources

12. The following minimum funding must be pooled into the BCF in 2022-23.

Source	2021/22 (£m)	2022-23 (£m)	Percentage change
NHS contribution	4,263	4,504	5.66%
Improved Better Care Fund	2,077	2,140	3%
Disabled Facilities Grant	573	573	0

National conditions

13. The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved. These are:

    1. **A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board.**
    2. **NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.**
    3. **Invest in NHS commissioned out-of-hospital services.**
    4. **Implementing the BCF policy objectives.**

14. Compliance with the national conditions will be confirmed through the planning template and narrative plans. Spend applicable to these national conditions will be calculated in the planning template based on scheme-level expenditure data.

National condition 1: Plans to be jointly agreed

15. National condition 1 requires that a plan for spending all funding elements is jointly agreed by the relevant local authority and ICB(s) and placed into a pooled fund, governed by an agreement under section 75 of the NHS Act 2006. 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 planning requirements.

16. Plans must be agreed by the ICB (in accordance with ICB governance rules) and the local authority chief executive, prior to being signed off by the HWB.

17. 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.

18. Systems should review the assessment of health inequalities and equality for people with protected characteristics under the Equality Act 2020 from their 2021-22 plans and update these, where appropriate. Narrative plans should briefly set out any changes to local priorities in terms of health inequality or equality for people with protected characteristics, and how BCF funded services are being delivered to address these, including data where this is appropriate. Where data is available, local areas should also consider any differential outcomes for people from groups with protected characteristics and other vulnerable groups in relation to the metrics of the BCF and how actions in their plan can contribute to reducing these.

19. Data on avoidable admissions and on discharge to be used in the BCF for 2022-23 will be made available on the Better Care Exchange. This will include ethnicity and age information to support analysis as well as links to guidance and documents on equality. ICBs will need to have regard to the NHS Operational Planning and Contracting Guidance regarding the reduction of health inequalities. This guidance emphasises the importance of partnership working for effective use of the available resources to ensure that reducing inequalities in access is embedded in the NHS's approach. While local authorities will have their own priorities under the Equality Act, BCF plans will need to reflect what NHS bodies are doing to address inequalities under Core20PLUS5, which focuses on the most deprived 20% of a population, the ICS-identified groups in each area that experience poorer than average access and five additional areas of focus.

Mandatory components of the Better Care Fund

NHS minimum contribution to the Better Care Fund

20. NHS England has published allocations from the national ringfenced NHS contribution for each ICB and HWB area for 2022-23 on its website. The minimum

NHS contribution to each HWB area is the 'NHS minimum contribution' or the 'NHS minimum'. The allocations for all mandatory funding sources are pre-populated in the BCF planning template at HWB level.

21. For 2022-23, the allocations of the NHS contribution to the BCF have been increased by 5.66% for each HWB area. The contribution for each HWB area continues to include funding to support local authority delivery of reablement (£300 million), carers' breaks (£130 million) and implementation of duties to fund carer support under the Care Act 2014 (£161.62 million). Local allocations of these elements of the NHS minimum contribution are not set for each area, and it is for local government and ICBs to agree the funding to allocate to these services as part of their local BCF plans. BCF plans should reflect clearly how this funding has been identified.

22. With particular reference to funding to support carers' breaks and carer support under the Care Act 2014, the narrative section of BCF plans should also include a brief overview of how BCF funding available in their locality is being used to support unpaid carers. This supports the government's recent commitments on empowering unpaid carers, as set out in the adult social care reform white paper: People at the Heart of Care.

23. When agreeing plans for use of BCF funding to support reablement, areas should consider how this expenditure and the approach to commissioning these services aligns to wider plans. Plans should set out how reablement (and rehabilitation) services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care, and how BCF funding is supporting capacity for these services, along with NHS and local authority funding (see national condition 4). For the BCF in 2022-23, systems are required to agree high level capacity and demand plans for intermediate care services, covering both BCF and non-BCF funded services (see paragraphs 45–52 and Appendix 4).

24. National conditions 2 and 3 apply only to spend from the NHS minimum contribution and are set out below.

National condition 2: NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution

25. National condition 2 requires that, in each HWB area, the contribution to social care spending from the NHS minimum contribution is maintained in line with the percentage uplift in the NHS minimum contribution to the BCF in that HWB area.

The NHS minimum contribution for each HWB area has been uplifted by 5.66%, and this uplift must be applied to the minimum expectation for social care spend in 2021-22 plans for the HWB.

26. 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 NHS minimum contribution to the BCF.

27. As in previous years, the minimum expectations in each HWB area will be confirmed in the BCF planning template. Any schemes where the spend type is 'social care' and the funding source is the NHS minimum will count towards this expectation. It is for local areas to agree the schemes that will be funded from this minimum. ICBs and councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

Revisions to baselines for social care maintenance

28. Baselines for social care contributions are based on local agreements for maintaining the financial contribution from the NHS to social care (baselined from 2016-17).

29. Areas were able to query the baselines in 2017 to 2019. However, if since then, an area has identified that the baseline used for calculating the minimum contribution is wrong, they can request that the figure is reviewed. This can only be done, by exception, in cases where activity has been miscoded and the request must be made by the HWB. Further details are set out in Appendix 2.

National condition 3: Agreement to invest in NHS commissioned out-of-hospital services

30. A minimum of £1.28 billion of the NHS contribution to the BCF in 2022-23 is ringfenced to deliver investment in out-of-hospital services commissioned by ICBs, while supporting local integration aims. Each HWB area's share of this funding is set out in the BCF planning template and will need to be spent as set out in national condition 3. 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 ICBs from the NHS minimum contribution.

Grant funding to local government

Improved Better Care Fund (iBCF)

31. The grant determination for the iBCF was issued on 22 April 2022. Since 2020-21, funding that was previously paid as a separate grant for managing winter pressures has been included as part of the iBCF grant but is not ringfenced for use in winter.

32. The grant conditions remain broadly the same as in 2021-22.

33. The funding may only be used for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready
- ensuring that the social care provider market is supported.

34. iBCF funding can be allocated across any or all of the four purposes of the grant in a way that local authorities, working with ICB(s), determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the purposes.

35. The grant conditions for the iBCF also require that the local authority pools the grant funding into the local BCF and reports as required through BCF reporting. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care (national condition 2).

Disabled Facilities Grant

36. Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local authorities. The statutory duty to provide DFGs to those who qualify for them is placed on local housing authorities. Therefore, each area must ensure that sufficient funding is allocated from the DFG monies to enable housing authorities to continue to meet their statutory duty to provide adaptations to the homes of eligible people of all ages.

37. In two-tier areas, decisions around the use of 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.

38. The DFG is pooled into the BCF to promote joined-up approaches to meeting people's needs to support more people of all ages to live in suitable housing so they can stay independent for longer. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care, and strategic use of the DFG can support this.

39. 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
- as DFG funding is capital funding, the funding can only be used for capital purposes
- the funding supports a strategic approach to housing and adaptations that supports the aims of the BCF
- the use of the funding in this way has been developed and agreed with relevant housing authorities.

40. The scope for how DFG funding can be used includes to support any local authority expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables local government to use specific DFG funding more flexibly. There are numerous case studies of innovative use of DFG funding on the Better Care Exchange[1] and Foundations websites.

41. 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. The Care Act 2014 also requires local authorities 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.

[1] An account is needed to access the Better Care Exchange, if you do not have one and would like to set one up, please email england.bettercarefundteam@nhs.net

42. The Government published updated guidance for local authorities on 28 March 2022 that sets out how they can effectively and efficiently deliver DFG funded adaptations to best serve the needs of local older and disabled people.

National condition 4: implementing the BCF policy objectives

43. National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:

i. **Enable people to stay well, safe and independent at home for longer.**

ii. **Provide the right care in the right place at the right time.**

44. For both objectives, areas should describe:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care.
- How BCF funded services will support delivery of the objective.

45. In addition to this, areas are asked to develop plans that outline expected capacity and demand for intermediate care services in the area, covering demand for both services to support people to stay at home (including admissions avoidance) and hospital discharge pathways 0–3 inclusive, or equivalent, for quarters 3 and 4 of 2022-23 across health and social care. This should cover both:

- BCF funded activity
- non BCF funded activity.

46. The NICE guidance on intermediate care defines it as "a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care".

47. A system-wide understanding of demand and capacity across intermediate care is critical to enabling areas to maximise both people's health, wellbeing and

independence, and utilisation of system resources. It enables areas to understand trends and variation, and so agree joint actions to anticipate demand more accurately across health and care in the medium and long term, and respond more effectively to shorter term or unpredicted demand or challenges.

48. While councils retain their Care Act 2014 duties in terms of market management, a joint approach to planning intermediate care enables areas to more effectively and holistically shape local health and care provision to develop the necessary capacity to meet anticipated demand. The Local Government Association (LGA) and partners' High Impact Change Model for managing transfers of care provides advice on developing effective capacity and demand systems.

49. As a first step, areas are asked to jointly develop a single picture of intermediate care needs and resources across health and social care funded by the BCF and other sources for quarters 3 and 4 of 2022-23. There is no expectation that the BCF should be used to fund all services within this capacity and demand plan.

50. Areas should work closely across all partners to produce the plan and utilise data submitted by NHS organisations on hospital discharge pathway activity as well as local authority service data as part of operational plans. NHS trusts should be involved in, and contribute to, the development of these plans. Further guidance is available in Appendix 4, and bespoke support will be available through the BCF external support programme delivered by the LGA.

51. When estimating capacity and demand at local authority level, ICBs should make use of the discharge pathways model that is available on NHS Foundry and the projected activity levels submitted as part of NHS planning. Plans should also take account of planning carried out in preparation for the winter.

52. These capacity and demand plans will need to be submitted with main BCF plans, but the content will not form part of the overall BCF assurance process.

Objective 1: Enabling people to stay well, safe and independent at home for longer

53. This objective seeks to improve how health, social care and housing adaptations are delivered to promote independence and address health, social care and housing needs of people who are at risk of reduced independence, including admission to residential care or hospital. This might include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

54. The LGA published a High Impact Change Model for reducing preventable admissions to hospital and long-term care in 2021. The document sets out five actions for systems that areas should consider:

- population health management
- target and tailor interventions for those most at risk
- effective multidisciplinary working
- educate and empower people to manage their own health and wellbeing
- provide a co-ordinated and rapid response to crises in the community.

55. BCF plans for 2022-23 should set out how BCF funding (including any voluntarily pooled funding) aligns in support of this objective. This should include:

- providing details in the BCF planning template of planned spend on prevention-related activity
- how joint health and social care activity will contribute to the improvements agreed against BCF national metrics, including prevention (unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)).

Objective 2: Provide the right care in the right place at the right time

56. BCF plans should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this. Systems should have regard to the guidance on collaborative commissioning

published by the LGA, in partnership with the BCF Programme, and guidance produced following the evaluation of the Hospital Discharge Policy and Discharge to Assess.

57. The High Impact Change Model for managing transfers of care was refreshed in 2019 and has been further updated in 2020 to reflect changes to discharge introduced to support the response to COVID-19. Continued implementation of the model is integral to delivery of this objective and the requirements of the BCF. As part of developing their BCF plan, areas should review and self-assess their implementation of the model. Narrative plans should include confirmation of this review and the planned actions arising from this.

58. The national Hospital Discharge Fund came to an end on 31 March 2022.[2] NHS England wrote to systems in March to encourage them to continue to make best use of existing resources to support safe and effective discharges within local priorities. BCF plans for 2022-23 should set out how BCF funding (including any voluntarily pooled funding) aligns in support of this objective. This should include:

- providing details in the BCF planning template of planned spend on discharge-related activity
- how joint health and social care activity will contribute to the improvements agreed against BCF national metrics for discharge (increasing the proportion of people discharged from hospital to their normal place of residence).

59. Local authorities and ICBs are expected to continue to pool pre-existing expenditure on discharge. Where this expenditure is from BCF sources, this should be indicated in the BCF planning template by selecting the appropriate scheme type and subtype in the expenditure worksheet.

Agreement of local plans

60. Areas will need to agree a narrative plan and confirm agreed expenditure and compliance with the requirements of the fund in the BCF planning template. Local

[2] https://www.england.nhs.uk/coronavirus/publication/funding-of-discharge-services-from-acute-care-in-2022-23/

NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans.

61. Final narrative plans, completed planning templates, and intermediate care capacity and demand plans should be submitted by 26 September. Areas are strongly encouraged to submit draft plans (including capacity and demand plans) to BCMs (copied to the BCF team) by 18 August for review and feedback.

62. Narrative plans should reflect how commissioners will work together in 2022-23 to:

- continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally
- set out how the area will make progress against the two objectives set out in national condition 4
- an overview of how BCF funding is supporting unpaid carers (with particular reference to how funding in the NHS minimum contribution to fund carer's breaks and local authority duties to support carers under the Care Act 2014 is being used)
- priorities for promoting equality and reducing health inequalities.

63. Narrative plans will be collected separately to the main BCF planning template. A narrative template has been made available on the Better Care Exchange site, but areas can use their own formats.

64. Intermediate care capacity and demand plans need to be submitted alongside main BCF plans but will not be subject to BCF assurance.

BCF planning template

65. The planning template will continue to be used to collect expenditure details, confirmed funding contributions and confirmation that planning requirements are met. This will include information on discharge and non-discharge spend, as in previous years.

66. The template will be pre-populated with:

- minimum funding contributions from all mandatory funding sources for each area
- minimum ringfenced amounts from the NHS minimum for:

- the contribution to social care (national condition 2)
- spend on NHS commissioned out-of-hospital services (national condition 3) for each area.

67. The template will calculate spend applicable to each of these national conditions automatically.

68. Areas will need to confirm:

    a. That all mandatory funds have been pooled and agreed.

    b. Scheme level spend by:

        - funding source
        - scheme type and subtype
        - brief scheme description
        - amount of spend in 2022-23
        - area of spend (that is, social care, community health, continuing care, primary care, mental health, acute care)
        - commissioner type
        - provider type.

    c. Performance ambitions for metrics and how BCF activity will contribute to making progress against these metrics.

69. A separate confirmation sheet will collect yes/no confirmation that the following requirements are met:

    - In two-tier local government areas, that DFG funding has either been passed to district/borough councils, or that there is agreement with district/borough councils on the use of any retained grant.
    - Funding for reablement, Care Act 2014 duties and carers breaks has been identified in spending plans and the BCF narrative plan sets out the approach to supporting unpaid carers through the BCF (see paragraph 62).

70. The specific scheme types and subtypes were updated in 2021 to collect better information on how BCF funding streams support discharge. This information will support future policy development and areas should aim to record these scheme types as accurately as possible in their spending plans.

71. When completing the BCF planning template, areas should, as far as possible, avoid classifying scheme types as ‘other’ where a specific scheme category can be used. The clarity of this information is important in being able to account properly for the effective use of the funding pooled into the BCF. Areas may be asked for further information on spend classed as 'other’ through the assurance process.

Metrics

72. The BCF Policy Framework sets national metrics that must be included in BCF plans in 2022-23. The metrics for the BCF in 2022-23 are:

- proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)
- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes)
- unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)
- improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of residence).

Please see Appendix 3 for further detail.

73. Ambitions should be agreed between the local authority and ICB(s) and signed off by the HWB. The BCF planning process will also collect rationales for the ambitions set for each metric, plans for achieving these ambitions and how BCF funded services will support this.

74. The metrics tab in the BCF planning template has been updated to include two narrative sections; ‘rationale for ambition’ and ‘local plan to meet ambition’. The first of these should be used to detail how the target has been arrived at (including analysis of historical data) and expected impact of planned funding (including the impact of previous investment). The second should outline the local plan for improving performance against each metric, including changes to commissioned services, joint working and how BCF funding will support this.

75. Baseline data on discharge and unplanned admissions for ambulatory care sensitive conditions will be made available on the Better Care Exchange. Hospital trusts, local authorities and ICBs should work together to continue to improve the use of situation reporting and other data to understand flow.

76. Ambitions for 2022-23 as a whole should be set based on:

- current performance (from locally derived and published data)
- local priorities, including COVID-19 recovery
- expected demand
- planned (particularly BCF funded) services and changes to locally delivered services based on performance to date.

Discharge metrics

77. Local systems should agree a plan to improve outcomes across the HWB area for the proportion of people discharged home using data on discharge to their usual place of residence.

78. The ambition should be developed with NHS trusts and foundation trusts. The ambition should be stretching and should build on performance from 2021-22.

79. From April 2022, the discharge ready date filed in hospital patient administration systems has become a required field and will be used to collect the date a person no longer meets any of the criteria to reside. From 2023, this data will be used as a basis for a metric linked to delayed discharge, as long as the data is robust and can be published. During 2022-23, systems should work together to improve data collection rates and quality with a view to being able to agree plans for performance on delayed discharge from April 2023. The measure of the percentage of acute hospital stays that are 14 days, or 21 days or over has been removed as a core metric for 2022-23, although length of stay remains a priority. Therefore, data on length of stay will continue to be made available on the Better Care Exchange for local areas and will continue to be monitored regionally and nationally with BCF support provided for areas facing the greatest challenges.

Assurance

80. Assurance processes will confirm that national conditions and planning requirements are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed.

81. Assurance of final plans will be led by Better Care Managers (BCMs) with input from NHS England and local government representatives. It will be a single stage exercise based on a set of key lines of enquiry (KLoEs).

82. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region. The purpose of the cross-regional calibration session is to:

- share the position on BCF plan assurance status across each of the seven regions
- provide confidence that the scrutiny during plan assurance has been consistent
- identify any variations between regions and discuss the approach taken to preserve consistency
- identify concerns that require clarity from outside the attendee group and determine next steps.

83. Following the calibration meeting, recommendation for approval will be made by NHS England regional directors – this will include confirmation that local government representatives were involved in assurance and agree the recommendations. NHS England will approve BCF plans in consultation with DHSC and DLUHC. NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released.

Table 1: BCF assurance categories

Category	Description
Approved	• Plan agreed by HWB • Plan meets all national conditions and planning requirements (including but not limited to the requirement to submit an intermediate care capacity and demand plan)

	• Agreed ambitions for BCF metrics are sufficiently stretching • Agreement on use of local authority grants (DFG and iBCF) • No or only limited work needed to gather additional information on plan – where there is no impact on national conditions • Area has submitted an intermediate care capacity and demand plan
Not approved	• One or more of the following apply: – plan is not agreed – one or more national conditions are not met, taking into account the associated planning requirements – no local agreement on use of local authority grants (DFG and iBCF). – no intermediate care capacity and demand plan submitted

84. Where plans are not initially approved, the BCF team may implement a programme of support, with partners, to help areas achieve approval as soon as possible or consider placing the area into formal escalation.

85. Escalation will be considered in the event that:

- the ICB and the local authority are not able to agree and submit a plan to their HWB; or
- the HWB does not approve the final plan; or
- the NHS England regional director does not recommend a plan for approval.

86. 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, facilitated by the BCF programme and team. 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.

87. In instances where an area is unable to agree a compliant plan following a national escalation panel with support from BCMs and external advisors commissioned by the BCF team, NHS England, in consultation with departments, will consider enforcement action, including directing the use of the NHS funds under the NHS Act 2006.

Monitoring and continued compliance

Updating BCF plans in year

88. It is recognised that areas may wish to amend plans in-year, following sign off and assurance, to:

- modify or decommission schemes
- increase investment or include new schemes.

89. In such instances, any changes to assured and approved BCF plans arising in-year must be jointly agreed between the local authority and ICBs and continue to meet the conditions and requirements of the BCF.

90. In both cases, revisions to plans should be approved by the HWB and confirmed in the end-of-year reporting template with an accompanying rationale. If the need arises to amend BCF plans in-year, please contact the relevant BCM in the first instance.

Monitoring compliance with BCF plans

91. BCMs and the wider BCF team will monitor continued compliance against the national conditions through their wider interactions with local areas.

92. Where an area is not compliant with one or more conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan and risk the national conditions being unmet, then the BCF team, in consultation with national partners, may make a recommendation to initiate an escalation process. Any intervention will be proportionate to the risk or issue identified.

93. The intervention and escalation process could lead to NHS England exercising its powers of intervention, in consultation with DHSC and DLUHC, as the last resort.

Reporting in 2022-23

94. 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.

95. These reports are discussed and signed off by HWBs as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into section 75 agreements. Monitoring will include confirmation that the section 75 agreement is in place.

96. Reporting will recommence in 2022-23 and will cover progress in implementing BCF plans, progress against metrics and ongoing compliance with the national conditions of the fund. Timely submission of reports is a requirement for the BCF, including as a condition of the iBCF. Therefore, areas that do not comply with the reporting timescales and detail may be subject to the procedures set out in Appendix 1 on support, escalation and intervention.

Timetable

The timescales for agreeing BCF Plans and assurance are set out below:

BCF planning requirements published	19/07/2022
Optional draft BCF planning submission (including capacity and demand plan) submitted to BCM and copied to the BCF team (england.bettercarefundteam@nhs.net)	18/08/2022
BCF planning submission from local HWB areas (agreed by ICBs and local government). All submissions will need to be sent to the local BCM, and copied to england.bettercarefundteam@nhs.net	26/09/2022
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	26/09/2022 - 24/10/2022
Regionally moderated assurance outcomes sent to BCF team	24/10/2022
Cross-regional calibration	01/11/2022
Approval letters issued giving formal permission to spend (NHS minimum)	30/11/2022
All section 75 agreements to be signed and in place	31/12/2022

Appendix 1: Support, escalation and intervention

1. Where performance issues or concerns over compliance with the requirements of the BCF are identified, the BCF team 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 (eg requirement to submit an intermediate care capacity and demand plan) d. Area is no longer compliant with their approved plan (in year)	The BCM and regional partners in consultation with the BCF team 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 BCF team 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 BCF team 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. **Escalation panel**	The escalation panel will be jointly chaired by DLUHC and DHSC senior officials, supported by the BCF team, with representation from: • NHS England (as the accountable body for NHS spend and for plan approval) • The LGA, in its role as a national partner for the BCF. Representation from the local area needs to include the: • health and wellbeing board chair • accountable officers from the relevant ICB(s) • chief executive from the local authority.
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 BCF team.
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 • directing the ICB, eg regarding its use of resources. 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.

2. If an area fails to develop a plan that can be approved by NHS England, or if a local plan cannot be agreed, any proposal to issue directions will be subject to consultation with DHSC and DLUHC ministers. The final decision will then be taken by NHS England.

3. The escalation panel may make recommendations that an area should amend plans that relate to spending of the DFG or iBCF. This money is not subject to NHS England powers to direct. However, a BCF plan will not be approved if there is no 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 not to be met.

Appendix 2: Querying baseline for social care maintenance contributions

1. Required contributions to social care from NHS minimum contributions at HWB level have been calculated from locally agreed figures assured in 2016/17 BCF plans, uprated in line with growth in that area's ICB contribution in each subsequent year.

2. In 2022-23, if local areas believe that this baseline is not correct, they will be able to request that it be reviewed. A review can only be requested where the baseline is not correct because historical schemes have been incorrectly coded. A review can be requested because the current baseline overstates or understates social care spend.

Process

3. Areas should inform their better care manager (BCM) if they believe that the baseline for maintaining social care spend is incorrect, setting out their reasoning, confirming the miscoded schemes and any supporting documents. Areas must confirm that both the relevant ICB(s) and local authority(ies) agree that the baseline is not correct, and the HWB supports the request..

4. The query and supporting evidence will be reviewed by the BCF team with the BCM. Recommendations for amending a baseline will be made to the BCF Programme Board. If the BCF Programme Board agrees to amend a baseline, areas will be notified as soon as possible.

Appendix 3: Detailed definitions of BCF metrics

Metric 1: 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 admission to residential or nursing care homes can improve 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 April to March) Timing of availability: data typically available 6 months after year end.
Historical	Data first collected 2014-15 following a change to the data source.

Metric 2 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 is provided 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, 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 2 x 3 months of data – see definition above) Timing of availability: data typically available 6 months after year end.
Historical	Data first collected 2011-12 (currently five years' final data available: 2011-12, 2012-13, 2013-14, 2014-15 and 2015-16).

Metric 3 Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Outcome sought	Improved health status for people with chronic ambulatory care sensitive conditions
Rationale	This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. The numerator is given by the number of finished and unfinished admission episodes, excluding transfers, for patients of all ages with an emergency method of admission and with a primary diagnosis of an ambulatory care sensitive condition such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, pulmonary oedema. Because the denominator for the official published measure (mid-year population estimates for England published by the Office for National Statistics (ONS) are only available in June following the end of year in question, baseline data provided in the BCF template shows uses mid-year estimates for 2020-21 as a denominator).
Definition	**Numerator: Unplanned admissions by quarter for ambulatory care sensitive conditions.** Hospital Episode Statistics (HES) admitted patient care (APC). A fuller code and historical data is provided on the Better Care Exchange.
Source	NHS Outcomes Framework

Reporting schedule for data source	Data will be extracted monthly by the BCF team
Historical	Quarterly and annual data from 2003-04 Q1 for all breakdowns

Metric 4 Discharge to usual place of residence

Outcome sought	Improving the proportion of people discharged from hospital to their own home using data on discharge to their usual place of residence.
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. Maximising the proportion of people who return to their usual place of residence at the point of discharge enables more people to live independently at home. This indicator measures the percentage of discharges that are to a person's usual place of residence.
Definition	**Numerator:** The number of discharges of people over the age of 18, following an inpatient stay, that are recorded as being to a person's usual place of residence. **Denominator:** All completed hospital spells recorded in SUS for people over the age of 18 – calculation on monthly total.
Source	NHS Secondary Uses Service (SUS)
Reporting schedule for data source	Monthly. Data is extracted by the BCF team and updated monthly on the Better Care Exchange. SQL codes are available for systems on the Better Care Exchange.
Historical	Monthly data from 2018-19 Q1 for all breakdowns.

Appendix 4: Capacity and demand planning

Introduction

1. All systems must submit a high-level overview of expected demand for intermediate care and planned capacity to meet this demand alongside their BCF plans. The content of capacity and demand plans will not be assured in 2022-23 but their completion is a condition of BCF plan approval.

2. For capacity and demand planning to work well in an integrated context, there needs to be a joint understanding of the demand for health and social care and a comprehensive picture of capacity.

3. This is the first time that capacity and demand plans have been required through BCF. As far as possible, areas should aim to use their existing data and plans to ensure alignment. For example, using ICS level projections for expected discharges per month and by discharge pathway. Areas can also make use of the Discharge Pathways Model Analytical Tool, available on the NHS Futures site. In both cases, these will need to be mapped to local authority footprints and agreed locally, making use of local management information data.

4. Plans should be agreed between local authority and Integrated Care Board partners and signed off by the HWB as part of the wider BCF plan for 2022-23. Service capacity should cover health, social care and jointly commissioned services. Plans should also consider the full spectrum of care supporting recovery, reablement and rehabilitation, such as from the voluntary and community sector.

5. A template is provided for areas to complete with this information, and guidance for filling this in is provided separately.

Services to be included in plans

6. All local authority and health commissioned intermediate care services, not just those funded by the BCF, should be included in capacity and demand plans.

7. The NICE guidance on intermediate care defines it as "a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care". The capacity and demand plans should cover:

   - reablement/short-term domiciliary care to support someone to remain at home following a deterioration, fall, or following a spell in hospital
   - home-based intermediate care, provided to people in their own homes by a team with different specialities but mainly health professionals such as nurses and therapists
   - bed-based intermediate care involving therapy, either to recover function and avoid admission to hospital/residential care, or to return home following a spell in hospital
   - crisis response (two-hour response/short term) to prevent hospital admissions.

8. Where the source of demand is to support hospital discharge; this should be broken down by discharge pathway, as defined in the Hospital discharge guidance (2022).

Why capacity and demand?

9. Demand for services changes across a year, but comparing demand data against available resources, allows systems to model future demand and anticipate pressures before they arise. Capacity and demand modelling can help visualise performance and increase the likelihood that demand will be met, through service redesign and efficient use of resources, and help reduce the need for costly measures such as using agency staff and spot purchased provision.

10. The aims of requesting these plans are to:

    - ensure that an integrated approach to capacity and demand planning is happening across health and social care

- improve understanding (locally, regionally and nationally) in systems of how capacity is used and inform commissioning decisions – with a view to increasing use of support in a person's own home where appropriate
- inform nationally commissioned support (particularly BCF support) and policy
- provide insights regarding the potential to improve the impact and outcomes for people who use intermediate care.

Content of BCF capacity and demand plans

11. To develop capacity and demand plans, ICBs and local authorities will need to collaborate with input from providers (NHS trusts and social care providers) to review existing data, including NHS planning returns (this should include estimated discharge activity for 2022-23 and anticipated levels of urgent community response referrals). This should involve the following steps.

12. **Estimated current demand** – as a first step, expected levels of demand for intermediate care from a range of services will need to be reviewed and agreed. There is scope for areas to identify their own referral sources, but this section will likely include:

    - expected episodes of short-term care following community referrals for assessment (eg single points of access, 111, primary care, social workers)
    - current and expected demand for supported discharge by source (ie trust/site); these should draw on ICB-level data on expected discharge activity developed for NHS plans
    - referrals for rapid crisis response, again from data developed for NHS plans.

13. Expected demand levels should be projected on a month-by-month basis. Systems should review historical and current demand to identify the level of demand they will be expecting over this time period. We recommend that systems follow the guidance on the discharge pathways model. This involves:
    - Reviewing referrals that lead to short-term care (demand) by day across a period and ordering these in terms of increasing numbers of referrals.
    - Agreeing a level of demand that should be assumed to happen on a daily basis such that, if capacity were to meet this, it would enable people to commence their care package within the expected timeframe. The discharge pathways model recommends that assumed demand should be the 95th

centile (eg if looked at across 100 days, the 95th centile would be the sixth busiest). Depending on the source of demand, a different threshold may be set.

  - Repeat this for different sources of referral.

14. **Current commissioned capacity** – across health and social care. This will include:

    - service type (eg bed-based/home-based, reablement/rehabilitation)
    - where applicable, discharge pathway. Show pathway 0 discharges with no further support needs as a single service
    - capacity: this should show the number of new referrals the service could normally accept each month
    - for services that accept community and hospital referrals – expected split between discharge and community referrals.

15. **Estimated spend** – the template does not collect detailed spending on intermediate care at a service level, but areas are asked to estimate the total annual spend on intermediate care in the area from:

    - BCF sources – including additional voluntary contributions
    - other funding.

16. This information is being collected to improve understanding of current investment in intermediate care and to support policy development. As with the capacity and demand plans in general, this information will not be subject to assurance or used for performance management.

Narrative

17. Systems will be expected to include a narrative explanation of any assumptions they have made in their plans – for example:

    - changes in demand over winter
    - assumptions about services in scope
    - mapping figures from an ICS onto a local authority footprint
    - data gaps

- support needed, eg to help improve demand modelling or to agree action to reduce capacity gaps.

18. It is expected that, especially this first year, many systems could encounter some difficulty with projecting expected demand because of, for example, masked unmet needs and the impact of COVID-19. This narrative section should be useful for summarising data gaps, limitations and assumptions systems have had to make to complete their plans.

19. The narrative section should also include an overview of expected demand and planned services, likely gaps in provision and any changes as a result of the planning process.

Other sources of guidance

20. Further guidance and advice on capacity and demand planning is available.

- Report for the LGA on developing a capacity and demand model for out-of-hospital care by Professor John Bolton, based on work with seven systems.
- NHS England guidance on capacity and demand modelling for health.
- The Better Care Exchange, where some additional supporting documents including an FAQ will be published.

Contact us:

If you have any queries about this document, please contact the BCF team at: england.bettercarefundteam@nhs.net

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

For more information and regular updates on the Better Care Fund, sign up to our fortnightly bulletin and the Better Care Exchange by emailing england.bettercarefundexchange@nhs.net

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Cost of Living – Herefordshire Response

Health and Wellbeing Board

26th September 2022

Background

The rising costs of energy, food and other essentials are combining with existing disadvantage and vulnerability within our communities to put many households at greater risk of both immediate hardship and reduced opportunity and wellbeing.

With our partners, Herefordshire Council will continue to do what we can to protect people against higher costs, targeting help at those facing the most complex challenges

Impact

Added to these pressures, cost of living increases will impact on health and social care services in many ways, such as:

Patients: Downward pressure on incomes is expected to be greater than ever and there is already well-documented evidence to show the link between deprivation and poorer health outcomes across physical and mental health conditions. For example:

- Poor home heating properly over winter leading to exacerbated health conditions, particularly for older people.
- Impact on people's mental health and likelihood of cost pressures leading to poor dietary habits.
- There is likely to be less take up of co-paid health services such as prescriptions, optometry and dental services

Recommendations

1. Continue to promote the range of ways in which the council and its partners supports residents in need, particularly through Talk Community and Money on your Mind.

2. Ensure that specific support is in place for those for whom Herefordshire Council is a corporate parent.

3. Establish a Cost of Living Commission to gather information and identify other actions that the council and its partners can take to support residents.

4. Develop a longer term strategy for working with the voluntary and community sector, building on the foundations established over the last two years.

Current Support

Ongoing – advice and support

- Talk Community funded development of **community money management and debt advice** provision at a local level across all of the market towns and augmented by CAB outreach
- Network of **over 60 Talk Community Hubs** across the county supporting local residents and providing signposting to services with many also offering affordable / free activities
- **Talk Community Money on Your Mind website** – provides information on local and national support available to those who are struggling with money or debt problems
- A **generous Council Tax Reduction Scheme** to assist people on a low income with their Council Tax bill. The amount of reduction depends on individual circumstances but is designed to benefit those on a low income whether from benefits, low-paid work or self-employed work, those with no than £6,000 in savings and capital, and those on Universal Credit.
- The **Council Tax Discretionary Hardship Policy** offers eligible residents short term assistance, up to a maximum of six months, towards the cost of their council tax due to exception and temporary hardship.
- **Free school meals** - all primary school children in Reception year, Year 1 and Year 2 in Herefordshire are entitled to school meals.
- **Herefordshire Community Foundation** has worked collaboratively to support grants programmes targeting those most in need,
- **Home energy efficiency** – advice on how to save energy in the home and access to energy efficiency grants.
- **Emergency Welfare Provision** service for those who are at crisis point.
- Advice and support for households who are **homeless or at risk of homelessness.**

One-off funding and Developing initiatives

- **Household Support Fund** – majority used to support families and pensioners on local incomes with essential bills.
- **Discretionary Fund of Energy Rebate Scheme** –identification of households to benefit from discretionary element (£481,350) of the Energy Rebate Scheme.
- **More than £1million** spent on Covid 19 Recovery Grants for activities and services to encourage residents to increase physical activity and socialisation has been delivered free to participants
- **Mental Health** Provided funding for mental health and wellbeing support including Qwell (free, on line safe and anonymous mental wellbeing support for adults); free training in mental health awareness and Mental Health First Aid to community organisations; funding for a community mental health co-ordinator employed by Mind to encourage a network of community organisations supporting mental health for local people
- **Holiday Activities and Food Programme** provides support for families on low incomes during main school holidays with over 1000 children taking part in the activities during the summer and 30 providers delivering the offer, funding provided for three years.

In development

- Scoping and developing **warm hubs across the county** by utilising the libraries and archive building as well as Talk Community hubs.
- Scoping a '**community chest' fund for charities** by working with Community Foundation to identify businesses who may wish to donate money into a fund that will be distributed to community organisations that supports the wellbeing of residents.

Next Steps

- Bring together a range of partners to look at how to support residents further by holding a summit in early October.
- Gather information from identified groups and cohorts on the challenges they are facing and the ideas that they have, across the county (urban and rural) to understand better the impact of the crisis on their day to day lives. This could be run on a Ward/Primary Care Network basis with Ward Councillors leading/promoting it in their wards.
- Run a series of bespoke events in each of the Community Hubs during October and November offering personalised advice to individuals. The events to be run jointly with other partners, such as housing associations.
- Develop and run a Herefordshire-wide communications and engagement campaign from mid-September promoting the help that the council and others can provide, including creating a specific page on the council website with links to all available support options and encouraging all partners to link to it.
- Explore the feasibility of setting up a community lottery in Herefordshire which will raise money specifically for good causes in the county.
- Gather the themes emerging from Community Hubs work into an initial position statement and where appropriate, make recommendations for the Cabinet and other partners in January 2023.
- Hold a further summit in July 2023 to review actions and identify further work required, shaped around the longer term issues of debt, mental health, economy and housing.

Any other opportunities/risks?

- Impact on staff, how as a system are we supporting our workforce?
- Five health inequality work streams in collaboration with VCSE and through the Community Partnership

Joint Health and Wellbeing Strategy (HWBS)

Progress Update

Joint Health and Wellbeing Strategy

- Statutory requirement since Health and Social Care Act 2012
  - Last strategy published 2017
- Core aim: set out strategies for meeting the local needs as set out in the Joint Strategic Needs Assessment (JSNA)
- Consideration to the impact of Covid-19
- Draft vision for the new strategy

‘Everyone in Herefordshire is resilient, leads a fulfilling life and is healthy’

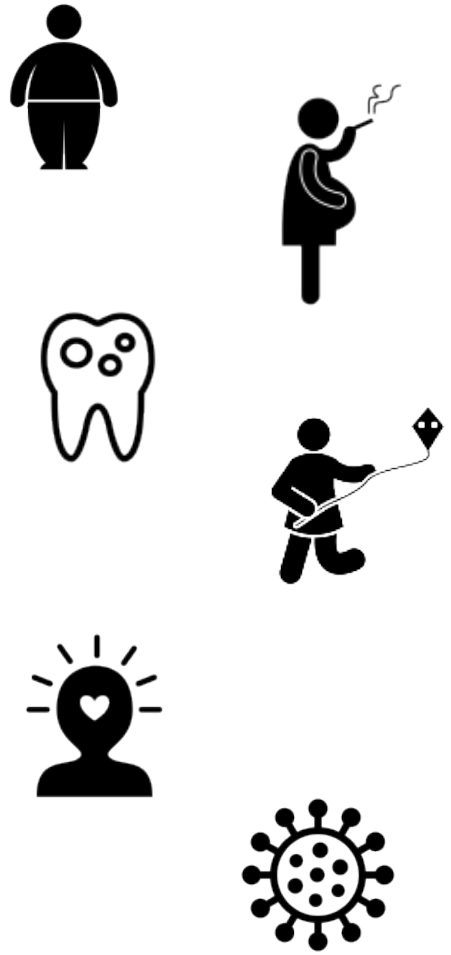
Our roadmap for developing the strategy

Progress to date

1. Established a Health and Wellbeing Strategy Task & Finish Group
2. Identified impact of delivery of existing strategy
3. Analysed Public Health data for Herefordshire
4. Reviewed existing Herefordshire plans, strategies and consultations
5. Identified best practice from health and wellbeing strategies from other areas
6. Engaging key stakeholder groups
7. Preparing a communication and engagement plan

Areas of concern

- 30.9% of adults are classified as obese and 25.8% of children are classified as overweight or obese at Reception ↑
- 11.5% of mothers smoking at time of delivery
- 31.9% of 5 year olds with experience of visually obvious dental decay
- 49.3% of children and young people are physically active
- 180.4 children per 100,000 are admitted to hospital for mental health conditions
- 51.1% estimated dementia diagnosis rate (aged 65+)
- 4.1% of Herefordshire and Worcestershire respondents with Long COVID-19 symptoms



Areas of concern

- 1.137 million tonnes of CO_2 emissions in 2018, with two local Air Quality Management Areas
- Infant mortality rate of 6.4 per 1,000
- Up to 33% of students reported ‘never’ feel safe going out after dark in their local area
- 19.9% of people successfully completed alcohol treatment and 10.7% of non-opiate users successfully completed drug treatment
- 13% of people aged 15-24 screened for chlamydia
- 58.2% screening coverage for breast cancer
- 24,845 adults have a common mental health disorder

Areas of concern emerging from Community Partnership feedback

Problem area	Feedback
Access to Services	Waiting lists, access to mental health services, GPs, Pharmacies & Dentists
Homelessness and Housing	Rough sleepers and those at risk, hidden homeless, good housing stock, cold homes
Rurality and Transport	Rurality increases cost of service provision, dwindling transport infrastructure, travelling to access care and services
Cost of Living	Financial health impact of the growing cost of living, “people just can't afford to live”
Dementia	“Dementia diagnosis require more awareness raising to break the stigma that prevents people asking for help”
Loneliness and Isolation	“There are deep issues with loneliness & isolation in a county where the transport infrastructure is dwindling rather than growing”
Food Poverty	Education and affordability of/access to nutritional food, Extending free school + holiday time meals
Digital Exclusion	Areas without broadband and/or people without digital skills, digital website needs

Identification of priorities for consideration

The following criteria have been used to identify potential priorities:

1. Herefordshire outcomes or indicators that are poor and are worsening or have plateaued (hereafter referred to as problems)
2. Problem(s) that affect a significant number of people or groups of people
3. Problem(s) that requires system/partnership working and responses to address
4. Problem(s) amenable to change with a strong evidence base for potential interventions
5. Problem(s) with evidence of inequalities in their effect on the population

Herefordshire priorities for consideration

Priority	This may include
1. Increasing access to healthy and sustainable food and physical activity	-Promoting a healthy weight across the life course -Increasing number of active children and young people -Reducing cardiovascular disease -Promoting food education and tackling food poverty
2. Tackling climate change	-Reducing emissions -Tackling fuel poverty and cold homes -Protecting and promoting green spaces
3. Promoting positive mental wellbeing in adults	-Decreasing rates of suicide and self harm -Supporting people with serious and long term problems -Improving wait times and access to services and support -Considering effects of Long COVID-19
4. Promoting positive mental wellbeing in children	-Addressing social, emotional and mental health needs -Decreasing mental health hospital admissions for children -Adopting a trauma informed approach & preventing ACE's -Helping children to feel safe

Herefordshire priorities for consideration

Priority	This may include
5. Making smoking obsolete and improving substance misuse outcomes	-Targeting groups where smoking prevalence remains high -Eliminating smoking in pregnancy -Decrease hospital admissions relating to alcohol in under 18s -Improving rates of drug and alcohol treatment completion
6. Improving oral health	-Decreasing tooth decay in children and promoting good hygiene -Improving oral health care plans for older adults in care -Increasing access to dental care -Delivering oral health education
7. Giving the best start in life	-Reducing infant mortality -Improving maternal health -Decreasing emergency hospital admissions in under 5 years old -Supporting children in care & with special educational needs (SEN)
8. Supporting people to age well	-Improving dementia diagnosis rates and support -Preventing falls and associated hospitalisations -Supporting people living with frailty and chronic disease

Herefordshire priorities for consideration

Priority	This may include
9. Reducing loneliness and social isolation across all ages	-Improving communication and connectivity among older adults -Helping children reconnect after the pandemic -Facilitating positive and healthy opportunities for adults to meet -Overcoming challenges of rurality
10. Supporting people through the cost of living crises	-Continuing and significantly elevated numbers of people claiming Universal Credit and out-of-work benefits vs pre-pandemic levels -Reducing risk of homelessness or rough sleeping -Reducing rates of children living in poverty
11. Improving access and transport	-Improving timely access to appointments, treatment and services -Increasing signposting and improving communications and outreach -Addressing rurality in planning the delivery of services and care -Decreasing digital exclusion by improving literacy and infrastructure
12. Improving social mobility and economic prosperity	-Less young people not in education, employment or training (NEET) -Reducing gap in the employment rate for those who are in contact with secondary mental health services

Cross cutting themes

There are also a number of cross-cutting themes that will underpin each priority and how our actions will be delivered:

1. Looking through the lens of inequalities - reducing the differences in health between different groups of people
2. Working with our communities as equal partners to co-produce local solutions
3. Considering digital and health literacy and ensuring people access the right support at the right time
4. Empowering people to become more actively involved in their own health using a strength based approach

Next Steps

1. Online public consultation on long list of priorities
2. Further engagement with partners and stakeholders on priorities
3. Health and Wellbeing Board Workshop (October 22)
4. Targeted engagement activity with seldom heard / key groups inc:
    1. Lower socio economic groups
    2. Individuals with learning and physical disabilities
    3. Children and young people
    4. Migrant workers
    5. Traveller community
    6. Ethnic diverse communities