Herefordshire Council

Agenda

Health and Wellbeing Board

Date:	**Monday 25 September 2023**
Time:	**2.00 pm**
Place:	**Conference Room 1, Herefordshire Council Offices, Plough Lane, Hereford, HR4 0LE**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Henry Merricks-Murgatroyd, Democratic Services** Tel: 01432 260239 Email: henry.merricks-murgatroyd@herefordshire.gov.uk

If you would like help to understand this document, or would like it in another format or language, please call Henry Merricks-Murgatroyd, Democratic Services on 01432 260239 or e-mail henry.merricks-murgatroyd@herefordshire.gov.uk in advance of the meeting.

Agenda for the Meeting of the Health and Wellbeing Board

Membership

Chairperson	Councillor Carole Gandy	Cabinet Member Adults, Health and Wellbeing, Herefordshire Council
Vice-Chairperson	Jane Ives	Managing Director, Wye Valley NHS Trust
	Jon Butlin	Assistant Director (Prevention), Hereford & Worcester Fire and Rescue Service
	Ross Cook	Corporate Director for Economy and Environment, Herefordshire Council
	Darryl Freeman	Corporate Director for Children and Young People, Herefordshire Council
	Hayley Allison / Julie Grant	Assistant Director of Strategic Transformation / Head of Delivery and Improvement at NHS Improvement, NHS England
	Hilary Hall	Corporate Director for Community Wellbeing, Herefordshire Council
	Dr Mike Hearne	Managing Director, Taurus Healthcare
	Jane Ives	Managing Director, Wye Valley NHS Trust
	Councillor Jonathan Lester	Leader of the Council, Herefordshire Council
	David Mehaffey	Executive Director of Strategy and Integration, NHS Herefordshire and Worcestershire ICB
	Matt Pearce	Director of Public Health, Herefordshire Council
	Councillor Ivan Powell	Cabinet Member Children and Young People, Herefordshire Council
	Christine Price	Chief Officer, Healthwatch Herefordshire
	Simon Trickett	Chief Executive, NHS Herefordshire and Worcestershire ICB
	Superintendent Helen Wain	Superintendent, West Mercia Police
	Mark Yates	Chair of Herefordshire and Worcestershire Health and Care NHS Trust

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

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

3. DECLARATIONS OF INTEREST

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

4. MINUTES 9 - 18

To approve and sign the minutes of the meeting held on 26th June 2023.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.

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

www.herefordshire.gov.uk/getinvolved

The deadline for the receipt of a question from a member of the public is 20th September 2023 at 9.30 am.

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

6. QUESTIONS FROM COUNCILLORS

To receive any written questions from councillors.

The deadline for the receipt of a question from a councillor is 20th September 2023 at 9.30 am, unless the question relates to an urgent matter.

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

7. APPOINTMENT OF VICE-CHAIRPERSON

Recommendation: That board members consider candidates and appoint a vice chairperson in accordance with section 2.8.10 of the constitution.

8. HEALTH AND WELLBEING BOARD TERMS OF REFERENCE 19 - 26

For the Health and Wellbeing Board (HWB) to consider the revised terms of reference at appendix 1 and provide comments before recommending the changes to Council.

9. HEREFORDSHIRE'S BETTER CARE FUND (BCF) INTEGRATION PLAN 2023-25 27 - 130

To update Health and Wellbeing Board members on Herefordshire's Better Care Fund (BCF) Integration Plan 2023-25 and seek formal Health and Wellbeing Board approval.

The public's rights to information and attendance at meetings

You have a right to:

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

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

Recording of this meeting

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

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

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

Minutes of the meeting of Health and Wellbeing Board held in Conference Suite, Herefordshire Council Offices, Plough Lane, Hereford, HR4 0LE on Monday 26 June 2023 at 2.00 pm

Board members present in person, voting:

Darryl Freeman	Corporate Director for Children and Families, Herefordshire Council
Councillor Carole Gandy	Cabinet Member Adults, Health and Wellbeing, Herefordshire Council
Jane Ives (Vice-Chairperson)	Managing Director, Wye Valley NHS Trust
David Mehaffey	Executive Director of Strategy and Integration, NHS Herefordshire and Worcestershire Integrated Care Board
Matt Pearce	Director of Public Health, Herefordshire Council

Board members in attendance remotely, non-voting:

Jon Butlin	Assistant Director for Prevention, Hereford & Worcester Fire and Rescue
Kevin Crompton	Independent Chair, Herefordshire Safeguarding Adults Board
Christine Price	Chief Officer, Healthwatch Herefordshire

Note: Board members in attendance remotely, e.g. through video conference facilities, may not vote on any decisions taken.

Others present in person:

Stephen Brewster		VCS
Henry Merricks-Murgatroyd	Democratic Services Officer	
Nisha Sankey	Director of Strategy and Primary Care Networks	Taurus Healthcare

Others in attendance remotely:

Hayley Doyle	Service Director All Age Commissioning	Herefordshire Council
Marie Gallagher	Integrated Systems Lead	
Gail Hancock	Service Director Improvement	

14. APOLOGIES FOR ABSENCE

Apologies were received from: Hilary Hall, Dr Mike Hearne, Councillor Jonathan Lester, Councillor Ivan Powell, Simon Trickett, and Mark Yates.

15. NAMED SUBSTITUTES (IF ANY)

Nisha Sankey acted as a substitute for Dr Mike Hearne from Taurus Healthcare.

16. DECLARATIONS OF INTEREST

There were no declarations of interest.

17. MINUTES

The board approved the minutes of the meeting 27th April 2023.

18. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions were received.

19. QUESTIONS FROM COUNCILLORS

No questions were received.

20. BETTER CARE FUND (BCF) YEAR END REPORT 2022-2023

Hayley Doyle (All Age Commissioning) provided an overview of the Better Care Fund year-end report 2022-23. The principal points included:

1. There are three ambitions that are not on track to meet the planned performance by the end of the year:
    a. Avoidable admissions to hospital:
        i. The planned performance at year-end was 1,106 against a metric of 605
        ii. A programme of admission avoidance including virtual ward and urgent care programmes are being implemented currently and the development of an approach to integrated long-term conditions management is envisioned to help improve future performance.
    b. The discharge to normal place of residence
        i. This relates to the percentage of people who are discharged from acute hospitals to their normal place of residence.
        ii. The metric was set at 91.6% but was not met with data showing a year-end total of 90%.
        iii. There is a key lack of capacity within Herefordshire's re-enablement and home care markets and the ability to discharge patients from acute beds to home, in a timely manner, has seen some patients being transferred to community hospital beds or to discharge to assessed beds in the community.
        iv. This has been necessary in order to release acute bed capacity within the hospital, however, work is being done to improve in this position.
        v. There has been further recruitment to vacancies within the home first team and the re-enablement service provided by Hoople and this position has increased at the latter end of 2022/23 with Hoople moving toward full recruitment across those service areas.
    c. The effectiveness of re-enablement:
        i. This relates to the proportion of older people who are still at home 91 days after discharge from hospital into re-enablement/rehabilitation services.
        ii. The metrics show that Herefordshire failed to meet this target with a figure of 70.8% against a target of 80%.
        iii. The CQC registered re-enablement service was transferred from Herefordshire Council to Hoople in June 2022 and there were some reporting issues due to staff changes at this time. This has impacted some of the data collection but have since been addressed.
        iv. Reporting has improved in the remaining quarters in 2022/23 with the percentage of individuals remaining at home 91 days after leaving the service averaging around 78% for the latter quarters.
        v. The issues in the recording in quarter 1 have impacted upon the overall year percentage. Therefore, there are some nuances around the accuracy of data which have been since corrected. Nevertheless, the re-enablement service are experiencing an increase in the complexity of patients being taken on by the service which has an impact on the results in this area.

    vi. Work continues to be done as a local authority with Hoople to improve this position.
2. Overall, the Better Care Fund pools represent a significant increase in investment in core services and there are a number of areas where by end of year, the system can be successful in reaching planned ambitions and improving outcomes for people who receive services.
3. The Better Care Fund approach is considered to be a success in helping increase community teams to support council re-enablement teams and improve outcomes for people.
4. Teams continue to work together across the system to provide a joint approach to help create an outcome of improved flow in the re-enablement team which helps support better outcomes by maximising re-enablement capacity.
5. Recent workshops across the system have been created to look at the discharge to assess pathway which looks at how the promotion of outcomes for people can be achieved to ensure the best outcomes and maximise flow to support the system as a whole.
6. Recently, a discharge to assess board has been established which will meet later this month.
7. There also exists a strong system approach with the development of the One Herefordshire Forum and partners meeting together to provide governance learning and leadership on a weekly basis.
8. A significant remaining challenge around capacity in the market for a number of service areas exist.
9. For Herefordshire, a particular challenge remains around rural communities where the sourcing of care at home is a particularly difficult issue.
10. The local authority are leading on a piece of work which looks at all aspects to provide and create more capacity within the marketplace to increase the range of domiciliary care offered in rural areas and this includes additional commissioning activity, working with system partners.
11. Currently across the system, the Better Care Fund is being worked on which will cover the period of 2023-25 and is currently being drafted.
12. There will be a national deadline for submission and will be subsequently be presented at the following Health and Wellbeing Board meeting on 25th September 2023.

The Chair thanked Hayley Doyle and asked members for questions and comments.

Jane Ives (Managing Director of Wye Valley Trust) thanked Hayley Doyle for the overview of the Better Care Fund. The key issue in the system exists around home care capacity and backs up into other services. Although national conditions are being met, the most difference made to people is currently poor in terms of the resources being invested in and for value for money from those resources.

The Chair asked why a decision was taken to transfer from Herefordshire Council to Hoople the re-enablement service.

Hayley Doyle was unable to provide a response as to why this took place but noted that she would aim to provide an answer after the meeting.

The Chair also commented about Talk Community and the issue around rural health where there are a significant number of people who cannot access Talk Community facilities due to poor public transport, in particular. The Chair suggested a potential workshop on rural health and how Herefordshire sees itself as a rural county and how to tackle these issues of both rural health and access to Talk Community facilities.

The Chair noted that there were no amendments to be made the template and therefore the board accepted both the report and template in its present condition.

The recommendation was proposed, seconded, and approved unanimously.

Resolved that:

a) **The Better Care Fund (BCF) 2022-2023 year-end template at appendix 1, as submitted to NHS England, be reviewed and the board determine any further actions necessary to improve future performance.**
b) **The board accept the report and template as presented to members in the meeting.**

21. CHILDREN'S SERVICES IMPROVEMENT PLAN

Darryl Freeman (Corporate Director for Children and Young People) gave a brief introduction to the Children's Services Improvement Plan. The principal points included:

1. The Improvement Plan follows the inspection by Ofsted last summer where Children's Services in Herefordshire were rated as inadequate.
2. Thereafter, a statutory direction followed in addition to the appointment of a children's commissioner.
3. The improvement plan was agreed by Children's Scrutiny and Cabinet in December 2022 and was submitted to Ofsted.
4. Progress against the improvement plan is primarily monitored by the improvement board as there is no governance role for the Health and Wellbeing Board, however, some of the elements of the improvement plan have connections to the wider Health and Wellbeing Board agenda.
5. The improvement board meets six-weekly and an update will be provided in addition to a thematic review which covers looked-after children.
6. Progress is also monitored by Ofsted and they have commenced a programme of monitoring visits, the first of which was in March 2023 and the feedback report was published in June 2023.
7. In the first monitoring visit, the focus was on the front door multi-agency response to risk in which good feedback was received by Ofsted with regard to progress that had been regarding the multi-agency response and the multi-agency safeguarding hub.
8. Within the same report, there's also a reminder that there is much more to do to improve the consistency of the quality of the practice, particularly of the quality of assessments in that particular visit.
9. Ofsted were returning later this week to focus on child protection.
10. The visits from Ofsted will form a regular pattern for the next couple of years.
11. Children's Services have been in decline for many years and improvement to a standard of 'good or more' will not happen overnight. Rather this will be a 2-3 year improvement plan activity.
12. The general direction of travel continues to be positive and the vast majority of activities are on track and the impact of the activity are now being measured. A lot of work is being done to change systems and processes, including IT systems, and it takes time to see the impact of that and the difference it makes with children and young people.
13. Gail Hancock (Service Director Improvement) and her team have started to provide some impact measures for the future.
14. Recruitment remains the single greatest challenge and to recruit experienced social workers is a particular challenge in Herefordshire.

The Corporate Director for Children and Young People then invited questions and comments from members of the board.

Jane Ives asked the Corporate Director how much the current rating of the service as 'inadequate' is impacting on the ability to recruit

The Corporate Director answered that the two are inextricably linked and that the competitiveness of Herefordshire's offer including quality of supervision, stability of leadership and management will help make a difference.

The Director of Public Health noted that the link to the Health and Wellbeing Strategy and in particular, the 'Best Start in Life' provides an opportunity to bring together a lot of prevention and early intervention work to help support this agenda.

The Chair asked about foster carer recruitment and sometimes foster carers leave as local authority foster carers to become agency foster carers, and whether they are asked if the decisions as to why they do is mainly financial related.

The Corporate Director responded that exit interviews are carried out in order to better understand why local authority foster carers have left their positions, but noted that there was not a lot of movement with a mostly stable set of foster carers in place.

The Chair also asked about health related priorities and that not necessarily the health history of the child is up-to-date and wondered whether that followed with the life story books that social workers provided and whether there is a similar lack in that area too.

The Corporate Director noted that health history relates to children who have been in and left care and accessing those children's health histories is difficult.

Gail Hancock (Service Director Improvement) also noted that the link is made because there is some direct work with children and young people so the practice principle is that life story work should happen very organically throughout the child's life. With respect to care histories, there is expectation for children to be supported to understand the relative issues about their health and wellbeing during their time in care but specifically health histories relate to what a child who has been in Herefordshire's care has when leaving that care and becoming a young adult and independent.

The Chair also asked about NEETs and that it appears to be a clear issue and within this local authority, it has been an issue for a long time. How many of the partner agencies offer, or we approach to offer work experience, apprenticeships, or job interviews for care leavers?

The Corporate Director answered that NEET is not in education or training and that figures for Herefordshire are comparable to the national figures. The overall figure is skewed by young people/care leavers who may be unwell, for example, along with other reasons why they would not be in education, employment or training. There are also a group of young people who may choose to not be in touch with the local authority. Therefore, while there is likely to be an under-report, it is unlikely to be a significant under-reporting of the figures. The Corporate Director also noted that conversations are being held with colleagues and a wide-range of agencies and are looking at contracts as well as developing apprenticeships in children's services for care leavers.

The Chair asked whether figures for the number of in-house foster care households and the number of placements offered and the proportion of in-house fostering capacity utilised were available.

The Corporate Director noted that these figures were not available. There are 155 children in the local authority's own foster care provision and 70% of children in our care are in family placements and about 45-50% are in our own provision. However, more foster carers are still needed.

The Chair asked about dental health and whether amongst looked-after children, are there significant problems about getting dental care for them.

The Corporate Director answered that there was a dedicated resource for children in care and children who are in care that needed to urgently access dental care, they can.

David Mehaffey (Executive Director of Strategy and Integration) commented that with regard to NEETs an action can be taken away to speak to NHS colleagues to make sure that partners are supported in that area.

The recommendation was proposed, seconded, and approved unanimously.

Resolved that:

a) The Health and Wellbeing Board note the progress reported on the children's services improvement plan and recent feedback from Office for Standards in Education, Children's Services and Skills (Ofsted) following the first Monitoring Visit since the inspection in summer 2022.

Action - David Mehaffey to speak to NHS colleagues to make sure that partners are supported with regard to NEETs.

22. ONE HEREFORDSHIRE PARTNERSHIP UPDATE

Jane Ives provided an update on the One Herefordshire Partnership. The principal points included:

1. What the One Herefordshire Partnership is.
2. There are joint appointments from Herefordshire Council, Wye Valley NHS Trust, NHS Herefordshire and Worcestershire, GP Leadership Team, and System NED which form the partnership.
3. The partnership meets weekly which helps keep decision-making frequent and agile to ensure that decisions are made quickly.
4. The partnership translates the national strategy into something practical and pragmatic which is deliverable and is assessed against KPIs and objectives that holds the partnership to account.
5. The Clinical Practitioner Forum (CPF) is chaired by Mike Hearne and has a responsibility for the GP leadership team and meets once a fortnight.
6. The Integrated Care Executive's responsibility holds the partnership responsible and accountable for the objectives that the partnership intends to deliver.
7. Therefore, the ICE will scrutinise the partnership how money is invested, whether it is making a difference, and whether it is good value for money.
8. The partnership and the CPF have an established way of working whilst ICE is a little less mature and is expected to gain momentum later this year.
9. ICE meets monthly as it is able to be less agile than the other partnerships/forums.
10. There are joint partnerships between the different organisations which emphasises real partnerships between stakeholders.
11. The partnership operates learning forums including 'Transformation Tuesday' and 'Safety in Sync' which emphasises the work that is being done as well as the help that is needed going forward.
12. In terms of achievements, the One Herefordshire Partnership has integrated its GPs and Community Integrated Response Hub which delivers a 2-hour response.
13. There has been a lot of work done in care homes which delivers high levels of personalised care and support plans that has reduced admissions by 30% and falls by 15%.

14. There have been numerous PCN developments including health inequalities priorities such as adverse childhood experiences, cancer screening, vaccine hesitancy, childhood obesity, and fibromyalgia.
15. Urgent care has a much more integrated redesign plan which has been agreed and drafted.
16. A lot of work has been done regarding ambulance turnaround times over the winter.
17. Value for money is important and the Chief Financial Officers meet regularly to look at a set of financial principles that are developed and agreed among themselves and they are starting to look at how money can be managed in different ways.
18. Workforce partnership working is the biggest challenge and there are a number of things being done to tackle this including work with Hoople to support them to make the difference to recruitment in the Wye Valley Trust.
19. With respect to the partnership's priorities for the coming year, these include a number of priorities such as PCN development, Integrated Urgent Care, Health and Wellbeing Strategy priorities, planned care, workforce, working with communities, and working well together.

The Chair thanked Jane Ives for the presentation and asked whether people in Herefordshire knew that the partnership was better prepared going forward.

David Mehaffey noted that with respect to ambulance response times, for example, this is an area where Herefordshire has improved significantly in comparison to national statistics. Whether people will be aware of these improvements, there will better experiences for people in the county.

Jane Ives noted that people need to see the difference in services and that delivery is particularly significant to people.

Stephen Brewster (VCS) asked if the preventative agenda was part of the conversation around preventative work.

Jane Ives noted that this was particularly relevant among the PCNs including work with Talk Communities, the voluntary sector, and health and social care.

Nisha Sankey (Taurus Healthcare) added that there is a strong commitment within Herefordshire to prevention and wellbeing as well as an acknowledgement that service demands support individuals with ill-health have taken a significant proportion of time and capacity. Making that shift is critical at every level and there is an absolute commitment to ensure capacity going into the prevention agenda.

David Mehaffey commented that with the Joint Forward Plan the first part of the title is to drive the shift upstream to more prevention and thus is embedded across all services in primary, secondary, and tertiary care.

Stephen Brewster asked if there was capacity within the system and investment in the preventative agenda.

David Mehaffey noted that this was a challenge and that there is about to be work done to develop a medium-term financial strategy to underpin the work around preventative care.

The Director of Public Health added that sometimes money is not always necessary to make a difference.

The recommendation was proposed, seconded, and unanimously approved.

Resolved that:

a) The Health and Wellbeing Board considers and notes the presentation at Appendix 1.

23. JOINT LOCAL HEALTH AND WELLBEING STRATEGY

The Director of Public Health provided a brief report on the Joint Local Health and Wellbeing Strategy to update the board on the strategy. The principal points included:

1. The strategy was endorsed by the board in April and a new version of the strategy is being developed which should be available by end of June.
2. Work has been taking place on governance on the two core priorities including the best start in life which the Children and Young People partnership will be accountable for the delivery.
3. A workshop was held last week to work through what issues should be focused on the most – including child obesity, trauma informed practice, and access to NHS services.
4. An early-years partnership group sits below that as a sub-group which works on what best start in life looks at.
5. Some of the existing groups will be absorbed in the Children and Young People partnership which will help consolidate some of the governance and help deliver the children improvement priority going forward.
6. With respect to mental wellbeing, there is an mental health collaborative where two groups lead on mental wellbeing – 1. Adult Mental Health partnership, 2. Children Emotional Health partnership board.
7. The Adult Mental Health partnership is currently an advocacy sharing best practice networking but are keen to be more action-oriented and develop a delivery plan for mental wellbeing.
8. A following workshop for that partnership will take place on the 6th July.
9. The Children Emotional Health partnership will feed into the Children and Young People partnership and focuses on the NHS long term plan.
10. The aim is to bring a draft plan to the board later in the year on both of the strategy's priorities including the identified resources to support those priorities with a plan that can be regularly monitored which the One Herefordshire partnership will have oversight over.
11. The Mental Health collaborative executive approved funding for a suicide prevention coordinator who will be appointed and will sit in the public health team.
12. An outcomes framework is being looked at for the two core priority areas which focuses on logic models including what the intended outcomes are, what the indicators are, and what actions are wanted to deliver these.
13. The Health and Wellbeing Strategy event is taking place on July 12th at Hereford Racecourse and will cover what the strategy entails, past achievements, and how to deliver the two core priorities within the strategy.

The Chair noted it was good news to have someone appointed as a suicide prevention coordinator.

The Director of Public Health commented that there was also work to appoint a partnership and strategies officer to support the work of the board and wider networking with the primary care networks to help drive work going forward to meet the priorities of the board as well as providing a systematic approach.

The recommendation was proposed, seconded, and unanimously approved.

Resolved that:

a) The Board to note progress to date on work to deliver the strategy.

24. WORK PROGRAMME

The Chair asked whether the August workshop would be too soon for a session on rural health.

The Director of Public Health recommended that the session could be used to discuss the Joint Strategic Needs Assessment.

The board was happy with the recommendation made by the Director of Public Health.

The Director of Public Health wanted oral health as an update to be added to the agenda for the September board meeting.

The Chair asked if there were any items that could be moved to the December meeting.

The Director of Public Health stated he would take that away and review the work programme for future meetings.

David Mehaffey suggested that the mental health collaborative item could be moved to the December meeting.

The Chair responded that the mental health collaborative could be moved to the December meeting and that an item on oral health update could be included in the September meeting.

25. AOB

No other business was raised.

26. DATE OF NEXT MEETING

The next scheduled meeting is 25th September 2023, 14:00-17:00.

The meeting ended at 3.39 pm **Chairperson**

Herefordshire Council

Title of report: Health and Wellbeing Board Terms of Reference

Meeting: Health and Wellbeing Board

Meeting date: Monday 25th September 2023

Report by: Director of Public Health

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose

For the Health and Wellbeing Board (HWB) to consider the revised terms of reference at appendix 1 and provide comments before recommending the changes to Council.

Recommendation

That:

a) **The Health and Wellbeing Board considers the revised terms of reference at appendix 1 and provides comments before being ratified by Full Council**

Alternative options

1. The current terms of reference could remain unchanged. However, this option would not assist the board with the changes that have been made to the constitution since its last publication.

2. Alternative terms of reference/membership could be adopted by the board.

Key considerations

3. The report is for the board to consider and make comments on the proposed changes to the Health and Wellbeing Board's terms of reference.

Community impact

4. In accordance with the adopted code of corporate governance, Herefordshire Council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development and review. Topics selected for scrutiny should have regard to what matters to residents.

Environmental Impact

5. There are no general implications for the environment arising from this report.

Equality duty

6. 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.

7. 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. Our Health providers will be made aware of their contractual requirements in regards to equality legislation.

Resource implications

8. There are no resource implications associated with this report. The resource implications of any recommendations made by the HWB will need to be considered by the responsible body or the executive in response to those recommendations or subsequent decisions.

Legal implications

9 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.

10 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.

11 The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution. There are no specific legal implications arising from the proposed Terms of Reference.

Risk management

12 There are no risk implications identified emerging from the recommendation in this report.

Consultees

None

Appendices

Appendix 1 – Herefordshire Health & Wellbeing Board Terms of Reference

Background papers

None identified.

Appendix 1

Herefordshire Health & Wellbeing Board Terms of Reference

Purpose

Herefordshire Health and Wellbeing Board (the board) works together to improve the health and wellbeing of the people of Herefordshire by working collaboratively with partners to join up commissioning and provision (where it is appropriate to do so) across the NHS, social care, public health and other areas related to health and wellbeing.

Roles and Responsibilities

The board is responsible for:

a) Developing a joint strategic needs assessment (Understanding Herefordshire)

b) Preparing a joint local health & wellbeing strategy

c) Reviewing whether the commissioning plans and arrangements for the NHS, public health and social care (including Better Care Fund submissions) are in line with and have given due regard to the joint local health and wellbeing strategy

d) Reporting formally to the council's executive, the Herefordshire Integrated Care Board and the NHS England if commissioning plans affecting Herefordshire have not had adequate regard to the joint local health & wellbeing strategy

e) Formally signing-off required submissions and direct the use of any performance related funding received on achievement of targets.

The board will seek to:

f) Promote joint working and integration and support the effective delivery ofthe joint local health and wellbeing strategy

g) Influence the strategic planning and service delivery of the council and the NHS in Herefordshire through promotion of Understanding Herefordshire and the joint local health and wellbeing strategy

h) Influence the planning and delivery of economic development, planning, transport, housing, community safety, environment and community services in order to address the wider determinants of health & wellbeing

i) Strategically performance manage key activity against the priorities of the joint local health and wellbeing strategy

j) Provide leadership across the whole health and wellbeing system in Herefordshire to enable improved health and wellbeing outcomes and to tackle health inequalities

Responsibility for the scrutiny of health and wellbeing in Herefordshire remains the responsibility of the Health, Care and Wellbeing Overview and Scrutiny Committee.

Accountability

Accountability for the discharge of statutory responsibilities remains with the council, Integrated Care Board and Herefordshire Healthwatch

Accountability for safeguarding lies with the Herefordshire Children Safeguarding Partnership and Herefordshire Safeguarding Adults Board both of which will report to the board on relevant performance outcomes against the joint local health and wellbeing strategy's priorities through a regular performance reporting process.

The Board is supported by a number of sub-bodies that support delivery of strategic commitments and outcomes in line with the joint local health and wellbeing strategy. These sub-bodies will report to the board on relevant performance outcomes against the joint local health and wellbeing strategy's priorities through a regular performance reporting process.

Current sub-bodies include;

- One Herefordshire Partnership
- Children and Young People Partnership
- Community Safety Partnership
- Health Protection Assurance Board
- Health Inequalities Personalisation and Prevention Board
- Physical Activity Strategy Board
- Adults Mental Health Partnership
- Oral Health Improvement Board

The Sub-Bodies may have responsibility for overseeing implementation of particular aspects of the Joint Local Health and Wellbeing Strategy and its associated Delivery Plan. The Sub-Bodies may have their own Terms of Reference; or act in accordance with any resolution of the Board establishing them, or any other resolution of the Board.

The Board is supported by One Herefordshire Partnership which is chaired by the Vice-Chairman of the Board. The One Herefordshire Partnership shall provide oversight of the delivery of the core priorities within the Joint Local Health and Wellbeing Strategy

Membership

Membership of the board consists of:

- Herefordshire Council Leader of Council;
- Herefordshire Council Portfolio Holder with responsibility for Adults, Health and Wellbeing
- Herefordshire Council Portfolio Holder with responsibility for Children and Young People;
- Herefordshire Council Corporate Director – Community Wellbeing
- Herefordshire Council Corporate Director – Children and Young People
- Herefordshire Council Corporate Director – Economy and Environment
- Herefordshire Council Director of Public Health
- A nominated representatives from the Integrated Care Board;
- A nominated representative from Wye Valley NHS Trust;
- A nominated representative from Herefordshire & Worcestershire Health and Care NHS Trust;
- A nominated representative from Healthwatch Herefordshire;
- A nominated representative from the Voluntary and Community Sector;

- A nominated representative from Thames Valley Police;
- A nominated representative from Herefordshire and Worcestershire Fire and Rescue Service

Chairmanship, Quorum and Voting

The Chairman of the Board shall be selected by The Council, at its annual meeting

The Vice-Chairman of the Board shall be the chair of the One Herefordshire Partnership. Should this be an already identified member of the board, that person shall also represent their respective organisation

The quorum for a meeting shall include one member from each of the council, Integrated Care Board and Healthwatch.

Board members may nominate a named substitute from their organisation.

Wider Engagement

The Board will seek to engage all stakeholders in the development of the joint health and wellbeing strategy and will invite representatives from relevant stakeholder bodies to attend board meetings as relevant to the agenda.

The Board will ensure that effective communication and engagement mechanisms are in place to enable good public, patient, service user and stakeholder engagement.

By working together the board will proactively seek to embed good partner, public and patient engagement within the day to day business of the board through adherence to the following principles:

- Being clear of purpose
- Taking responsibility for good public engagement including feedback of engagement results
- Committing to culture change
- Providing access to information
- Fostering effective working relations based on mutual trust
- Acting with collective responsibility
- Developing an understanding of the working cultures operating within Herefordshire's health and wellbeing system.

Business Management

The board is a statutory committee of the council and will be treated as if it were a committee appointed by the council under s102 of the Local Government Act 1972; it is exempt from the rules on political proportionality.

The board will act in accordance with the council's committee procedure rules and access to information rules.

The board will develop an operating model and work programme to support delivery of the health & wellbeing strategy.

The board will produce an annual report.

The board will meet not less than 4 times a year and at other times by arrangement in accordance with the committee procedure rules.

Herefordshire Council

Title of report: Herefordshire's Better Care Fund (BCF) Integration plan 2023-25

Meeting: Health and Wellbeing Board

Meeting date: Monday 25 September 2023

Report by: Integrated Systems Lead

Classification

Decision type

This is not an executive decision

Wards affected

Purpose

To update Health and Wellbeing Board members on Herefordshire's Better Care Fund (BCF) Integration Plan 2023-25 and seek formal Health and Wellbeing Board approval.

Recommendation(s)

That:

a) **The Herefordshire Better Care Fund 2023-25 narrative plan (Appendix 1), planning template (Appendix 2) and the ICB Discharge template (Appendix 3) be approved; and**

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

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

1. 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.

2. 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 2023-25 in April 2023. Better Care Fund (BCF) plans are required to be submitted by 28 June 2023.

3. The Better Care Fund (BCF) requires integrated care boards (ICBs) and local government to agree a joint plan, owned by the health and wellbeing board (HWBB), and governed by an agreement under section 75 of the NHS Act (2006).

4. As per the requirements for the national programme, this plan will be submitted on the national deadline of 28 June 2023, following approval from the board. BCF planning requirements were published 5 April 2023. A scrutiny process will then be undertaken from 28 June – 28 July 2023 and approval letters should be received week commencing 3 September 2023, after which the council and ICB will need to revise the s75 agreement.

5. The BCF provides a mechanism for joint health, housing, and social care planning and commissioning. The Better Care Fund is made up of several funding streams: the NHS minimum contribution, Improved Better Care Fund grant (iBCF), Disabled Facilities Grant (DFG) and Adult Social Care Discharge Fund.

6. The plans should reflect local health and care priorities and must be jointly agreed by integrated care boards (ICBs) and local authorities with involvement of local partners. Each of the grants that make up the pooled fund are ring-fenced to adult social care and community health services. The partners have agreed a risk-share arrangement for any under or over spending in each pool of the Better Care Fund.

7. The BCF Plan is a two year plan covering the period 1 April 2023 to 31 March 2025 for meeting national conditions and objectives, a two year spending plan (with funding allocations provisional for the second year for some aspects of the plan), and a one year plan for key performance metrics and capacity & demand plans, with a refresh of those plans required for 2024/25.

8. The BCF in 2023-25 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.

9. 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, Integrated Care Strategy and the NHS Long Term Plan.

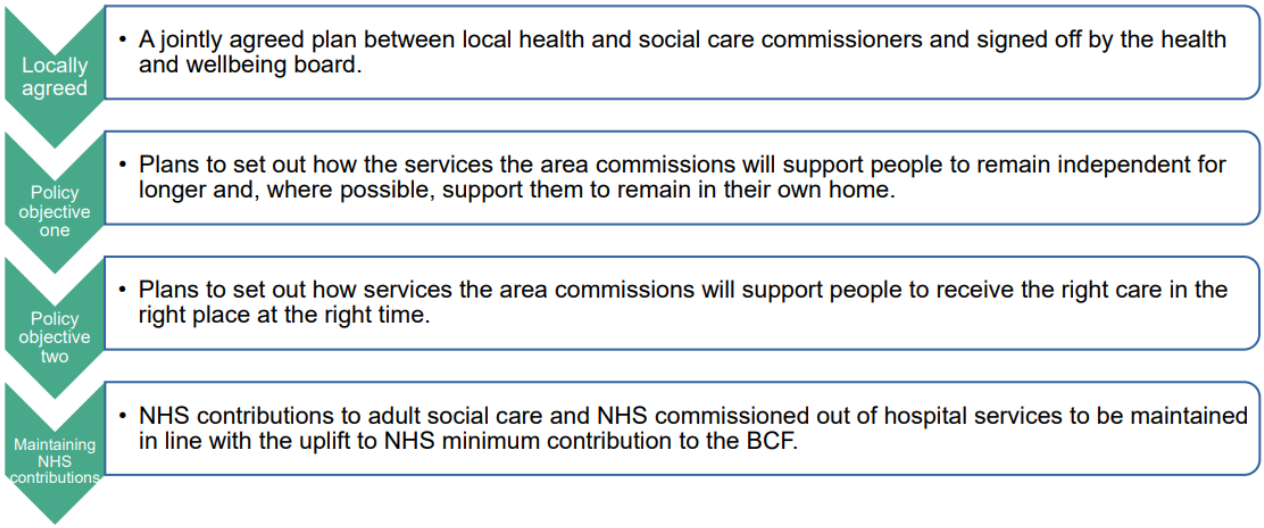
10. For 2023/25 submissions consist of:

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

    ii 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 ICB Discharge Funding 2023-24 and 2024-25 template, showing the ICB to HWB funding allocation to support discharge from hospital. (**Appendix 3**)

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



12. The BCF has two key objectives for 2023-2025.

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

Objective 2: to provide people with the right care, at the right place, at the right time.

13. The BCF policy framework sets out the national metrics for the BCF 2023-24, as follows:

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
Avoidable admissions to hospital	Unplanned admissions for chronic ambulatory care sensitive conditions
Falls	Emergency Hospital Admissions due to falls in people over 65.
Discharge to usual place of residence	Improving the proportion of people discharged home, based on data on discharge to their usual place of residence
Reablement/Rehabilitation	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

14. This year, a greater level of detail is required within the planning templates compared with previous plans. Capacity and demand planning for intermediate care has been integrated into the main BCF programme for local areas to demonstrate that they have assessed the capacity and demand for intermediate care, especially in the context of capacity to facilitate hospital discharge. Within the narrative planning, areas must set out progress in the implementation of the High Impact Change Model for managing transfers of care. This has been integral to meeting

BCF requirements around supporting discharge and guidance on hospital discharge and community support since 2017.

15. The governance arrangements for the BCF will change for 2023-25. HWBB remains ultimately responsible for agreeing the BCF plan and for overseeing delivery through quarterly reports.

16. Herefordshire & Worcestershire NHS ICB and Herefordshire Council retain statutory responsibility for the pooled services through an agreement under section 75 of the NHS Act (2006).

17. The Herefordshire integrated care partnership (One Herefordshire Partnership) has agreed a memorandum of understanding with Herefordshire and Worcestershire ICB (HWICB) that will see responsibility for BCF planning and performance management delegated to the partnership.

18. Oversight of programme delivery will be by monthly reports to the integrated care executive (ICE) meeting with highlight reports to One Herefordshire Partnership Board.

19. The BCF plan and the performance of programmes of integration work will be reported quarterly to the ICB's Strategic Commissioning Committee and the Council's Commissioning Programme Board.

Community impact

14. 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.

15. Talk Community brings together community, third sector and statutory services to connect with peers and share ideas and experiences within the local Primary Care Network (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

16. 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.

17. Whilst this is a decision on programme delivery 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

18. 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.

19. 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.

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

21. The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the act. This is through improving the health and wellbeing of people in Herefordshire by enabling them to take greater control over their own homes and communities.

22. 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.

23. 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

16. Each element of the Better Care Fund is funded by allocations from DHSC or DLUHC. The Better Care Fund plan for 2023-25 includes no additional voluntary contributions from the core funding of either partner.

17. The National Health Service (Expenditure on Service Integration) Directions 2023 under section 223B of the NHS Act ring-fences £5.059 billion nationally to form the NHS mandatory contribution to the BCF for 2023-24. That figure includes £300 million additional funding for discharge allocated to ICBs. Under section 223B of the NHS Act 2006 NHS England directs ICBs to pool their allocations into the BCF in line with the planning requirements. This condition is met in the BCF plan.

18. The Disabled Facilities Grant (DFG) is a grant made directly to local authorities by DLUHC under section 31 of the Local Government Act 2003. A clear DFG spending plan is in place, as instructed by BCF requirements.

19. The Improved Better Care Fund is a grant made directly to local authorities by DLUHC under section 31 of the Local Government Act 2003. Grant conditions for iBCF require that the council

pool the grant funding into the local BCF; that the funding is not offset against the NHS minimum contribution to social care; and that sufficient non-financial resources are also in place to deliver the proposed plan. The iBCF grant conditions are met by the BCF plan.

20. The Adult Social Care Discharge Fund is a grant made directly to local authorities by DLUHC under section 31 of the Local Government Act 2003. The grant conditions require that the funding is pooled in the BCF, used, in conjunction with wider funding (including relevant BCF investment) to build additional adult social care and community-based reablement capacity to reduce hospital discharge delays and deployed to support the principles of 'Discharge to Assess' (D2A). The conditions of the grant are met by the BCF plan.

21. The Herefordshire BCF plan 2023-25 maintains the key schemes identified in the 2022-23 submission. These include operational social work, NHS community services, Talk Community, Home First, brokerage, support for carers, discharge to assess, trusted assessors and falls response and prevention.

22. Herefordshire Better Care Fund Financial Summary 2023-24

Minimum Mandatory Contribution from the NHS	**2022/23 £**	**2023/24 £**	**Change Between Years**
Planned Social Care Expenditure	6,505,974	6,874,212	5.66%
NHS Commissioned Out of Hospital Care	8,625,984	9,114,215	5.66%
NHS Minimum Mandatory Contribution from NHS	**15,131,959**	**15,988,427**	**5.66%**
Disabled Facilities Grant (Capital)	2,268,653	2,268,653	0.00%
Total Minimum Mandatory Contribution	**17,400,612**	**18,257,080**	**4.92%**
Improved Better Care Fund	**2022/23 £**	**2023/24 £**	**Change Between Years**
iBCF Grant	6,782,841	6,782,841	0.00%
Total Improved Better Care Fund	6,782,841	6,782,841	0.00%
Adult Social Care Discharge Fund	**2022/23 £**	**2023/24 £**	**Change Between Years**
ICB Allocation	557,967	1,047,772*	87.78%
Council Allocation	733,845	950,944	29.58%
Total Adult Social Care Discharge Fund	1,291,812	1,998,716	55%
Total Better Care Fund	25,475,265	27,038,637	6.14%

*ICB allocation for ASC Discharge Fund is on the basis of ICB footprint (i.e. one allocation for Herefordshire and Worcestershire). How that allocation is divided between the two counties is for local determination.

HWICB total allocation is £2.069 million. £1.048 million is Herefordshire's share of the allocation as notified by HWICB.

23. A detailed spending plan is included in the expenditure plan tab of the BCF planning template.

24. Where any procurement activities arise from the plan they will be procured in line with the contract procedure rules of the lead commissioner.

Legal implications

25. 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 Integrated Care Boards to pool the necessary funding. The council is legally obliged to comply with grant conditions, which have been complied with.

26. 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.

27. 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.

28. 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

29. 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.

30. 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

31. 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.

32. A review of performance and investment will be undertaken throughout 2023 under the new arrangements and development of a Herefordshire Memorandum of Understanding (MOU) between the One Herefordshire Partnership and HWICB. The MOU aims to set out keys areas of work including BCF.

33. The One Herefordshire Integrated Care Executive (ICE) will undertake scrutiny of performance monitoring of BCF by:

- Building consensus between partners and setting objectives beyond the nationally determined outcomes as part of the annual planning of the Better Care Fund, including the BCF Plan.
- Development and implementation of new and/or revised services or care pathways.
- Monitoring, delivery and reporting of performance and outcomes.

- Budget management and ensuring spending lives within the resources allocated, identifying remedial actions where spending is off trajectory.

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 ICE.
Overspending, particularly on discharge capacity	The council and HWICB are working with One Herefordshire Partnership to revise and improve the service model for Discharge to Assess to be recurrently sustainable.

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 deliver best outcomes for local people.

Appendices

Appendix 1 – Herefordshire's BCF narrative plan 2023-25
Appendix 2 – BCF planning template (planned expenditure)
Appendix 3 – ICB Discharge Funding Template
Appendix 4 – Better Care fund planning requirements 2023-25

Background papers

None identified

	Glossary of terms, abbreviations and acronyms
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
1HP	One Herefordshire Partnership
ICE	Integrated Care Executive
STP	The Sustainability and Transformation Partnership
PCN	Primary Care Network
EIA	Equality Impact Assessment

Herefordshire Better Care Fund and Integration Plan 2023-2025

Herefordshire Health and Wellbeing Board

June 2023

Executive Summary

The Better Care Fund (BCF) is pooled budget held between the council and the NHS that funds a range of essential community based health and adult social care services. 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. The BCF Plan is a two year plan, to enable the national conditions and objectives to be met. The plan covers 2 financial years, income and expenditure for the second year being provisional pending confirmation of allocations and review of all BCF schemes by the Integrated Care System for Herefordshire. The plans for metrics and capacity demand are one year plans and will be refreshed accordingly for the second year plan.

Our priorities for 2023-25

Herefordshire's Better Care Fund (BCF) Plan for 2023-25 will continue to support our long-term vision, and build on previous system priorities to 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. Herefordshire's priorities for the BCF 2023-25 include:

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

Herefordshire's BCF funding continues to be used for several key adult social care and NHS community services - operational social work, brokerage, integrated discharge, community health and care services, Deprivation of Liberty Safeguards (DoLS), urgency community response, falls prevention 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.

Detailed information regarding spend allocation for the BCF 2023-24 is available in the planning template. The table below provides a high level summary which highlights sources of funding and expenditure against them.

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,268,653	£2,268,653	£2,268,653	£2,268,653	£0
Minimum NHS Contribution	£15,988,427	£16,893,372	£15,988,427	£16,893,372	£0
iBCF	£6,782,841	£6,782,841	£6,782,841	£6,782,841	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£950,944	£1,584,907	£950,944	£1,584,907	£0
ICB Discharge Funding	£1,047,772	£2,221,943	£1,047,772	£2,221,943	£0
Total	**£27,038,637**	**£29,751,716**	**£27,038,637**	**£29,751,716**	**£0**

Key changes since our previous plan

In last year's plan we provided a summary of the arrangements in place for the BCF and wider services, including joint commissioning, partnerships, funding and strategies, lead commissioning arrangements and integrated approaches to training and market management

These arrangements continue, with a joint commitment that the BCF will support ways we can further integrate our services to support people, and focus on broader engagement and links with primary care and the voluntary sector. Responsibility for planning and delivery of the BCF will shortly transfer to the One Herefordshire Partnership within the Integrated Care System which will ensure jointly agreed and locally-focussed approaches to challenges and opportunities.

Several key 'place' level challenges are understood which partners are working together to address, for example, recruitment and retention of staff across the health and care sector and the increased cost of providing care in a rural community with an ageing, sparse and very dispersed population. There are many opportunities for further joined up working and the BCF will be central to delivery of Herefordshire's Health and Wellbeing Strategy (HWBS) and Integrated Place Strategy and Priorities.

Improved health and wellbeing will be achieved through better support and high-quality services, but also through preventing people from becoming unwell and supporting them to remain independent and live well in their communities. We recognise that we need to look beyond health and care services to understand the barriers and opportunities to living a healthier life and are committed to working with people and communities to address them.

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. Some of the key challenges for Herefordshire include 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.

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.

1. National Condition 1: Overall BCF Plan and approach to integration

Planning Requirement (PR1) - A jointly developed and agreed plan that all parties sign up to

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 BCF plan 2023/25.

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 the Community Partnership has enabled the VCSE sector to contribute to priorities and 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.

Bodies involved strategically and operationally 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 plan and for overseeing delivery through quarterly reporting.

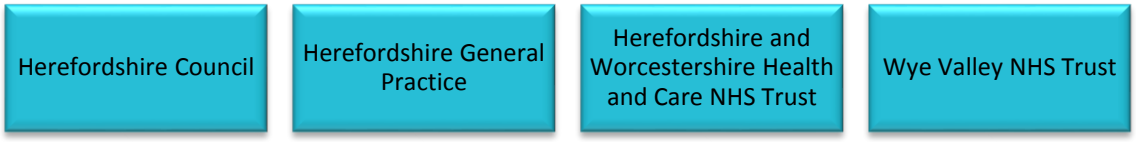
The responsibility for the BCF is embedded within the Senior Leadership Teams of both the Community Wellbeing Directorate of the council and the Herefordshire and Worcestershire Integrated Care Board (ICB). In each organisation, chief officers and their senior leadership teams, are able to maintain the 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.

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.

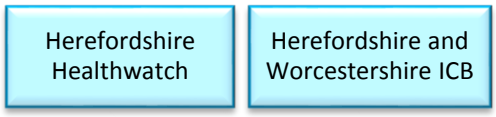
This year, it is the intent that that Better Care Fund has the engagement of the One Herefordshire Partnership (1HP) to support the delivery of the plan. One Herefordshire Partnership is the vehicle by which Herefordshire Place partners work together at a strategic level and is a key enabler of the BCF plan delivery.

The establishment of a Memorandum of Understanding (MOU) has been agreed and signed by the four partners to provide a formal basis for the collaboration and working arrangements between organisations involved in the 1HP specifically to detail the collaborative approach to delivery and oversight of integrated health and care delivery in Herefordshire. The MOU sets out a framework of roles and responsibilities for the participants engaged in Place collaboration.

The four One Herefordshire partners are:



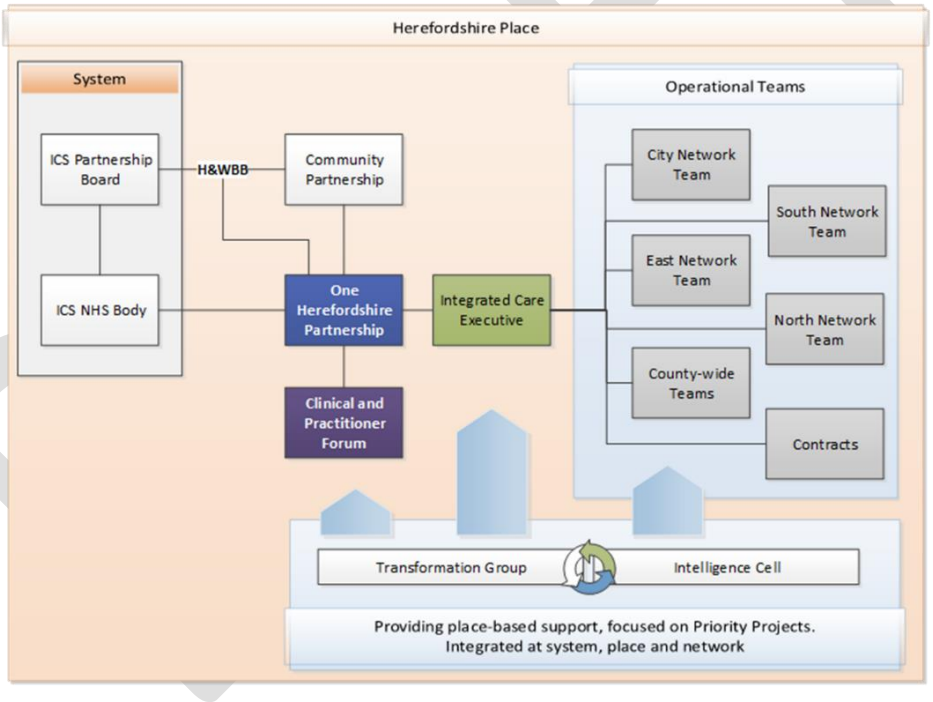
The following organisations are invited members of the Partnership



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.

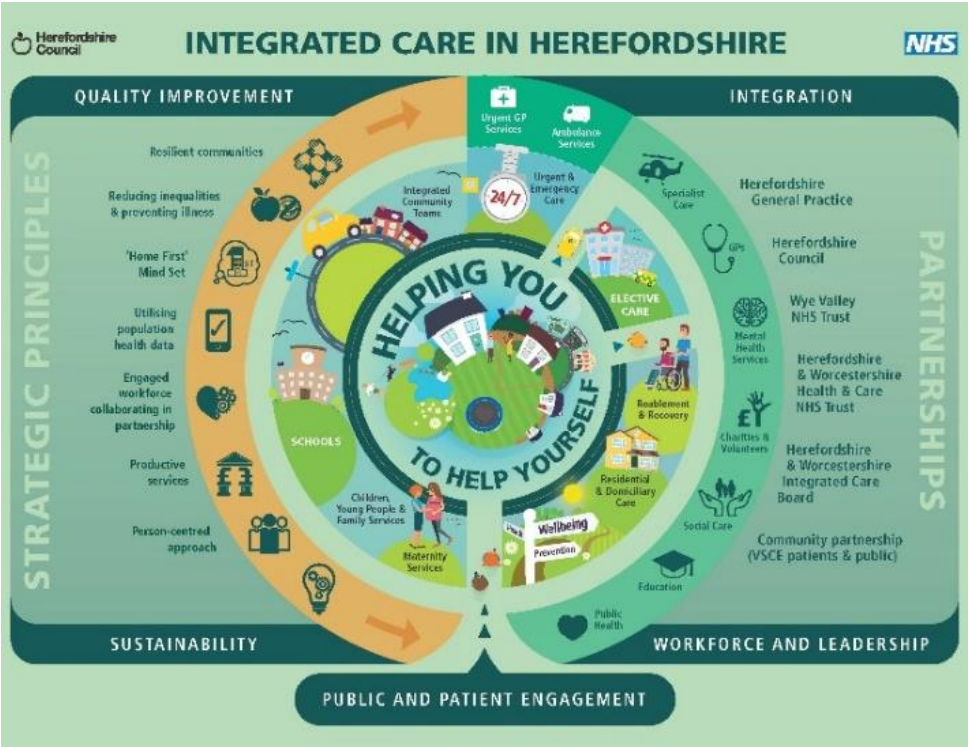
One Herefordshire Partnership will be held to account by Herefordshire and Worcestershire ICB for the day to day delivery of the Better Care Fund. A MOU has been established setting out the roles and responsibilities of local partners with the ICB. This has been developed to facilitate the objectives set out above.



Partners have agreed the 2023-25 BCF Plan and metrics following approval at relevant leadership and committee meetings.

Planning Requirement (PR2) - A clear narrative for the integration of health, social care and housing

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 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

Fuller Delivery Plan	•PCN development and priorities •Integrated Urgent Care •Chronic & Complex Care •Prevention and Wellbeing •GP access
HWBB Priorities	•Mental Health •Best start in life
Planned Care	•Long term conditions •Reducing waiting lists (Making Every Referral Count)
Workforce	•Opportunities for joint roles •Herefordshire public sector organisations recruitment •Agency spend linked to pathway change •Workforce Culture
Working with Communities	•Community Paradigm •Co-ordinating engagement •Maximising the role of the VCS •Working jointly on transport, housing, children & young people

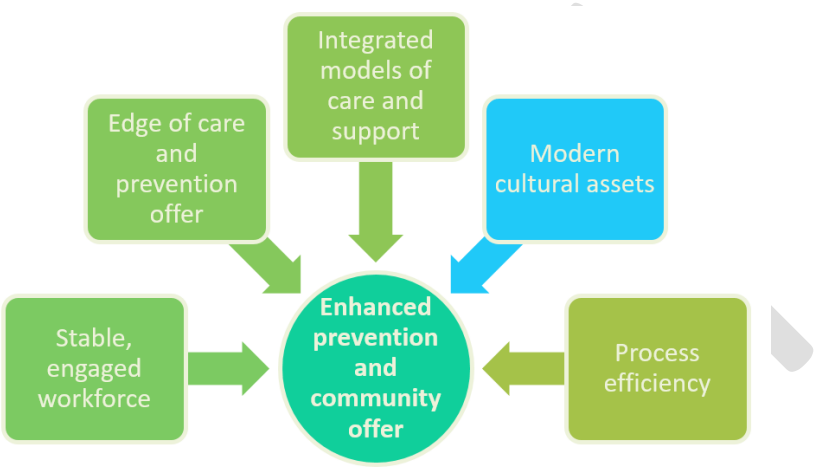
The following programmes of work and strategies set out a range of priorities, many of which are enabled by the BCF, connections and linkages are ensured via the 1HP arrangements.

Transformation

The aim of **transformation** in Community Wellbeing is to increase and diversify the prevention and community offer in order to reduce demand on formal services and offer quality and value, whilst ensuring that our internal processes operate at maximum efficiency. The principles that underpin the strategy are:

- Designing and delivering the solutions with the people who use our services, their carers and families, and the workforce;
- Integration with partners where that makes sense to do so; and
- Value for money and efficiency.

The Community Wellbeing Transformation Strategy will be delivered across five key work streams:



The Health and Care Act 2022 gave the Care Quality Commission (CQC) new regulatory powers to undertake independent assessment of local authorities' delivery of regulated care functions.

Strategic Housing - Housing and Health

National and international research has repeatedly demonstrated the importance of housing and a stable home in the maintenance of good personal health. Not only does poor housing, and indeed no housing, lead to poor physical health, it also leads to worsening mental health, increased rates of addiction, family break up and criminality. It costs society more; not just in terms of the impact upon citizens, but the fiscal impact and how society is viewed more widely. The personal impact is catastrophic. Rough Sleeping is proven to lead to early mortality, nearly 50% earlier in men and women, than the general population. The impact upon residents who live in poorly maintained housing stock places a greater burden on health services to treat the associated physical and mental health impact of the living conditions. The financial impact is significant. It costs society nearly six times more to provide services to our residents who are homeless. Finally, there are multiple national and international examples of how the reputation of a 'service' is impacted when services fail or things go wrong. It is difficult to recover from.

In 2020 the COVID-19 Pandemic and the 'Everyone In' program presented Herefordshire with an opportunity to embark upon a new pathway to achieve good quality housing for all its residents. This pathway built upon our 2018 thematic review of housing, homelessness and rough sleeping services in the county, drew upon best practice and guidance from across the globe and listened to the voices of people who use our services. This pathway became known as Project BRAVE – it set out three questions: -

1. How do we provide a safe and secure emergency accommodation for people required to be housed under the 'Everyone In' program? ;
2. How do we sustain people in this accommodation?; and
3. How do we support them to secure and sustain a long-term home?

Not only did this initiative seek to deliver a housing led model of accommodation for all its citizens, it also sought to develop a multi-agency and cross sector response to housing and homelessness. Project BRAVE facilitated a wide range of statutory and voluntary sector partners to work in concert to deliver services both through the pandemic and beyond. This approach delivered tangible results for people affected by poor or no housing. To list a few, they include: -

- All rough sleepers securing registration with and access to a GP;
- All rough sleepers and other homeless individuals being offered a COVID-19 vaccination;
- All rough sleepers and other homeless individuals being able to readily access mental health support services;
- All rough sleepers and other homeless individuals having access to and support from addiction treatment services;
- Accommodation being provided to over 300 people in the first six months of the pandemic;
- Demand for ambulances and access to A&E dropping by 90%;
- Reduced impact upon policing and the criminal justice system;
- Following a charitable donation of clothing from a national supplier, All rough sleepers and other homeless individuals having access to new clothing

A new model of partnership working in Herefordshire, recognising the specific needs of people with multiple complex vulnerabilities including, homeless and rough sleepers. This multi-agency / cross sector approach to a coordinated response to the provision of good quality accommodation with appropriate levels of support from health, justice and the voluntary sector is driving tangible change for Herefordshire and in the recent study of rural homelessness by the University of Kent has been recognised for its innovative approach to addressing these intertwined issues.

Rough Sleeper Accommodation Programme

The councils Strategic Housing team submitted a bid application to government for funding under their Rough Sleepers Accommodation Programme with the aim of purchasing 6, one bed properties. Following a successful bid of £423,360.00 together with additional funding of £535,040.00 from the council the properties were all purchased by March 2023. Over the period January 2022 to March 2023 the council successfully purchased and refurbished the properties and made them available to clients that have a history of rough sleeping.

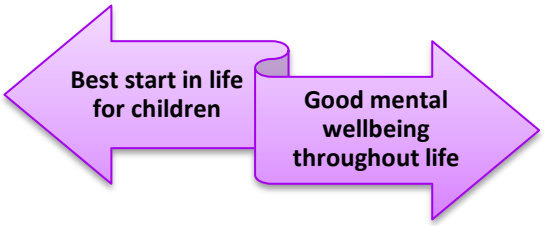
Herefordshire's Joint Local Health and Wellbeing Strategy 2023-2033 presents an outline for improving health and wellbeing of the population in Herefordshire over the next 10 years.

The strategy sets out how the Council and its local partners plan to address the health and wellbeing needs of its population (identified through the Joint Strategic Needs Assessment) and is a key document that is jointly owned and promotes collective action to meet those needs. The implementation of the Health and Care Act of 2022 and the consequent establishment of the Integrated Care System (ICS) for Herefordshire and Worcestershire provides a timely opportunity for this new strategy to deliver action by any of the partners within the Herefordshire and Worcestershire ICS or more locally within Herefordshire, according to what is most appropriate to the issue.

This new joined up way of working has enabled Herefordshire and the ICS to align our strategies, commit to those priorities that are jointly owned and contribute to the overall system goals. It is a significant statement of our intent to work together that the Herefordshire HWBS and the Worcestershire HWBSs have been incorporated into the Integrated Care Strategy document. This strategy will be accompanied by a monitoring and implementation plan, setting out the responsibilities of all partners. It is ambitious in aspiration but realistic and measurable in its objectives, demonstrating our intent that it will serve to make a tangible difference to peoples' lives.

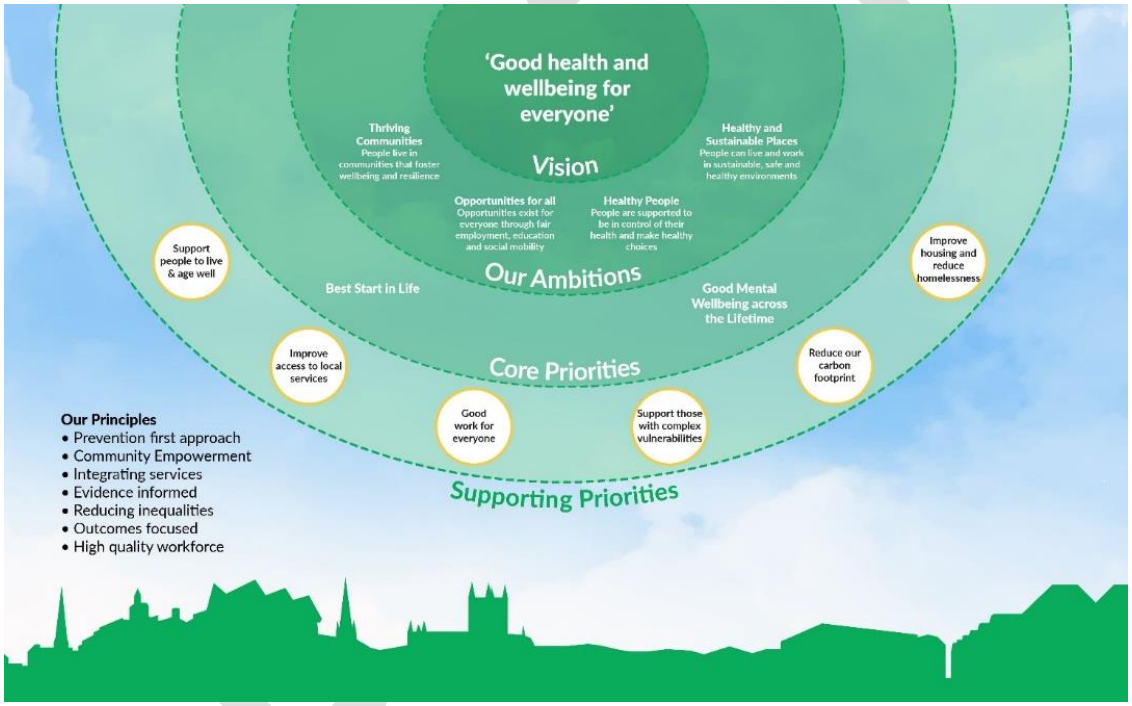
The strategy is developed in close collaboration and consultation with residents and local partners from health, social care, local authorities and voluntary sector.

Having taken into account the views and comments from residents and partners and what we know about the issues from our Herefordshire data, the central focus of the strategy at the beginning of this ten year period will be:



In addition to these core priorities, a further six supporting priorities have been identified recognising that they are also critically important in how they affect our broader wellbeing, but that they also support and contribute towards giving children the best start, as well as the development and retention of good mental health.

All of the six supporting priorities have a role in reducing inequalities by addressing the wider issues that affect health, including housing, employment, and crime. Employing community-based approaches need to be driven by partnerships at a place level involving the council, health services, the voluntary sector, police, public sector employers and businesses.



Community Paradigm

Herefordshire is actively developing a new approach of working in partnership with its communities, building on the strong ethos of community that exists in the county. It is doing this because public sector services alone will never be able to create a state system big enough to address demand now, or in the future. The aim of the work is to reduce demand, intervene sooner with community led solutions, and invest in prevention for better wellbeing outcomes.

Taking the work of New Local Community Paradigm, Herefordshire is making a fundamental change away from doing *TO* people, to building a relationship *WITH* people, to develop community solutions. Clearly, this isn't a quick fix; this is a long-term way of working and the approach is probably best known through The Wigan Deal which made savings and invested £15m over five years. This funded over 500 projects in communities, coproduced by communities, increased healthy life expectancy by 7 years and is continuing today. Whereas

the Wigan Deal was started within the council and then extended to other public sector bodies, Herefordshire is pioneering this work through a cross sector approach.

An initial summit has been held and stakeholders and partners working together to develop this approach and this will grow throughout the duration of the 2 year plan.

How is our BCF 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.

A new Inequalities Strategy 2023-2026, developed by a sub-group of the One Herefordshire Partnership with full engagement across the partnership, was approved by the Health and Wellbeing Board in March 2023. The strategy aims to create a framework to shape the direction and the objectives of work over the next three years to reduce inequalities across the county.

There are three over-arching objectives that the strategy seeks to confront:

1. **Digital and health literacy:**
   - i) There is a lack of digital and health literacy at a time when accessibility to services has become increasingly digitalised.
   - ii) A key aim of the strategy is to help staff to improve their digital and health literacy so that they can assist patients and the public and in turn, reduce inequalities.
2. **Empowering workforces:**
   - i) This objective seeks to ensure that staff understand what is meant by health inequalities, how they approach them, and ultimately reduce health inequalities amongst the workforce.
3. **Reaching our communities:**
   - i) There is already a lot of work being done in the county, which is reflected in the plan at the end of the strategy.
   - ii) The work of the Community Partnership, led by Herefordshire Healthwatch, who have looked at the factors driving health inequalities and consider what can be done by partners in the statutory and voluntary sectors, together around that.
   - iii) The work of primary care networks of general practice, community staff, and social care workers is also important to understanding the needs of their population, in addition to dealing with those needs in defined areas and in defined ways.

Plan on a Page

Vision;	Herefordshire residents are resilient; lead fulfilling lives; are emotionally and physically healthy and feel safe and secure.		
The Challenge	Requires inequalities in health outcomes between different groups of people to be reduced. This necessitates a mix of short, medium and long term action including upon the wider determinants.		
We will focus on;	Reducing health inequalities across the population, particularly within:		
	Rurally dispersed	**Travelling Community**	**Unregistered individuals**
To do this we will;	Work in partnership to develop local solutions, using national frameworks and best practice, which encourage and empower people of all ages and abilities to reduce inequalities and improve health and wellbeing; focusing on;		
1.	Engaging healthcare professionals to improve digital and health literacy		
2.	Empower and support workforces to understand and deliver equitable services that reduce inequalities and address workforce inequality and training needs		
3.	Reaching communities to work in partnership to reduce inequalities		

In July 2022, the Health and Care Bill came into force which saw the establishment of Integrated Care Boards (ICBs), taking on the commissioning responsibilities of Clinical Commissioning Group and bringing a wider focus on the delivery of improved health, care and wellbeing outcomes. The 42 ICBs across England sit within wider Integrated Care Systems (ICS) which bring together partners from across health and care enabling mutual support between different parts of the system to further integrate the provision of care, reducing health inequality and unwarranted variation and give a shared focus on delivering improved outcomes.

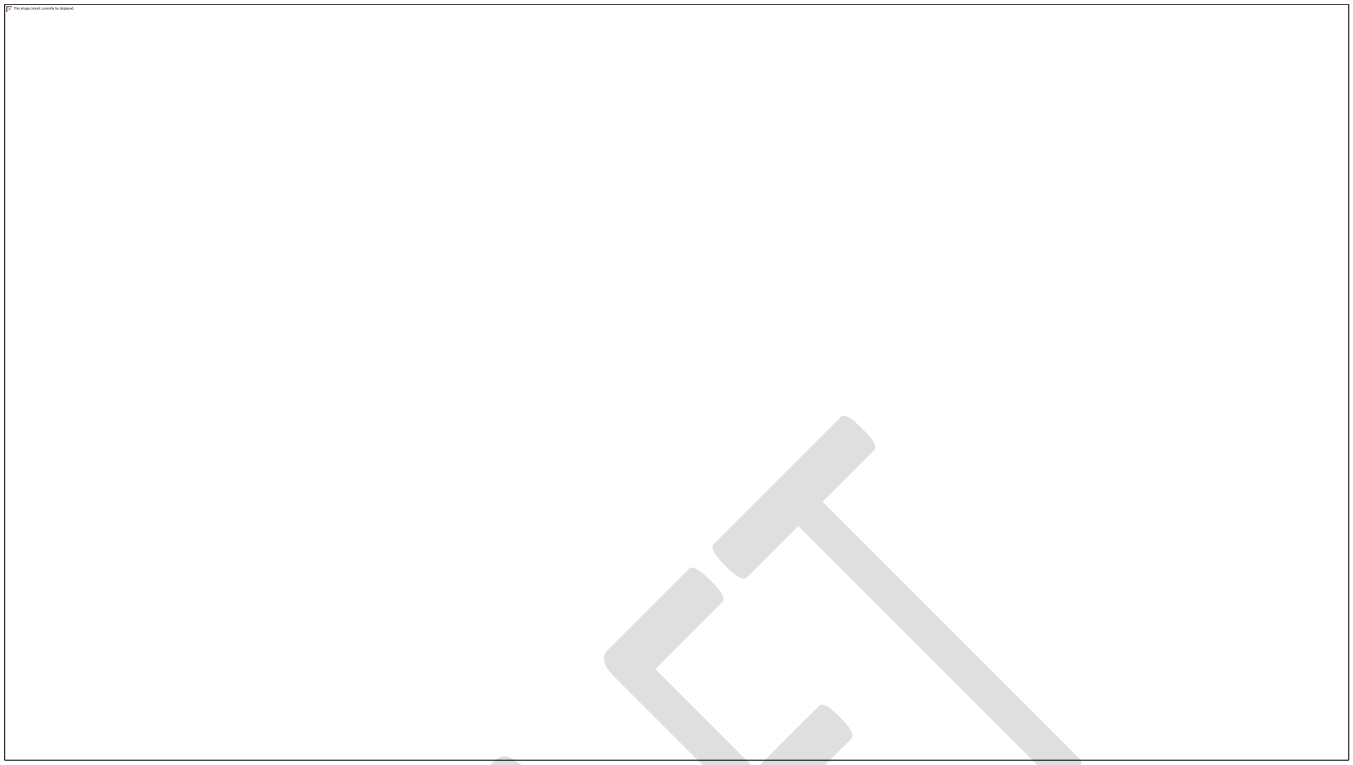
Herefordshire and Worcestershire ICB serves a population of over 800,000 people across two diverse counties where there is variation in health outcomes across communities, and differences can be seen when considered by ethnicity, deprivation and rurality. The factors which drive this variation can be 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.

Integrating Primary Care – Anchoring transformation around our neighbourhoods

One Herefordshire partners are working together to build on the quality of care already provided in the county by primary care colleagues and ensure care for key communities is joined up, ensuring access to services and support when its need and sustainable services for the future.



The Fuller Stocktake, published in May 2022, sets out a vision to improve access, experience and outcomes for people and communities, the recommendations from which form a key part of our strategy and plans going forward. These recommendations centre around three essential areas.

Reporting to the One Herefordshire Partnership, senior managers from across the county are working together to develop detailed delivery plans based on the following principles and priorities:

Key Principles

- Reduce demand on statutory services
- Reduce duplication
- Clear pathways
- Empower residents to manage their own wellbeing
- Community driven and development focus
- Improved relationships between teams, improved job satisfaction, staff retention and wellbeing

Key Priorities

1. **Integrated Neighbourhoods Teams –** developing and supporting services delivered at a neighbourhood level

    a) **Community health & social care teams** – District nurses and social workers co-located alongside General practice teams where possible, with integrated access points, assessment processes and efficient, streamlined communication.
    b) **Safeguarding teams** - multi-agency professionals working together at the point of referral, with common values that respect professional expertise and perspectives, and is integrated into everyday practice.
    c) **Proactive care teams** - working alongside the developing INTs, there will be a focus on developing proactive care for patients with 2 or more long term conditions at risk of deterioration in the next 12-24 months. A single point of access will be developed so that patients are able to be supported with continuity of care from an identified group of professionals to meet their needs across a clinical and non-clinical team. This team will include well-being, such as social prescribing, to link the patient with community groups following a personalised care planning discussion. This will ensure a 'what matters to me' approach is followed to empower the patient to manage their well-being. The ambition is to align the team with CIRH so seamless care can be provided if the patient deteriorates further and is at risk at hospital admission. The aim is to support the patient to remain well, at home, with the right care, in the right place, by the right person for as long as is appropriate. It is hoped that this will improve outcomes for patients as they're able to remain at home within their community, whilst reducing pressures on general practice and secondary care.

2. Joined up approach to prevention & Well-being

    a) **Strengthening community-based Well-being support,** such as Talk Community Development Officers, PCN Well Being teams, MIND link workers and more, enabling teams to work better together, removing duplication and optimising outcomes by developing clear pathways, processes and team working.
    b) **Talk Well-being Integrated Outreach** – working to engage with underserved communities and addressing the wider determinants of health across Herefordshire to increase health checks and other screening tests to ensure earlier identification of otherwise undetected/unknown health conditions and increasing patients registered at a GP practice. This will be through outreach clinics, mobile approaches and working with community champions to identify areas to target where our population are facing barriers to accessing care, including registering with a GP practice. The team will clinically-led, but also include social prescribers and will collaborate across other organisations also providing outreach services to ensure all teams are making every contact count. This is a strength based, personalised care approach to empower patients to better manage their own health and well-being.

Planning Requirement (PR3) - A strategic, joined up plan for Disabled Facilities Grant (DFG) spending

Herefordshire's 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.

Supported Housing

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. Tillington Road is a collection of 6 newly built houses. The purpose of the accommodation is to enable people with enduring mental health conditions to be able to step down from more supported accommodation, into their own houses with floating

support available. Residents moved into the houses during August and September 2022, and all have maintained their tenancies. Each person has the availability of up to 14 hours support each week by Lifeways SIL.

Older Persons

An 80 bed care home to be delivered as 100% affordable housing with Platform Housing has achieved planning permission in Hereford. Contractors are currently on site building out the development with the apartments due to complete in spring 2024. All apartments will be for those aged 55 and over and have a local connection to Hereford.

Veterans Self-build

19 high quality affordable homes have been developed with a housing association and contractor on a former site of a 16-flat housing association scheme built in the 1970s and adjacent land that was donated by Herefordshire Council. The scheme is the first self-build veterans' development in the County and has been highly commended. Taking over four years to deliver, collaboration was key to its success. The project involved developing strong partnerships with the local planning authority, self-build specialists, armed forces charities and contractors; as well as winning the local community's support. The council also supported a grant funding application to Homes England and provided additional grant funding. The first keys were handed over on 17th December 2020 and all units occupied by February 2021; the scheme continues to succeed.

Disabled Facilities Grant (DFG)

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 council's Housing services we 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.

Herefordshire Council's DFG allocation is £2,268,653m for 2023/24. The table below shows the funding split. The target remains as previous years being to complete 200 mandatory DFG grants and 20 discretionary DFG or assistance grants in the financial year.

2023/24 DFG Grant	**£**
DFGs	1,236,658
Discretionary DFGs	7,597
Discretionary Fast track Adaptations	3,590
Emergency Repayable Grant	16,590
DFG - Strategic Housing	63,790
Staffing Costs	310,618
Professional fees	9,468
NRS assessments	39,708
Digital Switchover	4,299
Rough Sleepers Accommodation Property	276,335
ICES Recharge	200,000
Telecare Recharge	100,000
Total Expenditure	**£2,268,653**

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.

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 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.

This is in line with government guidance on use of DFG to support capital projects that benefit social care.

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.

2. National Condition 2: Objective 1 – Enabling people to stay well, safe and independent at home for longer

Planning Requirement (PR4) - A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home

The Council's transformation agenda sets out as a priority that opportunities for integrating care and support will be identified and followed through. We have increased the number of social workers in both the discharge team and the Care Act assessment team to support a person-centred approach which adheres to individual's needs. Pathways to services are reviewed to ensure the quality of discharges and that patients are discharged safely, in a timely way.

Activities which are in process include:

- A review of Herefordshire's Discharge to Assess (D2A) model is being undertaken, reviewing the service model for integrated discharge services, KPI's and processes; considering quality of outcomes, timeliness, effectiveness and affordability. An integrated D2A board has been convened and commenced in May 2023. A workshop is scheduled for 19th June 2023.
- Support is delivered at place via locality teams within Primary Care Networks and greater steps towards integration have been taken, which support the D2A pathway. A lead post has been developed to include District Nurse provision within the PCN.
- A new Learning log concerns form has been specifically devised for professionals to identify areas of process or practice that need to be improved that have been identified from complaints or concerns relating to a discharge process.
- Central referral points for therapy and urgent response allows for holistic review at triage and access to multi agency services locally is in place.
- Long Term Condition pathway and service is available working with and aligned with community teams.
- Implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches.
- Alternative models of delivery for occupational therapy are currently being considered, including a potential integrated model across health and social care. Reviewing establishment of a joint post – aiming for September 2023.
- Within the Council's housing solutions team the post of Housing Discharge Officer provides an early point of contact to create and maintain pathways to ensure that no one is discharged from hospital without accommodation being available to them where possible.
- The provision of a Service Manager, social care delivery – Urgent care/Initial contact manager is being proposed to lead the front of house urgent care and initial contact services. It is envisaged that this post will manage Care Act responsibilities in relation to Discharge to assess social care pathways including initial assessments; Advice and Guidance and signposting and Safeguarding referral and triage hub. The service manager will form close operational links with the Wye Valley Trust (WVT) Operations manager for urgent care and key partners which support operational pathways for urgent care and support services in WVT and in the community:
    - Hospital liaison workers who form part of the integrated discharge team.

- Care Act assessment team who manage the pathway. (CAAsT)
- Safeguarding concerns - to be developed into a multi-agency safeguarding service.
- Adult advice, referral and signposting team (ART) which includes Community brokerage services and has direct links with CIRH.

- A Senior Social worker- hospital avoidance post is also being proposed within the CAAsT team with close links with the integrated discharge team and CIRH, ART and Community resources. This new post will lead on working with key professionals in A&E to identify individuals who do not need to be admitted and work with all agencies to seek appropriate care and support options. This will be a key post to provide professional Social care assessments of individuals who do not need to be admitted and ensure plans are in place to return home or to an appropriate care setting. Additionally this post will develop reports to understand social reasons for admittance and to identify gaps in provision in the community response. There is potential that this post can also provide liaison support with people admitted from Out of county by liaising with other Local Authorities and agencies.
- Resource from both health and social care teams is being used to ensure there is increased opportunity for discharge home. A NHS bridging team was established in March 2023, as an interim measure, to support reablement and increase capacity. Care support workers (attached to Hospital @ Home) will be employed to support discharge from hospital where Home First do not have capacity available. This bridging team will hold the cases and handover to Home First or most appropriate other service when capacity is available and where reablement is the appropriate pathway.
- Age UK have been commissioned to pilot a Hospital to Home Discharge Service providing a facilitative service to support the local health and social care system on discharges (pathway zero). The pilot runs from April–July 2023. Monthly monitoring and an evaluation of the pilot will be undertaken. The first 3-4 weeks were carried out by 2 paid staff, 3 volunteers and have delivered 33 hours of support. It is early in its contract so it is anticipated will grow steadily. The support offered can include low level tasks including food shopping, home and welfare checks and signposting to other agencies.

Planning Requirement (PR5) – Additional discharge funding - An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.

Additional Discharge Funding

Allocation of the Adult Social Care Discharge Fund has been agreed by partners.

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Herefordshire, County of	£950,944	£1,584,907

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Herefordshire and Worcestershire ICB	£1,047,772	£2,221,943
Total ICB Discharge Fund Contribution	£1,047,772	£2,221,943

ASC Discharge funding will be used alongside other BCF funding and other funding from partners to ensure that there is sufficient capacity to meet discharge requirements.

Herefordshire integrated discharge services comprise:

- Home First (rapid response and reablement at home services provided by Hoople Ltd)
- Hillside Care Centre (bed-based residential reablement provided by Hoople Ltd)
- Hospital @ Home (provided by WVT)
- Ledbury Intermediate Care Unit (bed-based short-term nursing provided by Shaw Healthcare Limited)
- Integrated Discharge Team (multi-disciplinary discharge team with staff from WVT and Herefordshire Council)

- Care Act Assessment Team (CAAsT) (Herefordshire Council social workers focussed on discharge)
- D2A therapy (therapy across all discharge settings provided by WVT)
- Voluntary sector services (provided by Age Concern and through Talk Community)
- Short-term nursing and residential beds contracted and spot-purchased from a number of Herefordshire providers
- Home care placements spot-purchased from a number of Herefordshire providers

Herefordshire has recently incepted an Integrated Discharge Board for local system partners to work together for sustainable improvement for patients and to draw planning and delivery of all discharge services into a single board with representation from all relevant local partners.

The Board has four strategic aims:

1. Increase the number of people receiving rehabilitation and recovery services after an acute hospital admission, increasing people's functional outcomes and ability to remain independent at home.
2. Decrease the need for long-term care by decreasing need.
3. Reduce length of stay and bed days lost by decreasing the number of people staying in an acute hospital who should be at home or in more appropriate community bed-based care.
4. Provide an integrated system approach to the development of new models of care to address challenges within the current model.

The Integrated Discharge Board will lead the review of the service model for discharge. In June 2023, a One Herefordshire Partnership strategy forum will focus on understanding the issues in home care, followed by inaugural further meeting of the Integrated Discharge Board and an integrated discharge service model workshop. The new service model and pathways should be more effective and should reduce the current reliance on spot-purchasing short-term care in the local market, improving both outcomes for service users and financial sustainability. A workshop is scheduled for 19th June 2023, with an intended revised service model agreed by the end of June 2023. Transition to the new model will commence in July 2023 and it is anticipated it will take a few months to embed.

Capacity and Demand

Demand and capacity planning is based on previous patterns of activity adjusted for projected local population growth and demographic change.

Demand, expressed as number of discharges from acute beds, is assumed to be stable, neither increasing nor decreasing appreciably in the planning period, reflecting the system's current focus on improving discharge services. Once the improvements in discharge services are embedded then the system may be able to shift focus to admission prevention, but this is unlikely to have a significant impact until much later in the planning period.

Capacity is based on the current service model; the reorganisation described above should see changes in capacity requirements, with use of some services increasing and use of some services, particularly spot-purchased care, decreasing; however, as with any transformation it will take a little time for the results to be seen and transition to new ways of working to be effected.

Analysis of discharge activity across 12 months has identified a number of learning points:

Referrals and Assessments

- 20% of pathway assessments need no further support upon discharge, suggesting risk-averse behaviour in initial discharge planning and referral to the integrated discharge service
- 52% of pathway assessments are assessed as needing reablement or rehabilitation at home
- 28% of pathway assessments are assessed as needing short-term residential or nursing care. In part, this very high proportion of patients moving to bedded care will be due to Herefordshire's demography, but it also suggests an over-reliance on bedded care in the integrated discharge model and is a key area for further analysis.

- 32% of patients assessed as requiring reablement or rehabilitation at home are subsequently discharged by the Home First team as needing no further support, suggesting an over-prescription of care and a disparity between the assessment model used at discharge and the assessment model used by Home First.

- 25% of patients assessed as requiring reablement or rehabilitation are referred to other services due to lack of capacity in the Home First service. Increasing the capacity in Home First through recruitment and improvements in productivity is a key priority of the Integrated Discharge Board. Resolving this capacity issue will reduce or remove completely the need to purchase short-term care in the homecare care market. As an interim measure a bridging team is being provided by Wye Valley Trust NHS to pick up the excess demand. The plan to reduce the capacity gap is to increase both staffing numbers and productivity in the Home First service. The recruitment aspect of this plan has been in place throughout 22/23 and the service is approaching full establishment of reablement workers.

Discharge Services Provided

- 52% of service users received reablement or rehabilitation at home
- 18% of service users received short-term residential home care
- 29% of service users received short-term nursing home care
- The average length of stay in discharge services is 39 days, but there are a number of service users with very short and very long lengths of stay

Discharge Destination

After receiving short term discharge services:

- 23% of service users need no further long-term service
- 11% of service users are readmitted to hospital
- 19% of service users go on to a local authority funded long-term placement
- 4% of service users go on to an NHS funded placement
- 22% of service users fund their own long-term placement
- 6% of service users pass away while receiving discharge services

The Herefordshire system can experience difficulty in finding long-term placements in the care market, especially for more complex needs. This can lead to delays in moving on service users from their short-term discharge service and cause 'silting-up' of the discharge system.

Re-commissioning the integrated discharge service model to reduce the need for short-term placements in the market will release some capacity for long-term placements; but the difficulty in recruiting care workers in the local labour market, and a strong self-funder market for care will continue to present challenges to increasing the capacity for local authority or NHS funded care at sustainable prices.

3. National Condition 3: Objective 2 – Provide the right care in the right place at the right time

Planning Requirement (PR6) –A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time

We will continue ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the government's hospital discharge and community support guidance.

A number of actions continue to support recruitment and retention of staff. Additional staff have been recruited to the CAAsT responsible for assessing all patients who have been discharged under D2A to pathways 1 2 and 3.

Ward discharge coordinators are now in place at the acute hospital to support the Multi-Disciplinary clinical teams' decision making with a focus on Pathway 0; this team are part of our Integrated Discharge Team which comprises health and social care staff working as one team. Where the patient requires additional support on discharge, an assessment of need is undertaken to identify the most discharge appropriate pathway.

Joint roles allow for timely escalation regarding delays and immediate action required. Utilisation of commissioned services in Pathway 1 is a priority along increasing provision by with the voluntary sector.

Other systems responses:

- Additional block discharge provision for discharge to assess domiciliary care.
- Additional funding to fund 12 beds in nursing and residential settings to provide for Pathway 3
- Provision of spot beds as over flow.
- 24 hour Integrated urgent care response currently in the planning stages.
- System calls in place for both in and out of county actions regarding delays.

Short term block purchased beds pilot

The Council set up 12 short term block purchased D2A beds from January – 31 March 2023. This has been extended until June 2023 in a bid to support the local system. It has been well utilised at over 95% and supported discharges during the peak winter pressures. On the back of the above pilot the council are going out to tender in early summer 2023 for a long term block beds service which will take referrals from the community and D2A. This will enable greater capacity and control over provision as well as reducing costs compared to spot-purchased beds.

Herefordshire and Worcestershire is developing a joint contract between Herefordshire council, Worcestershire council and Herefordshire and Worcestershire ICB for residential and nursing care home placements. This will provide a collaborative approach, consistency and revised specifications including for complex care. It should also give greater control over spot purchase fees. The new joint contract should be in place in by early 2024.

Herefordshire Council is embarking on an ambitious transformation programme for social care and community services and is actively exploring alternative models of care and support. These options include:

- Consideration of council owned provision
- Additional extra care housing
- Supported living transformation programme
- Moving away from traditional bed based residential provision
- Maximising the use of digital and technology to support more people to remain in their homes
- Enhancing the shared lives model to ensure choice, quality and cost effective delivery.

For Home Care these options include:

- Building capacity with providers to develop rounds
- Development of Personal Assistant (PA) provision
- New models of care delivery
- Community support for customers and care staff

Herefordshire Home Care Framework was launched in November 2021 with 11 local providers across 4 locality areas. Due to the increased demand for more capacity in the market from hospital discharges and the community the framework has been re- opened to allow a secondary tier of providers.

Herefordshire Council is taking action on areas to improve market sustainability across home care, D2A and Home first, in order to improve waiting times, capacity and flow, support discharge and support the workforce challenges. The table below sets out our plans:

Commissioning Activity for homecare	Outcomes	Timescales
Engagement with the care at home sector	An engagement forum in now in place. This is enabling the council to expand its capacity and build relationships	November 2022
Workforce challenges	Fee rate of 8.7% applied to domiciliary care market The Herefordshire Cares website (recruitment)	April 1 2023

Commissioning Activity for homecare	Outcomes	Timescales
Secondary Provider framework for Home Care reopens	Additional providers on the framework will increase capacity to deliver homecare and reduce waiting lists and improve capacity and flow.	April 2023
Expanding the Herefordshire Talk Community offer to support people to live in their communities and receive informal support	Linking care at home more with Talk Community, so local residents are aware of the local offer	2022-23
Develop a Shared Living model	Opportunities for vulnerable people to share their homes in return for support and companionship	2023-24
Expand Shared Lives Options	Can provide additional safe and secure homes for vulnerable residents, including older people.	2023-24
Telecare and improving outcomes Improving digital offers	There are plans in place to increase the capacity of models such as Prevention and Predict telecare. This model can support people to remain independent for longer. It focuses on preventative data in the following areas • Falls • Dehydration • Reduce the need of care calls	2023-24

A block purchase arrangement for Discharge to Access (D2A) home care has been operational from April 2022 to May 2023. As part of the review of D2A provision, the council is exploring alternative ways of increasing capacity in areas where there is limited capacity and potential growth with current providers. A block purchase approach is being considered which would go out to tender through the council's procurement portal. In addition to this, as part of the council's transformation plan, a wider review of home care solutions, including geographically based personal assistants and micro providers will be completed during 2023/24.

Shared Lives is funded through iBCF and the expansion of the service is a priority of the Council's transformation agenda. Shared Lives Plus has been commissioned to support us with a review of how to take forward expansion opportunities. It will review what is feasible and how much would we need to expand the team to accommodate the new initiatives.

The following are being considered:

- Home Share, a matching service where an adult can offer accommodation to someone who can offer support and companionship.
- Discharge offer of short term accommodation, for people who need a step down from hospital but are not quite ready to go home.
- Expanding shared lives to people who are 16 plus or parents with a child for short term housing arrangement.
- Day support and care opportunities, including carer breaks.

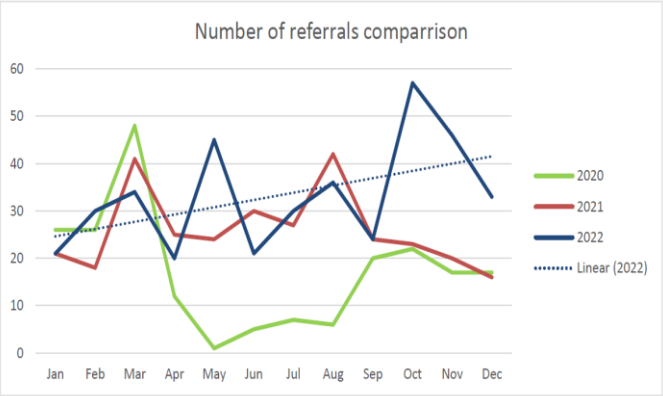
The **Care Home Clinical Practitioners (CHCP)** continue to be funded via iBCF. The CHCPs work within the Integrated Care Division, WVT and in close partnership with Herefordshire Council (HC) Quality Assurance team.

The underpinning work has been guided by HC Quality Assurance and ICB who have identified homes requiring additional support. The team respond to individual provider needs as required and requests referred from the HC QA team. Educational sessions to care homes within Herefordshire are developed to provide training which is underpinned by evidence based, gold standard practice for clinical skills which includes the initial training followed by any assessment of competencies.

- Overriding long term aims are to support home staff within 5 key areas:

- Recognising the deteriorating resident
- Respiratory support
- Slips, trips and falls
- Continence
- Tissue Viability

The **Trusted Assessor** model funded via iBCF, continues to be a valued resource in helping to reduce the number of delayed discharges and supporting individuals to be discharged to an appropriate care home. A further aim of the service is to improve the patient experience by reducing unnecessary days spent in hospital and by ensuring that they are accurately placed.



The service received 397 referrals in 2022, a 29% increase from 2021 (308).

Workforce, Recruitment and Retention

Recruitment and retention of the workforce, both within the community wellbeing directorate and also within the wider care sector, is challenging. General workforce shortages, coupled with pay inconsistencies and geographical distance, cause significant challenges.

In the wider sector, there are capacity shortfalls in care homes and particularly in homecare. Retail outlets offer significantly greater hourly rates and more flexibility around working hours. The lack of homecare capacity in particular has led to a significant number of people waiting in the community for commissioned homecare packages and an over-reliance on the reablement provision to cover the shortfall. There is limited new intake into the sector – where there is movement, it tends to be the workforce moving from one provider to another.

The Herefordshire Cares website and social media campaign is funded through iBCF. 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. The team are also linking with Skills for Care, local colleges and ICS on system workforce training and requirements.

Establishing a stable and engaged workforce is a key work stream of the council's Transformation plan. Key transformation activity for 2023/24 includes:

- Launch **Community Wellbeing recruitment microsite**
- Develop and implement a **directorate workforce strategy**
- Maximise opportunities to work with the **Integrated Care System** on wider recruitment and retention initiatives in social care and wider and to support multi-agency sector workforce planning
- Design and deliver an **entry level apprenticeship** scheme in the directorate

- Proactive campaign and promotion of **Herefordshire Cares**, including alignment with Talk Community and Integrated Care System.
- Delivery of **training activity to the care sector** (All Age), including carers and PAs, to support retention and high quality workforce

Implementing Care Act Responsibilities

The Health and Care Act 2022 gave the Care Quality Commission (CQC) new regulatory powers to undertake independent assessments of local authorities' delivery of regulated care functions.

Local authorities will be assessed against part one of the Care Act 2014, which has a different set of statutory duties than the Health and Social Care Act, used to assess care providers and integrated care systems.

The CQC local authority assessment framework has been launched and comprises of 9 quality statements mapped across 4 overall themes:

1. How local authorities work with people
2. How local authorities provide support
3. How local authorities ensure safety within the system
4. Leadership

To prepare for the implementation of the CQC Assurance framework, the council has completed a self-assessment (mapped against the framework) and is developing a range of improvement plans. Council officers are part of the ADASS CQC Assurance work group and are taking part in the ADASS readiness review process.

In relation to BCF spend to support the implementation of care act responsibilities, similar to previous years, a number of service areas that fulfil Care Act responsibilities are funded through the BCF. For example, the Carers Support Contracts, Deprivation of Liberty/AMHP and the advocacy contract. The council's CAAST is part-funded by BCF (£229K).

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.

The contract to provide a range of advocacy services for adults is via Onside Advocacy. The provision of adult advocacy promotes individual autonomy, protects against abuse/exploitation, empowers decision-making, supports individuals in understanding their rights, and ensures fair treatment and continuity of care for those who may require additional support in mental health or decision-making processes.

The council has a statutory duty to provide independent advocacy under the Care Act 2014, Mental Health Act 2007, Mental Capacity Act 2005 and the Health and Social Care Act 2012. This requires the provision of;

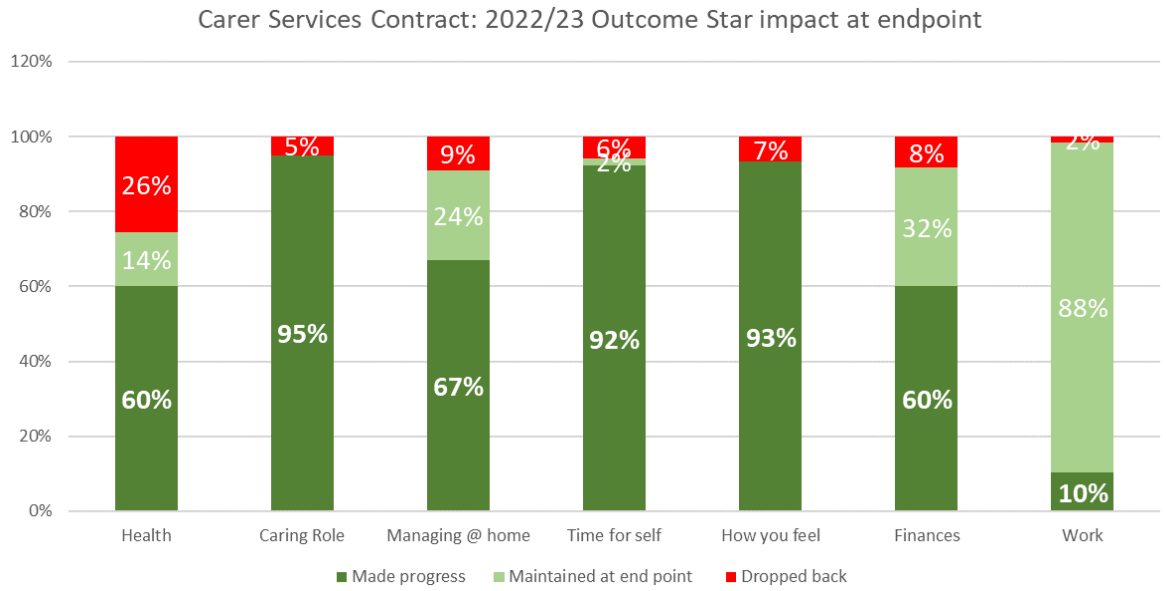
- Independent Mental Capacity Advocate (IMCA)
- Independent Mental Health Advocate (IMHA)
- Care Act Advocacy
- NHS Complaints Advocacy

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.

The Council commissions a Carer Services contract. The service worked with over 300 carers in 2022/23 to provide a range of outcome focussed information, advice and support relating to:

Health	Carers journey/experience with managing their own health and the person they care for
Caring Role	How they cope with their caring role
Managing at Home	How they cope with managing the day to day running of their home
Time for yourself	Do carers have enough time to have a break from their caring role
How You Feel	How the carer feels about their caring role and any other aspects of their life that may be affecting them
Finances	How they manage bills, earning, benefits, saving etc.
Work	How they balance the demands of caring, working or training



At end the of the support period, most carers report a positive impact across most outcome areas, above. There does appear to be more to achieve across the sector to support carers achieve good outcomes in relation to work and maintain and improve outcomes in relation to health. It is proposed that these should be areas of focus in the refresh of the Carers Strategy, which will be co-produced with Carers. While the strategy is being developed, it is intended to extend the current contract subject to the Council's governance and contract procurement rules, which will enable a review of the service scope and specification against the strategic priorities to ensure that the service remains fit for purpose over the next years.

The ICB continue to support carer's breaks through the BCF 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.

St. Michael's Hospice Carers Support (£261,345K) provides an integrated hospice at home service model for high-quality end of life and palliative care for people identified at end of life. The model provides planned day and planned night care services along with an urgent care service across a 24/7 period: 365 days a year. This is underpinned by clinical care coordination where patients and family's needs will be assessed, and care planned on an individual basis with on-going case management. The hospice at home clinical care coordination function will support development of an electronic end of life care plan and a palliative care register.

Acorns Childrens Hospice (£32,154K) provides planned and emergency respite care for babies, children and young people up to 18 years of age who have a life limiting, life threatening or end of life care needs. Approximately 20 babies, children and young people annually receive support. In addition to inpatient care an outreach service enables support to be provided to families in their own home, working with parents, the patient and siblings to live with the challenges of terminal illness. Transition support to enable a phased and personalised approach to accessing adult services commences at age 16yrs and builds on local community services, family strengths and adult hospice care to facilitate this stage of the young person's life journey.

Transforming the offer for cares, including respite provision and the development of an All Age Carers strategy is a key priority within the council's Transformation strategy and significant progress will be achieved during 2023/24.

The High Impact Change Model (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 HICM has been reviewed and updated.

HICM KEY:
Not yet established - Processes are typically undocumented and driving in an ad hoc reactive manner
Plans in place - Developed a strategy and starting to implement, however processes are inconsistent
Established - Defined and standard processes in pace, repeatedly used, subject to improvement over time
Mature - Processes have been tested across variable conditions over a period of time, evidence of impact beginning to show
Exemplary - fully embedded within the system and outcomes for people reflect this, continual improvement driven by incremental and innovative changes.

The table below provides an overview of Herefordshire's local, joint self-assessment.

High Impact change Model - Herefordshire self assessment and improvement plan

June 2023

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	**Established**	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. Introduction of Ward Discharge Coordinators across 5 wards at the acute hospital is providing opportunities for earlier discharge planning. Improvement programme launched to improve EDD setting across teams to better estimate discharge dates to support teams to prepare for discharge timely. Additional social worker to support the understanding and responsibilities for social care, based with the discharge team. A hospital to home pilot has been introduced with Age UK to support those on pathway zero. This pilot is looking to support earlier discharges.
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 took place in September and a demand and capacity dashboard has been developed. Discharge-System partners continue to work together to monitor and respond to demands, however capacity within home care market continues to impact ability to respond to demand in a timely way. System plan in place for a D2A review of model including capacity per pathway (June 2024) and to capture activity through a dashboard. Development of a D2A board. New post to be established based in A&E, making sure the right capacity, right resources, are in the right place to support D2A services and care act compliant. The council developed its market sustainability plan which has focussed on capacity and responding to market changes. It sets out the 2 year plans which include some service redesign of existing care facilities to increase blocked beds and some further dementia beds.
Change 3: Multi-disciplinary working	**Established**	The Integrated Discharge Team continues to develop and evolve. Partners work closely together throughout the Urgent Care Pathway including daily huddle meetings, where patient trackers and progress are discussed. Invested in additional management staff to support social care pathway out of hospital - recruited interim into post.
Change 4: Home First D2A	**Mature**	Wherever possible, people are supported to be assessed in their usual place of residence. The CAAST team, who complete Care Act assessments once people have been discharged, continues to respond to demands. Increased the staffing to facilitate the assessments. 80-85% of all discharges and pathways are assessed by CAAST - investment in our own staff. A new SLA, KPIs is being developed with the existing D2A service and Homefirst.
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	**Mature**	Admission advice and information leaflets are readily available, including web based information. Alternative languages and accessibility options are currently being explored. The council 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. Talk Commuhity Hubs 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**	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. There are early discussions on developing a provider portal whereby all future integrated information can be brought together on one portal. Information will include high level information from the council, PCNs and WVT.
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.

4. National Condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

Planning Requirement (PR7) - 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 to the overall contribution

Planning Requirement (PR8) - 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?

Herefordshire Council is working collaboratively with commissioning partners across the system in order to further develop integrated approaches to commissioning

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.

Falls responder service

The team responded to just under 1000 calls by the end of quarter 4 (2022-23). There were 187 repeat fallers and the last quarter fell to 39 in comparison to 54 the previous quarter which was the lowest quarter of the year. Referrals to the falls responder services continue to be made by all agencies but in the main by adult social care: Falls navigators – 111; Adult social care – 68; GP notification (3rd fall) 47; Telecare 34; Community Integrated Response Hub - 32

Falls Care Navigator service

Performance data shows the service continues to achieve outcomes and it plans to build upon this by undertaking a Predict and Prevent pilot in 2023. During 2022-23 there was a significant reduction in people with repeated falls across a 3, 6 and 9 month period. This equated to ranges of 40-60% in some cases. There was 127 repeat fallers of which 94 took up the offer of a service with the FNS. 100% of all individuals had an active support plan in place and were being supported to achieve their outcomes.

Pilot for Predict and Prevent model

Whilst the Falls Care Navigator (FCN) service yielded some excellent outcomes it works as a reactive service. The council's longer term plans include greater preventative work such as the Predict and Prevent model. This digital software uses monitoring and data to inform the existing falls responders and falls care navigators before falls occur.

The pilot will run for 6 months from April 2023 with the provider of the FCN service. The current service works specifically with repeat fallers and minimises the likelihood of further falls, but would benefit from understanding falls by analysing data much sooner and reducing unnecessary call outs of the falls responding service. This preventative model highlights high risk fallers before they present to services. It is anticipated it will contribute to hospital avoidance and more cost effective delivery.

The Predict & Prevent services use technology to monitor everyday activities such as movement, temperature, night-time activity and eating and drinking habits and using the data captured creates a baseline of each individual service-user's normal pattern of behaviour in their home. When a person's behaviour deviates from that baseline, such as a decrease in movement or reduced fluid intake, it may be an indication of a possible deterioration in health or wellbeing and increased risk of a fall. It is then that the falls team make contact, before the individual falls. With the deviation flagged, alerts can be sent to the team with reports of behaviour and insights into any changes, enabling follow-up interventions to be made quickly by appropriate staff. This

highly personalised approach means that the solution is uniquely appropriate to the individuals needs which enables prolonged independence at home for service users. The pilot will enable commissioners to understand the impacts on hospital avoidance, reduction in A & E admissions and costs to health and social care system

The data generated is key to supporting front-line care resources, allowing them to manage those that need care much more effectively and safely. Firm evidence allows more effective allocation of resources, which ultimately leads to an increase in the number of people that can be cared for without reducing the quality-of-care provision in any way. This pilot is an intervention that promotes the preventative agenda in falls and it is the ambition that this technology will be used by the existing falls team to strengthen the approach taken which focuses on prevention rather than reaction. It is the intention to re-design the exiting care navigator, fall responders to include a greater preventative approach by using digital data.

As part of several of the Predict and Prevent test and learn projects which there is falls equipment being trialled. This will be going live approximately August / September 2023. Some of the falls sensors are wearable but the one currently being looked at provides non-wearable imaging technologies. The non-wearable falls detection system uses radio waves to detect if a fall has occurred, the system will therefore pick up all types of falls and as it is non wearable can be used by anyone. Not only can it alert if the user has had a fall, the system will also provide data that will allow the identification of factors such as reduced mobility which increases the risk of falls allowing interventions to take place before the fall occurs.

Herefordshire council is undertaking a falls review and re-designing services within the pathway during 2023-24. This builds on the work last year undertaken 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.

Hillside

Hillside Care facility is currently fully funded through BCF as a bedded assessment and reablement service. Hillside's current primary function is to support hospital discharges as part of the Herefordshire system agreed D2A model. Additionally when there is capacity community teams can also access bedded reablement for people in the community in order to ensure access to therapy and care which prevents an unnecessary hospital admission or admission to nursing and residential beds where reablement is not readily available.

Hillside has 22 beds and is supported by a team of staff employed by Hoople Care with access to therapy services, medical cover and social work services. People will access this support for a period of up to 6 weeks.

The long term delivery model for the provision at Hillside will be established and approved during 2023/24.

Community commissioning

The community commissioning team manage a portfolio of commissioned services and associated programmes and projects focussing primarily on preventative interventions including; mental wellbeing, S117 provision, dementia, advocacy, suicide prevention, multiple complex vulnerability, high intensity, placement support, supported accommodation, domestic abuse, refugee resettlement, community equipment, technology enabled living, community and cultural services and voluntary sector infrastructure and systems.

Of these services and programmes several directly support discharge from hospital or admission avoidance including the provision of community equipment and technology enabled living whilst others have a more indirect but nonetheless meaningful impact. Indirect services and programmes include community and cultural services, voluntary sector infrastructure, mental wellbeing, dementia and supported accommodation offers for those with multiple complex vulnerabilities.

The programme of work to deliver improved care and support service provision within the adult Supported Living and Community Activities market demonstrates positive progress in terms of the supported living review, market engagement and a new community activities service specification, however further work is needed to deliver a new procurement framework, service improvements and system benefits.

The proposed approach is to bring together two areas of work and build on progress made in 2022 to implement new arrangements for Supported Living and Community Activities by reviewing and retendering services. This will:

- Provide a strategic approach in line with the Herefordshire Learning Disabilities strategy (2018-28) which sets out a collective ambition to move away from the idea of separate services and fully adopt the principle of supporting people with learning disabilities to successfully integrate, including where they live, where they work and spend their days.
- Ensure new arrangements are fit for purpose in line with customer needs and aspirations, innovation and best practice, sustainability and market stability within resources available.
- Opportunity to plan future needs, demand and capacity within a progression model of support providing increased opportunities for people with a learning disability to lead more independent lives including training, personal skills development, vocational training and paid and voluntary work opportunities which extends beyond the current offer in Herefordshire.
- Make better use of resources with the option of a single flexible framework agreement with new categories (lots) within a 'progression model' aligned with more effective market management. This will provide the opportunity for a more targeted commissioning approach and development of a 'progression model' based on individual needs and helping individuals realise their own potential for progression towards more independence.

(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.

Putting communities at the heart of all that we do

We recognise that that our communities have a vital role in improving health and wellbeing, where the solutions to health problems are not solely about the provision of formal health and care services. A cornerstone of the programme is our Talk Community Hubs which are located across Herefordshire and provide a safe place where people can access up to date wellbeing information and signposting to local and national resources. They also connect people to services, groups and activities, either within the local area or across the county, which can help them support their own wellbeing and independence.

Super hubs

Building on the success of the Talk Community model, capital funding is available to enable our hubs provide a 'one stop shop'. With an all ages approach to support local residents to access services within their local communities. Community led and driven with a focus on individual community need, allowing communities to design, own and deliver a Super Hub that meets the needs of their community.

5. Metrics

Planning Requirement (PR9) - Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?

System partners are working together to ensure that robust metrics are in place; and continues to work collaboratively to maintain performance in each area. The responsibility to monitor performance will be moving to the Integrated Care Executive (ICE) therefore looking to examine performance against metrics throughout the year. ICE will consider and agree local metrics, for example, falls outcomes and incidence, D2A capacity is fully utilised and meets Length of Stay targets, expenditure/impact of DFGs.

Metric	Detail
Admissions to residential care homes	Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.
Avoidable admissions to hospital	Unplanned hospitalisation for chronic ambulatory care sensitive conditions.
Falls	Emergency Hospital Admissions due to falls in people over 65.
Discharge to usual place of residence	Improving the proportion of people discharged home, based on data on discharge to their usual place of residence.
Reablement/Rehabilitation	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

Appendix 1: Planning template

Appendix 2: Demand and Capacity template

Appendix 3: ICB Discharge Funding Template

BCF Planning Template 2023-25

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

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 the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, 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'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

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 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. 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.

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

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

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

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, 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 Condition 4 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 6b.
- 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. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.

A table of each type of output and the units it will prepopulate with is viewable in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. 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 eligible expenditure on social care under National Condition 4.
- 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.

7. 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 on NHS commissioned out of hospital services under National Condition 4. 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.

8. 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.

9. 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.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

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

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service. Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

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 2023-25. 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 2023-24.

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 2023-24. 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 (2021)
- Actual performance for each quarter of 2022-23 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.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- 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. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. 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 2022-23, 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 2023-24 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 2022-23 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.

4. Residential Admissions:
- 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 2022-23. 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.

5. Reablement:
- 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 2022-23. 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.

8. Planning Requirements

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 Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 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 2023-25 Template

2. Cover

Version 1.1.0

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Herefordshire, County of
Completed by:	Marie Gallagher and Adrian Griffiths
E-mail:	Marie.Gallagher1@herefordshire.gov.uk
Contact number:	01432 260435
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 HWB is expected to sign off the plan:	

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Carole	Gandy	carole.gandy@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.

#NAME?

	Complete:
2. Cover	Yes
4. Capacity&Demand	#NAME?
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Herefordshire, County of

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,268,653	£2,268,653	£2,268,653	£2,268,653	£0
Minimum NHS Contribution	£15,988,427	£16,893,372	£15,988,427	£16,893,372	£0
iBCF	£6,782,841	£6,782,841	£6,782,841	£6,782,841	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£950,944	£1,584,907	£950,944	£1,584,907	£0
ICB Discharge Funding	£1,047,772	£2,221,943	£1,047,772	£2,221,943	£0
Total	**£27,038,637**	**£29,751,716**	**£27,038,637**	**£29,751,716**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£4,543,457	£4,800,617
Planned spend	£9,114,213	£9,630,079

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£6,874,213	£7,263,293
Planned spend	£6,874,214	£7,263,293

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	145.0	141.0	154.0	151.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,477.0	1,372.0
	Count	746	708
	Population	50481	51623

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 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)	91.8%	91.9%	91.7%	91.4%

Residential Admissions

		2021-22 Actual	2023-24 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	466	484

Reablement

		2023-24 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 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Herefordshire, County of

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

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 aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term social care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line 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 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section 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 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section 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:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Other short term social care
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

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.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section 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:
- Social support (including VCS)
- Urgent Community Response
- Reablement or rehabilitation at home
- Other short-term social care
- Rehabilitation in a bedded setting

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.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Estimates of demand and capacity are based on historic activity amended for changes in local population and demography. Activity changes with each month based on historic patterns of activity. Much of the activity in the Herefordshire system is spot purchased in the care market- Herefordshire has a sizeable and buoyant self-funder market whcih means that local providers are not usually interested in block contracts for care at local authority rates. Length of stay and hours of care per package are assumed to be in-line with historic patterns

	Complete:
3.1	#NAME?
3.2	#NAME?
3.3	#NAME?
3.4	#NAME?

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!
(Select as many as you need)

Trust Referral Source	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
WYE VALLEY NHS TRUST	Social support (including VCS) (pathway 0)	70.24	53.92	55.04	42.64	60.04	70.92	58.36	55.36	52.88	44.96	47.32	52.4
WYE VALLEY NHS TRUST	Reablement at home (pathway 1)	58.76	55.08	48.96	35.36	48.96	56.08	49.64	51.64	57.12	38.04	52.68	47.6
WYE VALLEY NHS TRUST	Rehabilitation at home (pathway 1)	10	15	10	22	13	10	12	15	11	7	9	7
WYE VALLEY NHS TRUST	Reablement in a bedded setting (pathway 2)	7.37	7.37	8.296	8.016	6.514	8.872	6.654	5.938	4.436	7.3	7.23	2.864
WYE VALLEY NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	22.637	18.262	20.444	21.069	23.103	18.368	19.364	21.747	19.565	26.334	30.02	24.724
WYE VALLEY NHS TRUST	Other short term social care (pathway 1 & 2)	0	0	0	0	0	0	0	0	0	0	0	0
WYE VALLEY NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	17.993	15.368	17.26	17.915	18.383	15.76	14.982	17.315	14.999	20.366	23.75	17.412

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)												
Urgent Community Response												
Reablement at home	86	67	76	69	63	78	69	86	82	88	89	79
Rehabilitation at home												
Reablement in a bedded setting												
Rehabilitation in a bedded setting												
Other short-term social care	22	28	29	33	31	30	24	26	38	36	22	38

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	20	20	20											100%	
Reablement at Home	Monthly capacity. Number of new clients.	44.07	41.31	36.72	26.52	36.72	42.06	37.23	38.73	42.84	28.53	39.51	35.7		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	24.69	28.77	22.24	30.84	25.24	24.02	24.41	27.91	25.28	16.51	22.17	18.9		100%	
Reablement in a bedded setting	Monthly capacity. Number of new clients.	34	34	34	34	34	34	34	34	34	34	34	34	35%	65%	
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	22.637	18.262	20.444	21.069	23.103	18.368	19.364	21.747	19.565	26.334	30.02	24.724		100%	
Other short term social care	Monthly capacity. Number of new clients.															
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	17.993	15.368	17.26	17.915	18.383	15.76	14.982	17.315	14.999	20.366	23.75	17.412		100%	

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.															
Urgent Community Response	Monthly capacity. Number of new clients.															
Reablement at Home	Monthly capacity. Number of new clients.	86	67	76	69	63	78	69	86	82	88	89	79		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.															
Other short-term social care	Monthly capacity. Number of new clients.	22	28	29	33	31	30	24	26	38	36	22	38		100%	
Reablement in a bedded setting	Monthly capacity. Number of new clients.															
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.															

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Herefordshire, County of

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Herefordshire, County of	£2,268,653	£2,268,653
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,268,653**	**£2,268,653**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Herefordshire, County of	£950,944	£1,584,907

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Herefordshire and Worcestershire ICB	£1,047,772	£2,221,943
Total ICB Discharge Fund Contribution	£1,047,772	£2,221,943

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Herefordshire, County of	£6,782,841	£6,782,841
Total iBCF Contribution	**£6,782,841**	**£6,782,841**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Herefordshire and Worcestershire ICB	£15,988,427	£16,893,372
Total NHS Minimum Contribution	**£15,988,427**	**£16,893,372**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£15,988,427**	**£16,893,372**	

	2023-24	2024-25
Total BCF Pooled Budget	**£25,039,921**	**£25,944,866**

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Herefordshire, County of

<< Link to summary sheet

	2023-24			2024-25		
Running Balances	Income	Expenditure	Balance	Income	Expenditure	Balance
DFG	£2,268,653	£2,268,653	£0	£2,268,653	£2,268,653	£0
Minimum NHS Contribution	£15,988,427	£15,988,427	£0	£16,893,372	£16,893,372	£0
iBCF	£6,782,841	£6,782,841	£0	£6,782,841	£6,782,841	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£950,944	£950,944	£0	£1,584,907	£1,584,907	£0
ICB Discharge Funding	£1,047,772	£1,047,772		£2,221,943	£2,221,943	£0
Total	**£27,038,637**	**£27,038,637**	**£0**	**£29,751,716**	**£29,751,716**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24			2024-25		
	Minimum Required Spend	Planned Spend	Under Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,543,457	£9,114,213	£0	£4,800,617	£9,630,079	£0
Adult Social Care services spend from the minimum ICB allocations	£6,874,213	£6,874,214	£0	£7,263,293	£7,263,293	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

#NAME?

									Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder				Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£42,883	£45,310	25%
51	Community Resilience & Prevention	Community Commissioning	Prevention / Early Intervention	Other	Commissioning & contracting for community-				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£387,361	£409,286	100%
52	Support for Hospital Discharge	Integrated Discharge Lead	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			NHS Acute Provider	Minimum NHS Contribution	Existing	£46,583	£49,220	50%
52	Support for Hospital Discharge	Integrated Discharge- Home First	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		1322	1550	Packages	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,363,048	£2,496,797	100%
52	Support for Hospital Discharge	Integrated Discharge- Hillside ICC	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users					Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£373,147	£394,264	27%
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	New	£289,870	£306,277	100%
52	Support for Hospital Discharge	Housing Hospital Discharge Team	High Impact Change Model for Managing Transfer of Care	Housing and related services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£86,492	£91,387	100%
52	Support for Hospital Discharge	Brokerage	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£265,991	£281,046	100%
52	Support for Hospital Discharge	Locality Manager- Urgent Care	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£85,847	£90,706	100%
52	Support for Hospital Discharge	ART	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£350,728	£370,579	100%
52	Support for Hospital Discharge	HLT	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£209,481	£221,338	100%
52	Support for Hospital Discharge	Emergency Duty Social Work	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£22,500	£23,774	100%
53	Partnerships & Integration Support	Partnerships & Integration Staffing	Enablers for Integration	Programme management					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£382,893	£404,565	100%

54	Social Care Complex Needs	DoLs / AMHPs	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£981,769	£1,037,337	100%
54	Social Care Complex Needs	Safeguarding	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£267,298	£282,427	100%
54	Social Care Complex Needs	Complex Needs	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£157,121	£166,014	100%
54	Social Care Complex Needs	Transitions	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£267,144	£282,264	100%
54	Social Care Complex Needs	Maximising Independence	Prevention / Early Intervention	Choice Policy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£69,058	£72,967	100%
57	Carers Support	Carers Support Contracts	Care Act Implementation Related Duties	Other	Carer support and advice				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£160,000	£169,056	100%
57	Carers Support	Carers Support Contracts	Care Act Implementation Related Duties	Other	Carer support and advice				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£65,000	£68,679	100%
51	Community Resilience & Prevention	Falls First Response	Prevention / Early Intervention	Other	Falls Prevention & Responder				Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£126,878	£134,059	75%
52	Support for Hospital Discharge	Integrated Discharge- LICU	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,003,305	£1,053,470	76%
52	Support for Hospital Discharge	Integrated Discharge	Residential Placements	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£0	£199,526	5%
57	Carers Support	Acorns Children's Hospice	Carers Services	Respite services		20	21	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£32,733	£33,322	100%
57	Carers Support	St Michael's Hospice Carer's Support	Carers Services	Respite services		288	288	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£266,049	£270,838	13%
60	Community Health Services	General Rehab Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		657	666	Number of beds/Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£5,618,768	£5,804,188	58%
60	Community Health Services	Neighbourhood Teams	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£2,066,480	£2,134,676	28%
33	Disabled Facilities Grant	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		165	165	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£2,268,653	£2,268,653	100%
151	Community Resilience & Prevention	Talk Community Grants	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF	Existing	£133,686	£133,686	100%
151	Community Resilience & Prevention	Talk Community Management	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF	Existing	£232,452	£232,452	100%
151	Community Resilience & Prevention	Talk Community Brokers	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF	Existing	£159,178	£159,178	100%
151	Community Resilience & Prevention	Talk Community Development	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF	Existing	£411,452	£411,452	100%
151	Community Resilience & Prevention	Talk Community Directory	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF	Existing	£109,280	£109,280	100%
151	Community Resilience & Prevention	Talk Community Service Director	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF	Existing	£125,501	£125,501	100%
151	Community Resilience & Prevention	Customer Services	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	iBCF	Existing	£603,781	£603,781	100%
151	Community Resilience & Prevention	Care Navigator Frequent Fallers	Prevention / Early Intervention	Other	Falls Prevention & Responder				Social Care		LA			Local Authority	iBCF	Existing	£44,000	£44,000	100%
151	Community Resilience & Prevention	Advocacy	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	iBCF	Existing	£207,950	£207,950	100%
152	Support for Hospital Discharge	Trusted Assessors	High Impact Change Model for Managing Transfer of Care	Trusted Assessment					Social Care		LA			Local Authority	iBCF	Existing	£79,866	£79,866	100%
152	Support for Hospital Discharge	Additional Costs of D2A beds (Ledbury ICU)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users					Social Care		LA			Local Authority	iBCF	Existing	£252,344	£252,344	34%

152	Support for Hospital Discharge	Integrated Discharge- Hillside ICC	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users					Social Care		LA			Local Authority	iBCF	Existing	£70,289	£70,289	5%
154	Social Care Services	Locality Social Work Teams	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	iBCF	Existing	£3,729,686	£3,729,686	100%
154	Social Care Services	Social Care Business Delivery & Practice Improvements	Enablers for Integration	Workforce development					Social Care		LA			Local Authority	iBCF	Existing	£341,824	£341,824	100%
154	Social Care Services	Shared Lives	Residential Placements	Other	Shared Lives	57	57	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£163,728	£163,728	100%
156	Care Market Development	Care Home Practitioners	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	iBCF	Existing	£92,824	£92,824	100%
156	Care Market Development	Minor Investments Fund	Prevention / Early Intervention	Other	Miscellaneous small grants and payments to aid				Social Care		LA			Local Authority	iBCF	Existing	£15,000	£15,000	100%
156	Care Market Development	Herefordshire Cares Website	Enablers for Integration	Other	Employment Services				Social Care		LA			Local Authority	iBCF	Existing	£10,000	£10,000	100%
401	Support for Hospital Discharge	Integrated Discharge beds @ Hillside Intermediate Care Centre	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users					Social Care		LA			Private Sector	Local Authority Discharge Funding	Existing	£222,364	£375,464	18%
401	Support for Hospital Discharge	Integrated Community Care	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£0	£1,139,594	15%
401	Support for Hospital Discharge	General Rehab Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		19	20	Number of beds/Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£226,596	£234,074	2%
401	Support for Hospital Discharge	Neighbourhood Teams	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£371,442	£383,700	5%
401	Support for Hospital Discharge	Pathway Transition	Community Based Schemes	Other	Hospital Transport for Discharges				Community Health		NHS			Private Sector	ICB Discharge Funding	New	£449,734	£464,575	20%
401	Support for Hospital Discharge	Bridging Service	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		120	120	Packages	Community Health		LA			NHS Community Provider	Local Authority Discharge Funding	New	£217,605	£361,224	100%
401	Support for Hospital Discharge	VSO Discharge Support	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Charity / Voluntary Sector	Local Authority Discharge Funding	New	£46,000	£76,360	100%
401	Support for Hospital Discharge	WVT Integrated Discharge Staffing	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		LA			NHS Community Provider	Local Authority Discharge Funding	New	£248,662	£412,778	100%
401	Support for Hospital Discharge	Medical Cover for D2A Care Home Beds	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Private Sector	Local Authority Discharge Funding	Existing	£48,000	£79,680	100%
401	Support for Hospital Discharge	Social Care Staffing	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Local Authority Discharge Funding	New	£168,313	£279,401	100%

Further guidance for completing Expenditure sheet

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

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. 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. Independent Mental Health Advocacy 2. Safeguarding 3. 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. Carer advice and support related to Care Act duties 3. 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 social 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 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. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. 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. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. 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 (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. 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.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	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.
16	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.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 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	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	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.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of beds/placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Herefordshire, County of

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	155.2	147.8	167.3	121.0	The ambition has been modelled using historic activity.	Key out-of-hospital workstream that incorporates primary and secondary care interface for admission prevention; use of UCR and SDEC. Proactive and effective relationship developed between WMAS and UCR with plans to strengthen relationship between UCR team and Care Homes across Herefordshire (supported by EHCH workstream). Planned health and care approach to improving availability of domiciliary care to help keep people at home where possible.
	Number of Admissions	397	378	428	-		
	Population	193,615	193,615	193,615	193,615		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
(See Guidance)	Indicator value	145	141	154	151		

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,552.4	1,477.0	1,372.0	Heferordshire's ambition is to achieve a 5% reduction in falls year on year.	Falls service in place. Local work to improve falls in care homes and falls prevention, linked to the council's work on Talk community and strength-based approaches.
	Count	785	746	708		
	Population	48,880	50481	51623		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	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 (%)	90.8%	92.0%	90.8%	91.1%	The ambition has been modelled using historic activity.	Continuing to invest in reablement and intermediate care. This includes supporting people to return home, with equipment and timely access to Home First. The use of an extended health based Hospital at Home service will add additional capacity and flexibility whilst the county works together to improve timely access to the domicillary care market.
	Numerator	3,280	3,387	3,378	3,193		
	Denominator	3,612	3,682	3,719	3,504		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	91.8%	91.9%	91.7%	91.4%		
	Numerator	3,650	3,652	3,606	3,422		
	Denominator	3,976	3,974	3,934	3,745		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
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	466.4	493.3	485.3	484.3	* denominator for 22-23 different from council information collected from ONS mid-year estimates. Annual rate against EOY 245 is 501.2 with denominator 48880 (these figures reported)	* Note denominator may be inaccurate. Embarking on an ambitious transformation programme exploring alternative models of care and support including enhancing digital and technology to support more people to remain in their own homes, providing additional extra care housing, enhancing the shared lives model and review the supported living offer.
	Numerator	226	249	245	250		
	Denominator	48,458	50,481	50,481	51,624		

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

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 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 (%)	65.6%	80.0%	70.8%	80.0%	Reablement service was outsourced to Hoople Cares in June 2022. Some reporting issues previously which has now improved. Recording improved from Q2 onwards and the percentage re-abled and still at home after 91 days has averaged around 78%.	Reablement service was outsourced to Hoople Cares in June 2022. Some reporting issues previously which has now improved. Recording improved from Q2 onwards and the percentage re-abled and still at home after 91 days has averaged around 78%.
	Numerator	42	320	155	320		
	Denominator	64	400	219	400		

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

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Herefordshire, County of

	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 all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* 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? *Paragraph 11* 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? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes	Yes - HWBB 26/06/2023 BCF Plan - Page 6 Infographic - One Herefordshire Partnership (1HP)		
	PR2	**A clear narrative for the integration of health, social care and housing**	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 integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • 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 *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* 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. *Paragraph 15*	Narrative plan	Yes			
	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? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • 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? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes			
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	Page 8 Transformation Strategy		

Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes	Page 18 Page 19		
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes			
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**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 to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes			
Agreed expenditure plan for all elements of the BCF	**PR8**	**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? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* 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? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	Carers - page 24-26		
Metrics	**PR9**	**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 based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes			

Additional ICB Discharge Funding 2023-24 and 2024-25: ICB to HWB allocation template

Guidance

Additional Funding for activity to support discharge from hospital has been provided via ICBs and LAs. This funding must be pooled into local Better Care Fund plans and used in line with the conditions set out in the BCF Planning Requirements.

Half of the Discharge funding has been distributed via ICB allocations. The funding must be pooled into HWB level BCF plans. Allocations to HWB (LA) level have not been set centrally and it is for systems to agree how to distribute this funding at HWB level. The distribution to HWB level should be agreed between the ICB and local authorities.

Agreed contributions from the ICB element of the discharge funding should be included in individual BCF Planning Templates. These HWB allocations will need to be agreed in sufficient time for local BCF plans to be finalised and agreed in time for the 28 June deadline. This template is for ICBs to confirm the distribution of ICB allocated funding across all HWBs within their footprint. ICB finance leads are responsible for ensuring that a completed version of this template is returned for each ICB to england.bettercarefundteam@nhs.net (copied to the Better Care Manager) on 28 June, separately from HWB level plans.

You should ensure that the total sum distributed to HWBs for 2023-24 and 2024-25 from your ICB is equal to the total allocation from the ASC DIscharge Fund.

As with all BCF templates, the information from this template will be shared with national partners, including finance colleagues. ICBs may be asked to report further on the use of this funding during the year.

	Yellow sections indicate required input
ICB name	NHS Herefordshire and Worcestershire ICB

	2023-24	2024-25
Total allocation	£3,143,104.80	£6,666,610.18

Name of person completing this form	Jade Brooks

HWB	2023-24 Funding	2024-25 Funding
Herefordshire, County of	£1,047,771.80	£2,221,943.18
Worcestershire	£2,095,333.00	£4,444,667.00
Total (Must equal allocation)	£3,143,104.80	£6,666,610.18

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HM Government

NHS England

Better Care Fund planning requirements 2023-25

4 April 2023, Version 1

Contents

Introduction

Key dates

Optional draft BCF planning submission (including intermediate care and short term care capacity and demand plan)	19 May
BCF planning submission (including intermediate care and short term care capacity and demand plan; and discharge spending plan) from local HWB areas (agreed by ICBs and local government).	28 June

Better Care Fund Vision and Objectives

1. The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations.

2. The vision for the BCF over 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

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

3. This document sets out the requirements for two year plans to enable areas to deliver tangible impacts in line with the vision and objectives set out in the Policy Framework. It is published by NHS England and Government to be actioned jointly by Integrated Care Boards (ICBs) and local councils. These requirements focus the use of BCF funding on the objectives of the fund and improving performance against

the metrics for working age and older adults. Intermediate Care Capacity and Demand plans will continue to be collected as part of BCF plans and should be used to estimate the existing or upcoming capacity deficits and inform the use of BCF pooled funding for delivery of the objectives.

4. BCF planning information in 2023-25 will be collected in a way that provides more data on the activity that BCF will fund, and the contribution of integrated working to improving outcomes for local people. This will include:

    - Expected outputs from scheme types related to discharge, intermediate care unpaid carers and housing.

    - Estimates of BCF spend on different services and activities as a proportion of all health and care spend on these services in the Health and Wellbeing Board (HWB) area. We are collecting this information to help better identify and articulate the contribution of BCF funding to delivering capacity, but, as estimates, these figures will not be subject to assurance.

5. Mental health, learning disability and autism continue to be an integral area of the BCF and should be considered on an equal footing to physical health. The objectives apply to all settings and contexts including preventative support or where a person may be discharged from adult or older adult mental health (including dementia), learning disability and autism inpatient settings as well as acute hospitals. People discharged from mental health, learning disability and autism inpatient services who need to access intermediate care services should be included in BCF intermediate care capacity and demand plans.

Legal framework

6. The Secretary of State for Health and Social Care has published a direction to NHS England under section 223B of the NHS Act 2006 to ringfence £5,059 million to form the NHS contribution to the BCF in 2023-24. This figure includes additional funding for discharge via ICBs (£300m) in 2023-24. The direction sets a requirement for NHS England to consult with The Secretary of State for Health and Social Care before giving any direction to ICBs under section 223GA(1) of the Act about designated amounts to be used for purposes relating to service integration, or before exercising any of its powers under section 223GA(5) of the Act relating to these designated amounts.

7. This document represents NHS England exercising its powers under section 223GA of the 2006 Act. It sets out the detail in relation to the conditions and requirements agreed with the government in relation to the receipt and use of NHS and local government contributions to the BCF, including details of how conditions and requirements will be monitored to ensure they are met. This guidance is also an annex to the NHS operational and contracting guidance for 2023/24. ICBs should ensure that plans for use of the NHS minimum contribution, discharge funding in ICB allocations and assumptions related to capacity and demand for intermediate care align to their wider activity and financial plans.

8. Grants to local government (improved Better Care Fund and Disabled Facilities Grant) will continue to be paid to local government under s31 of the Local Government Act 2003, with a condition that they are pooled into local Better Care Fund plans.

9. There will be an additional £600m in 2023-24, and £1bn in 2024-25 to support discharge from hospital and reduce delays, half of which will be allocated via ICBs in each year. The £300m NHS funding of the additional £600m in 2023-24 is included in the Secretary of State direction outlined in para 6. The other £300 million in 2023-24 will be paid as a grant to local government, under the condition that it is pooled into the Better Care Fund. Specific requirements and conditions in relation to this funding are included in paragraphs 41-51 and will be assured as part of wider BCF assurance.

10. The following minimum funding must be pooled into the BCF in 2023-25.

Source	2022-23 (£m)	2023-24 (£m)	2024-25 (£m)
NHS contribution	4,504	4,759	£5,029
Discharge Funding	500	600	1000
Improved Better Care Fund	2,140	2140	2140
Disabled Facilities Grant	573	573	573

National Conditions

National Condition 1: Plans to be jointly agreed.

11. BCF Plans must be agreed by the ICB(s) (in accordance with ICB governance rules) and the local council chief executive, prior to being signed off by the HWB. Once the plan is agreed and approved, the funding must be placed into one or more pooled funds under section 75 of the NHS Act 2006. Local NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans, including the strategic approach to delivering the objectives of the BCF. Areas can agree to pool additional funds into their BCF plan and associated section 75 agreement(s) where they are assured that voluntary pooling provides value for money. These additional contributions are not subject to the conditions of the BCF but should be recorded in the planning template.

12. The planning template will collect data on use of BCF funding and ambitions for performance on BCF metrics (performance objectives) and activity to achieve these as well as on Intermediate Care plans for capacity and demand (see Appendix 2). All sections of the template must be completed in line with this guidance.

13. Narrative plans will collect the joint approach to delivering the objectives of the fund (see para 2) and should also set out:

    - A brief summary of the strategic approach to integration of health, social care and home adaptations to support further improvement of outcomes for people with care and support needs. As part of this local areas should explain why particular services and schemes have been prioritised and what outcomes they are trying to achieve. This should include a local scheme of governance for plans that demonstrates how the plan has been signed off, and how oversight of ongoing delivery and performance and the section 75 agreement, will be achieved.

    - Areas for development (based on learning from previous years).

    - Actions resulting from Intermediate Care Capacity and Demand plans.

    - Approach to supporting unpaid carers.

- Joint commissioning – how the local council and ICB will work together to further join up commissioning and develop the care market (in support of the local government duty). This should complement planning undertaken as part of the Market Sustainability and Improvement Fund (MSIF).

- How activity in BCF plans will support equality and address health inequalities.

14. Systems should review the assessment of health inequalities and equality for people with protected characteristics under the Equality Act 2020 from their 2022-23 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 (for example those experiencing homelessness) in relation to the metrics of the BCF and how actions in their plan can contribute to reducing these.

15. Areas will also need to consider local government's priorities under the Equality Act and NHS actions in line with Core20PLUS5.

National Condition 2: Enabling people to stay well, safe and independent at home for longer.

16. Areas should agree how the services they commission will support people to remain independent for longer, and where possible support them to remain in their own home. This might include:

- embedding personalised care and delivering asset-based approaches

- implementing joined-up approaches to population health management and proactive care, and how the schemes commissioned through the BCF will support these approaches

- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake where appropriate

- how work to provide additional support to those who need it, such as unpaid carers and people who require adaptations and improvements to their home, will support this objective

17. Whilst there is no specific requirement to fund implementation of the Fuller Stocktake, there are clear overlaps between the delivery of the vision for Primary Care Network (PCN) level multi-disciplinary teams supporting prevention and focussing on people in the Core20PLUS5 population, and the aims of the Better Care Fund. Many areas are already funding neighbourhood teams. When developing BCF plans, areas should consider the extent to which delivery through neighbourhood teams would be beneficial in the context of existing local priorities.

18. The LGA published a high impact change model for reducing preventable admissions to hospital and long-term care in 2021.

19. BCF narrative and expenditure plans for 2023-25 should set out how BCF funding (including any voluntarily pooled funding) supports improvement against this objective. This should include:

    - the approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community, mental health and social care services are being delivered to help people to remain at home.

    - providing details in the BCF planning template of planned spend on prevention-related activity. You should indicate whether schemes contribute wholly or partly to this objective.

    - how joint health and social care activity under this objective will contribute to the ambitions agreed against BCF national metrics, particularly unplanned hospitalisation for chronic ambulatory care sensitive conditions, people over 65 who are admitted to long term residential care and rate of admissions to acute hospital following a fall.

20. Activity to deliver this condition should take account of the capacity and demand plan for intermediate care.

National condition 3: Provide the right care in the right place at the right time

21. Areas should agree how the services they commission will support people to receive the right care in the right place at the right time. 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, in line with the Government's hospital discharge and community support guidance[1].

    - Implement the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

22. This should include details of how additional funding for discharge in 2023-24 will be used in line with the conditions set out in paragraphs 40-50 to improve outcomes for people being discharged and performance against the relevant metrics. Planning for 2024-25 discharge funding is provisional at this point as conditions will be updated according to the evaluation findings of the 2022-23 ASC Discharge Fund.

23. Areas should review the self-assessment of the area's implementation of the High impact change model for managing transfers of care and summarise progress against areas for improvement identified in 2022-23.

24. BCF plans for 2023-25 should set out how BCF funding (including any voluntarily pooled funding) supports improvement against this objective. This should include:

    - a narrative detailing how BCF spending will support the area's approach and details in the BCF planning template of planned spend on discharge -related activity, taking account of the capacity and demand plan for intermediate care

    - how joint health and social care activity will contribute to the improvements agreed against BCF national metrics particularly discharge to usual place of residence and reablement.

[1] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

Funding sources

NHS minimum contribution to the Better Care Fund

25. NHS England has published allocations from the national ringfenced NHS contribution for each ICB and HWB area for 2023-24 and 2024-25 on its website. The allocations are pre-populated in the BCF planning template at HWB level.

26. As with 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 government delivery of reablement (£300 million), carers' breaks (£130 million) and implementation of duties to fund carer support under the Care Act 2014 (£197 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.

27. The way services and local areas work in partnership with, and support, unpaid carers is critical. We know that poorer health and wellbeing outcomes can be associated with caring as the intensity of the caring role increases.

28. The narrative section of BCF plans should include a brief overview of how BCF funding available in their locality is being used to support unpaid carers with reference to funding to support carers' breaks and carer support under the Care Act 2014. Areas will also be asked to improve the clarity and transparency of spend on unpaid carers through our reporting requirements and activity data. Local areas should also highlight good practice examples through their narrative plans to help aid understanding and improvement of unpaid carers services delivered via the BCF. 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.

Grant funding to local government

Improved Better Care Fund (iBCF)

29. The grant determination for the iBCF in 2023-24 was issued on 4th April 2023. 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. The value of the iBCF in 2024-25 is indicative only. Final decisions on the 2024-25 iBCF, (including allocations) will be made, and full details published, as part of the 2024-25 Local Government Finance Settlement. For planning purposes, pending those decisions, areas should plan on the basis that allocations will be consistent with the approach taken in 2023-24.

30. 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.

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

32. The grant conditions for the iBCF also require that the local council 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 4).

Disabled Facilities Grant

33. Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local councils. 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.

34. 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.

35. The funding allocations for DFG will be published soon. Once published, areas should input their figures into the relevant section of the income tab in the BCF Planning Template. Assumptions will be provided for DFG allocations in 2024-25.

36. 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.

37. Where some DFG funding is retained by the upper tier local council, plans should be clear that:

    - the funding is included in one of the pooled funds as part of the BCF
    - the DFG capital funding is used only for the allowed purposes as described in the DLUHC Guidance for Local Authorities.
    - 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.

38. The scope for how DFG funding can be used includes to support any local government 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 to help people live independently. There are numerous case studies of innovative use of DFG funding on the Better Care Exchange[2] and Foundations websites.

39. 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 councils 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.

[2] 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

40. The Government published updated guidance for local councils 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.

Additional Discharge funding

41. In 2023-24, the Government is providing £600 million (£300 million for ICBs, £300 million for local councils) to enable local areas to build additional adult social care (ASC) and community-based reablement capacity to reduce delayed discharges and improve outcomes for patients. As in 2022-23 the ICB will agree with relevant local HWBs how the ICB element of funding will be allocated rather than being set as part of overall BCF allocations, and this should be based on allocations proportionate to local area need.

42. This funding is intended to provide increased investment in social care and community capacity to support discharge and free up beds. Areas can use this funding where appropriate to continue to support investments made in services from the ASC Discharge Funding in 2022-23 but should not use the new discharge funding in 2023-24 to replace existing expenditure on social care and community services.

43. Local areas should use the discharge funding as part of BCF plans, particularly in relation to National Condition 3, and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvements for patients.

44. Local areas should plan how best to deploy this funding over the period April 2023 to March 2024, taking account of the capacity and demand work to identify likely variation in levels of demand over the course of the year, including winter pressures. Local areas should work with local providers to determine how best to build the workforce capacity needed for additional services.

45. Local areas should use the funding in ways that support the principles of 'Discharge to Assess': to enable timely discharge from hospital with appropriate short-term support, where needed, pending assessment of long-term care needs.

46. Local areas should take account of learning from previous discharge funding, including the evaluation of the impact of 2022-23 discharge funding when available.

47. As part of the BCF plan, local areas will be required to set out how they intend to deploy the additional discharge funding, and submit fortnightly reports throughout the year, setting out – among other information – the additional services commissioned with the funding and the numbers of patients receiving short-term support following discharge. Detailed reporting requirements and templates will be published as soon as possible.

48. £1bn has been added to the BCF for 2024-25 to provide ongoing support for discharge. We intend to update the 2024-25 discharge funding conditions according to the evaluation findings of the 2022-23 ASC Discharge Fund. This may impact priority areas for spending and reporting requirements. However, our overarching objective for the funding will remain to reduce delayed discharges. Therefore, areas should provisionally agree plans and include this in the spending template. Final details regarding the 2024-25 additional funding for discharge will be published in due course and plans may need to be amended or updated to reflect any changes to conditions once these are published.

49. ICB allocations for the 2024-25 discharge funding have been allocated solely on a 'fair shares' basis. Final decisions on the 2024-25 local council share of the discharge funding including allocations will be made, and full details published, as part of the 2024-25 Local Government Finance Settlement. For planning purposes, pending those decisions, guidance will be given to what areas should include in the Planning Template for 2024-5 to support planning over the two year period.

50. As set out in the Delivery plan for recovering urgent and emergency care services, DHSC, NHS England, the Department for Levelling Up, Housing and Communities (DLUHC), Local Government Association, and Association of Directors of Adult Social Services, have introduced an integrated approach to performance improvement and support in local systems, bringing together local leaders from across the NHS, local government and the social care sector to target support to the most challenged areas, and to rapidly identify and help spread innovative practice.

51. Information from this integrated approach to performance improvement and support will be made available to those involved in assurance. Systems that have been identified as requiring additional support and performance improvement in relation to discharge performance will be communicated to regional assurance teams and this will be considered in relation to BCF plans and metric ambitions. Additional

conditions relating to performance improvement and support may be included as part of approval of the discharge funding aspects of the BCF plan.

Spending related conditions

National Condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.

52. In each HWB area, the minimum expected expenditure on social care spending and spending on NHS commissioned out of hospital services from the NHS minimum contribution is maintained in line with the percentage uplift in the NHS minimum contribution to the BCF. The NHS minimum contributions for social care and NHS commissioned out of hospital spend for all HWB areas in both 2023-24 and 2024-25 has been uplifted by 5.66%.

53. As in previous years, the minimum expectations in each HWB area will be confirmed in the BCF planning template. ICBs and councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

54. For the purposes of the social care minimum spend - 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.

55. For the purposes of the minimum spend on NHS Commissioned out of hospital services, any schemes where the spend area is allocated to primary, community health, continuing care or social care that is commissioned by ICBs from the NHS minimum contribution will count towards this expectation.

Metrics

56. The 2023-25 BCF Policy Framework sets national metrics (performance objectives) that must be included in BCF plans.

57. The BCF planning process will collect agreed ambitions for 2023-24 only, including supporting rationales, plans for achieving these ambitions and how BCF funded services will support this. From Q3, areas will be required to set ambitions for a new metric that measures timely discharge (see below).

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

59. Ambitions for 2023-24 should be set based on:

- current performance (from locally derived and published data)
- local priorities and anticipated demand and available capacity. Ambitions should reflect demand and capacity planning for intermediate care as well as wider capacity planning as part of the Market Sustainability and Improvement Fund (MSIF) and the UEC capacity plan.
- planned (particularly BCF funded) services and changes to locally delivered services based on performance to date.

New discharge data collection

60. The discharge ready date field in the Commissioning Data Set 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 April 2023. This data will be used as a basis for a metric linked to delayed discharge, contingent on further testing and data quality.

61. As set out in the Delivery plan for recovering urgent and emergency care services, we will work with local systems to develop a new metric that measures the time from the discharge-ready date to the actual date of discharge. We will publish the new data as soon as possible ahead of next winter following trialling and testing with local providers and patient groups, in support of collaborative action across the NHS, local government

and the social care sector to improve discharge planning and capacity planning. Within the development of this metric we will consider how to include the clinically ready for discharge metric for mental health, leaning disability and autism services.

62. We have outlined expected changes to metrics for 2024-25 in the Policy Framework. Ahead of the start of 2024-25, local areas will be asked to review their metric ambitions in relation to BCF plans for 2024-25 in collaboration with health and social care partners. Metrics outlined for 2024-25 are designed to build on wider developments including the new Office for Local Government (OFLOG), client level data developments and the implementation of the new discharge delay metric. Areas will be required to submit metric ambitions for 2024-25 as part of this review. Further detail and the updated requirements and template will be published in early 2024. Monitoring and additional oversight is likely to be in place for areas where data shows that delayed discharges are significantly higher or increasing at a greater rate than the national averages.

63. It is recommended that systems update the Capacity Tracker with bed vacancy data daily, where possible, as this information can be used by local discharge and brokerage teams when planning patient discharges. It also helps ensure that patients are discharged to the right place for their specific care needs.

Process and Timeline

64. Final narrative plans and completed planning templates (including capacity and demand plans), should be submitted by 28 June. Areas are strongly encouraged to submit draft plans (including capacity and demand plans) to BCMs (copied to the BCF team) by 19 May for review and feedback.

Intermediate care capacity and demand planning

65. Capacity and demand planning for intermediate care is an integral part of the BCF this year and should be used to ensure areas are improving their performance against BCF metrics, as well as working towards the objectives of the programme and improving understanding of how funding could be best used locally. Intermediate care capacity and demand plans will need to be submitted as part of BCF plans and will form part of the assurance process. Assurers will review narrative plans and capacity and demand

information, looking at how estimates of capacity and demand have been taken on board and reflected in the wider BCF plans. Please see Appendix 2 for further detail and definitions.

66. The estimates of capacity and demand should be drawn up alongside, and influence, plans for delivering against national conditions 2 and 3, and plans for use of BCF funding. In relation to discharge, capacity and demand for Pathway 3 should also be captured where this is a short term placement prior to assessment for long term care. The template for collecting capacity and demand estimates is included in the main BCF planning template.

67. Areas will need 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 the financial year 2023-24 with a further review ahead of winter. Intermediate care capacity and demand plans for 2024-25 will be drawn up in the final quarter of 2023-24 so as to reflect the most up to date position and build on progress in 2023-24. There is no expectation that the BCF should be used to fund all services within this intermediate care capacity and demand plan.

68. Areas should work closely across all partners to produce the capacity and demand plan for intermediate care, and utilise data submitted by NHS organisations on acute, community and mental health hospital discharge pathway activity – as well as local government service data – as part of operational plans. NHS trusts should be involved in, and contribute to, the development of these plans; and areas should build a shared understanding of the data and evidence. The plans should also complement and build on the capacity and demand sections of UEC recovery plan returns in the NHS planning returns – where these can be mapped to local council area and wider capacity and demand planning initiatives such as those through the Market Sustainability and Improvement Fund (MSIF) where possible. MSIF aims to capture long term social care capacity whereas the BCF intermediate care capacity and demand plans will capture short term capacity across health and social care.

69. Further guidance is set out in Appendix 2, and bespoke support will be available through the BCF external support programme. This support will include specialised support on intermediate care capacity and demand, including working across organisational boundaries and sourcing capacity and demand data across all discharge pathways and sectors.

Narrative planning

70. Narrative plans must be submitted alongside 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.

71. Two or more Health and Wellbeing Board areas can agree and submit a joint narrative plan, where approaches to integration and meeting the requirements of the BCF are aligned. In these cases, a separate planning template will still need to be completed for each HWB.

Expenditure planning

72. 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.

73. The requirement to indicate planned activity and the percentage of planned spend that BCF activity represents are new for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity, but, as estimates, these figures will not be subject to assurance.

74. 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.

BCF Support Programme

75. The Better Care Fund Support Programme will ensure that local areas have the right support available as they work towards the requirements, conditions and metric ambitions set out in delivering their BCF plans. This will include support in relation to

reducing delays in discharge, improving prevention, managing overall system flow and improving integration between health, housing and social care services.

76. The support programme has now been expanded and will be in place for the next two years. A contract is in place with the LGA working with ADASS and Newton to ensure responsive and comprehensive support is available to all systems that need it, as well as supporting the development of national tools and good practice guidance (including in relation to capacity and demand). Regular webinars and events will also be part of the support on offer.

Assurance

77. The regionally led assurance processes will confirm that the content of local areas' plans enable significant progress towards delivering against the BCF objectives and priorities outlined in the BCF policy framework and these Planning Requirements. Spending and reporting requirements relating to the additional discharge funding may be impacted by updates to conditions in 2024-25 (see paragraph 47).

78. As set out in para 50 assurance panels will be provided with information on systems that have been identified as requiring additional support and performance improvement in relation to wider discharge performance in order to take this into account. Assurance of final plans will be led by Better Care Managers (BCMs) for each region 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).

79. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region.

80. 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 subject to ongoing compliance with the conditions. There may be additional approval conditions relating to discharge improvement and support.

Table 1: BCF assurance categories

Category	Description
Approved	• Plan meets all national conditions and planning requirements. Agreed ambitions for BCF metrics are sufficiently stretching • Agreement on use of local government grants (DFG, iBCF and discharge funding) • No or only limited work needed to gather additional information on plan – where there is no impact on national conditions
Not approved	• One or more of the following apply: – plan is not submitted – one or more national conditions or requirements are not met, including in relation to capacity and demand plans and metric ambitions. – no local agreement on use of local government grants (DFG, iBCF and discharge funding).

81. Where plans are not submitted or 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 (see Appendix 1).

Monitoring, reporting and continued compliance

Updating BCF plans in year and in 2024-25

82. 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.

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

84. 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.

85. Areas will be required to submit ambitions for BCF metrics and plans of intermediate care capacity and demand for 2024-25 in the final quarter of the 2023-24 financial year. Any changes to discharge funding requirements, or revisions to allocations for 2024-25 will also need to be included. Further information on these requirements will be published prior to 2024-25. These updates will be reviewed by BCF assurers at regional level.

Reporting

86. 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.

87. Quarterly reporting will recommence from Quarter 2 in 2023-24 and will cover progress in implementing BCF plans, progress against metrics and ongoing compliance with the requirements and conditions of the fund. Timely submission of reports is a requirement for the BCF, including as a condition of the iBCF. These reports need to be 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. Reporting will include confirmation that the section 75 agreement is in place. As set out in para 46 reporting requirements in relation to the additional discharge funding will continue on a fortnightly basis, further details and the templates will be provided as soon as possible.

Monitoring compliance with BCF plans

88. In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

89. Where an area is not compliant with the requirements and conditions of the BCF, or if metric ambitions are not being met, or if the funds are not being spent in accordance with the agreed plan and risk the requirements being unmet, then the BCF team, in consultation with national partners, including NHS England and the LGA, may make a recommendation to initiate an escalation process. Monitoring of the new metric on delayed discharge will be contingent on further testing and data quality. BCF monitoring will be linked to the integrated approach to performance improvement and support in local systems described earlier that brings together leaders from across the NHS, local government and the social care sector to target support to the most challenged areas, particularly in relation to discharge. Any intervention will be proportionate to the risk or issue identified.

90. The intervention and escalation process could lead to NHS England exercising its powers of direction through section 223G/223GA/223GB to ICBs, in consultation with DHSC and DLUHC. Further information on this approach is outlined in Appendix 1.

Timetable

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

BCF planning requirements published	5 April
Optional draft BCF planning submission (including intermediate care capacity and demand plan) submitted to BCM and copied to the BCF team (england.bettercarefundteam@nhs.net)	19 May
BCF planning submission (including intermediate care and short term care capacity and demand plan; and discharge spending plan) 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	28 June
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	28 June – 28 July
Regionally moderated assurance outcomes sent to BCF team	28 July
Cross-regional calibration	3 August
Approval letters issued giving formal permission to spend (NHS minimum)	8 September
All section 75 agreements to be signed and in place	31 October

Appendix 1: Support, escalation and intervention

92. Where plan development is a concern or a plan is not submitted or in-year there are concerns over compliance with the requirements of the BCF or concerns about progress against metrics, the BCF team and BCM will take steps to return the area to compliance or support improvement. In relation to discharge, this process will work with the integrated approach to performance improvement and support outlined earlier to identify if BCF escalation is appropriate.

93. The purpose of escalation in relation to plan approval is to assist areas to reach agreement on a compliant plan and support local areas to use BCF funding in the best possible way locally to enable them deliver against the objectives of the fund. It is not an arbitration or mediation process. This will initially be a regional process, facilitated by the BCF programme and team involving NHS England and local government. 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.

94. 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.

95. Broadly this will involve the following steps:

1. **Trigger:**	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.

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 d. Area is no longer compliant with their approved plan (in year) e. Area is not making progress against metrics	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 or national 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**	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 council.
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.

Appendix 2: Capacity and demand plans

Capacity and Demand Planning

Introduction

100. As in 2022-23, systems are expected to submit capacity and demand plans for intermediate care as part of their 2023-25 BCF plans. Areas are expected to agree estimated demand for intermediate care (rehabilitation and reablement) services, and other short term services lasting up to 6 weeks (including all other short term domiciliary services). This includes patients discharged from mental health, learning disability and autism inpatient services that need to access these services and before a long-term social care or health needs assessment is carried out (if necessary), covering demand for both services to support people to stay at home (including avoiding unnecessary hospital admissions) and hospital discharge pathways 0–3 inclusive, or equivalent. In line with the rest of the BCF planning requirements, references to hospitals include acute, mental health and community hospitals.

101. Intermediate care (rehabilitation and reablement) services are provided to individuals, usually older people, after leaving hospital or when they are at risk of being sent to hospital. Intermediate care helps people to avoid going into hospital or residential care unnecessarily, helps them to be as independent as possible after a stay in hospital, and can be provided in different places (for example community hospital, residential home or in people's own homes). Plans should cover all short term care, which in some cases may be separate to intermediate care.

102. Areas should outline expected capacity and demand for their intermediate care services lasting up to 6 weeks and before a long-term social care needs assessment is carried out (if necessary). Plans should cover demand for both services to support people to stay at home (including avoiding unnecessary hospital admissions) and hospital discharge pathways 0–3 inclusive, or equivalent, on a monthly basis for the whole of 2023-24. These plans should cover both BCF funded activity and non BCF funded activity.

103. Areas are asked to review actual demand and use of services from the previous year, expected changes, and use this to review capacity (including how utilisation of capacity could be improved). As set out earlier, these should initially cover the 12 months from April 2023 to March 2024, with refreshed plans required ahead of winter and before the start of 2024-25.

Aims of capacity and demand planning

104. For the commissioning of intermediate care to work well in an integrated context, there needs to be a joint understanding of the demand for health and social care services and a comprehensive picture of capacity. The aims of capacity and demand planning in the BCF are to:

- Ensure that an integrated approach to capacity and demand planning for intermediate care is happening across health and social care in all systems. This will ensure local areas are commissioning sufficient capacity to maintain individuals' independence, support flow through urgent and emergency care services (including mental health, learning disability and autism services), and improve hospital discharge.

- Continue to improve understanding (locally, regionally and nationally) of the capacity required and potential gaps in systems, with the resulting business intelligence driving commissioning decisions to support and enable long term planning and solutions.
- 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 – with a view to increasing the number of people receiving support in their own home, where appropriate.

- Ensure that areas are able to allocate resources effectively and improve value for money of these services.

105. The capacity and demand plans should also build, as appropriate, on any assumptions made in development of Urgent and Emergency Care Recovery plan capacity and demand plans in the NHS planning round.

Content of plans

106. Capacity and demand planning should include consideration of work to improve commissioning, the plans will need to reflect:

- Reducing over-prescription.
- Addressing duplication in terms of service and referral route.

- Anticipating staffing and resource needs.
- Expected demand and planned capacity for services to help a person remain independent at home.
- Expected demand and planned capacity for services to help a person be discharged from hospital.

107. The demand sections will now include a comparison of the previous year's demand with expected demand for the next year. Information will be gathered via the main BCF planning template.

108. The overall process includes:

- Using BCF narrative plans to review demand for intermediate care from 2022-23, including:
    - referrals in 2022-23, compared to expectations;
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services); and
    - expected increases in demand based on demographics or other factors from 2022-23.
- Considering capacity, including:
    - current commissioned services;
    - use of different pathways against plan and potential gaps (impact of efforts to reduce bedded intermediate care and long term care, where a different service would achieve a better outcome; and
    - areas for additional investment (including use of additional discharge funding) to improve access to intermediate care and outcomes for local people.

109. The capacity and demand template for BCF plans collects information on capacity for the following types of service:

- Short-term domiciliary care to support someone to remain at home following a deterioration, fall, or following a spell in hospital.

- Reablement and rehabilitation provided to people in their own homes either to recover function and avoid admission to hospital/residential care (step-up), or to enable a return to home, following a spell in hospital (step-down).

- Reablement and rehabilitation provided in a bedded setting, either to recover function and avoid admission to hospital/residential care (step-up), or to facilitate an eventual return home following a spell in hospital (step down).

- Urgent Community Response (crisis response) to prevent hospital admissions.

- Low level support provided to a person to help them return home following a stay in hospital, or to help someone stay at home in a crisis. This could include voluntary organisations that provide social and practical support to people or other neighbourhood support that is less intensive than reablement or intermediate care.

110. For discharge, capacity and demand for Pathway 3 should also be captured where this is specifically a short-term placement prior to assessment for long-term care.

Assurance

111. These capacity and demand plans will need to be submitted as part of BCF plans and the assurance process will review whether the plans are robust and ensure that the narrative, spending and metrics elements of the plan have taken on board the findings in the capacity and demand estimates. Assurance will be focused on how the modelling has been taken into account in the main BCF plan rather than the estimates themselves.

Completing the template

112. Some changes have been made to the capacity and demand sheets to reflect learning from 2022-23. The structure of each collection and additional guidance is set out below.

Community demand

113. Systems will need to use this section to estimate demand for each type of intermediate care service from people currently living at home. ‘Home’ should include care homes where this is the usual place of residence.

114. Consider different routes of referral – e.g. 111/999, Single Point of Access (SPA), and self-referral. The table has been updated to collect referrals from different sources. The name of the source is not pre-populated. Referrers should be involved in the process to help understand unmet demand – i.e. where a person has received care from a service, but their needs could have been more appropriately met

elsewhere. In reviewing demand, systems should try to avoid assuming that the actual number of users or capacity of services reflects demand.

115. These considerations could include:

- People who are not offered the support, due to capacity constraints.
- Unplanned admissions for chronic conditions – could some have been prevented?
- People offered long term care or short term care without reablement instead of reablement or rehabilitation (this might be care in their current place of residence or admission to a care home).

116. These factors from 2022-23 will need to be considered when recording expected community demand for 2023-24, as well as any expected changes from the previous year.

117. Demand for low level support should include people whose short term needs could be met by social support from Voluntary sector organisations or similar services (those that fall short of the definition of Urgent Community Response with a two hour response time.)

Community capacity

118. When reviewing the range of commissioned services that support people in crisis, areas should identify services in the LA area that provide intermediate care by service type, and review data on planned capacity, actual referrals and time spent in the service. You should review information from providers, data on the Community Services Dataset (for example on Urgent Community Response) and data submitted on ASC activity to the Short and Long Term Care dataset.

119. These estimates should cover current expected commissioned capacity (not including spot purchasing, although use of spot purchasing in 2022-23 should be reviewed to try and improve capacity assessments going forward).

120. Capacity is measured as the number of new users the service can accept per month. This should be based on the maximum safe capacity at any time, the average length of stay and the number of days in the month – see below.

$$\frac{\text{Number of people the service can support at any given time* x days in the month}}{\text{average length of stay (in days)*}}$$

* +/- 5%

121. Where services accept community and hospital referrals, the capacity available should be adjusted to reflect the estimated proportion of users that are accepted into the service from the community.

Discharge demand

122. The discharge expected demand section should also review activity from the previous year, including:

- Average discharges per month at LA level (SUS).
- Adjustments for population and possibly higher turnover with additional funding.
- The pathways people were discharged into.
- Number/proportion discharged into rehabilitation at home (SALT/Trust data that feeds ASCOF on coverage of reablement).
- Include people waiting for onward referral from community hospital/nursing home for support at home.
- Do not include people moving from a hospital ward to a virtual ward, but do include people coming out of virtual ward into the community.

123. Pathway 0 demand should reflect only those cases where a person may require support from VCS or neighbourhood team for a short period. Do not include simple discharges or where there is no support other than outpatient or GP follow up, or where a person is returning to an existing care home or domiciliary care package with no additional support needs.

Discharge capacity

124. As with last year, areas will need to set out expected intermediate care capacity available for supporting discharge at the HWB level, covering both LA and ICB commissioned activity and taking into account expected demand changes. Areas will need to:

- Set out planned commissioned services for the 12 months – not including spot purchasing but reviewing the use of this in 2022-23.
- Include additional services funded with the additional discharge funding for 23-24.
- The template will collect data from individual services – e.g. a set of intermediate care beds, or a reablement team.

125. Where packages of care are commissioned at ICB level, the capacity should be apportioned to LAs based on locally held data on hospital occupancy and discharges and service provision.

126. Capacity is measured as the number of new users the service can accept per month. This should be based on the maximum safe capacity at any time, the average length of stay and the number of days in the month – see below.

$$\frac{\text{Number of people the service can support at any given time* x days in the month}}{\text{average length of stay (in days)*}}$$

* +/- 5%

127. Where services accept community and hospital referrals the capacity available should be adjusted to reflect the estimated proportion of users that are accepted into the service from hospital.

Low level support for simpler discharges

128. We are collecting information on the number of less complex discharges (classed as Pathway 0 i.e. do not need a full package of reablement or intermediate care) but where support from the VCS or local services is needed to help the person return home. You should estimate number of people that can be supported/facilitated by commissioned VCS capacity and also expected numbers of people that will be supported by community providers and the local council (short of reablement) that can be delivered.

Other sources of guidance

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.
- The NHS England Demand and Capacity Team have resources available to support with capacity and demand planning including models, guidance about fundamentals and principles and other resources here.
- 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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Police and Crime Commissioner
West Mercia

WEST MERCIA POLICE AND CRIME COMMISSIONER
Health & Wellbeing Board (HWB)

Most Appropriate Agency (MAA)

Recommendation

1. Members are invited to note the report.

2. Members are invited to consider implications of the West Mercia Police policy as part of both their own organisations and the wider system.

3. Members are invited to consider potential options relating to joint / co-ordinated governance activity.

Background

4. On the 3rd of April 2023 West Mercia Police introduced a new policy and procedure referred to as 'Most Appropriate Agency' (MAA). This is an operational police force policy. The consent of the PCC is not therefore required to implement it.

5. The policy is based on Humberside Police's Right Care Right Person (RCRP) policy and procedure which has now been rolled out nationally. A precis / summary of the West Mercia Police force policy can be found at Appendix A. This includes the rationale for implementation, principles of the policy, consultation activity undertaken by the force to date and existing force-led governance.

6. This paper provides a summary of activity undertaken by the PCC in response to the force's MAA policy, in respect of oversight, scrutiny and convening powers. This highlights ongoing concerns that are held by the Commissioner as well as potential opportunities to work with partners to ensure the force's policy is effectively implemented, ensuring the best possible outcomes for communities and mitigating the risk of avoidable harm to vulnerable people.

Summary on PCC activity relating to MAA Policy post-implementation.

7. ***PCC John Campion: "I believe strongly that the principle of MAA is the correct one, but its implementation comes with significant risks. Done well, as a whole system, it will undoubtedly enhance the response communities receive to a wide range of incidents and circumstances. Done incorrectly, it has the potential to create wide gaps in service provision and leave vulnerable people exposed to greater risk of harm".***

8. The PCC has regular Assurance and Accountability meetings (A&A) with the Chief Constable. This is a key mechanism through which the PCC fulfils his statutory duty to hold the Chief Constable to account for the performance, effectiveness and efficiency of the force.

9. Given the potential impact of the force's MAA policy on communities and partners, the PCC has ensured that MAA has featured heavily at the A&A meetings this financial year to date. Scrutiny and oversight of MAA has also featured as part of the PCC's adhoc, virtual A&A requests to the Chief Constable. These requests are submitted via email with the Chief Constable providing a written response to the issues raised. This dynamic process has enabled the PCC to escalate any specific concerns in relation to MAA (e.g. specific incidents) outside of a formal meeting setting, ensuring a timelier response.

10. At the A&A meeting on the 29th June 2023, the PCC raised the following concerns around the force's MAA policy to the Acting Chief Constable (A/CC):

11. The PCC raised anecdotal feedback that other forces who were early adopters had taken a more phased approach to implementation, inc. more extensive consultation with partners. The A/CC confirmed that learning from other early adopters was used to inform local implementation and believed that these forces had seen similar issues to those in West Mercia. On reflection, the A/CC would change the approach to the Safeguarding Advice Team, ensuring that all members of the team had significant safeguarding training prior to the policy going live.

12. The PCC raised concerns regarding partnership engagement pre and post-implementation of the policy. As set out in Appendix A, the force's MAA policy was initially introduced to partners through the Vulnerability Partnership Executive Group (VPEG) in August 2022; 8 months before it was implemented. VPEG was not the only mechanism for partnership engagement, with further contact made through letters to strategic leads, a survey of partners and utilisation of the Strategic Crime & Vulnerability Forum. However, the partnership response to the survey was considerably low; limiting the ability for this consultation activity to inform implementation of the force policy and also providing little reassurance to the PCC regarding the preparedness of other partner agencies to actively support the implementation of the policy, and therefore increase the chances of its success.

13. The PCC felt there was potential learning for the force in relation to partner engagement. The A/CC felt initial partnership engagement was sufficient. Going forward, the force will consider how to engage with key partners post-implementation to understand concerns, as well as considering the feedback that has been shared directly with the PCC. The PCC was clear that his consent was not required to implement the force's MAA policy, however greater buy in and cooperation from the PCC could have helped the force, particularly in respect of convening partners. To further support ongoing work with partners, the force has commissioned a partnership review. The review aims to improve understanding of the partnership ecosystem and drive effectiveness.

14. On the 7th July 2023 the Deputy Police & Crime Commissioner on behalf of the PCC sought further reassurance from the Acting Chief Constable (A/CC) via an ad hoc A&A request.

15. Further assurance was sought in relation to specific incidents, mechanisms to review learning from high harm incidents, safeguarding responsibilities, referrals to the Independent Office for Police Conduct (IOPC) and the need to review the impact of the MAA policy to prevent harm as much as possible.

16. A request was also made for a member of the Office of the Police & Crime Commissioner (OPCC) Policy team to observe the force's governance arrangements in respect of MAA via monthly scrutiny panels. The first meeting was attended on 22nd August and attendance will continue in the short-meidum term to ensure appropriate OPCC oversight.

17. It was formally confirmed in response by the CC that a 6-month evaluation of MAA/RCRP is under way and to include an assessment of the model supported with data from April – October 2023. On completion of the evaluation, the Crime and Vulnerability directorate will facilitate consultation with external partners. The PCC has requested to have oversight of this consultation.

18. Outside of the A&A process, the PCC reported on the implementation of MAA at the West Mercia Police and Crime Panel (PCP) meeting on 27 July 2023. This report provided a detailed background on MAA, its implications and concerns surrounding the partnership approach and the potential gaps MAA could highlight in partner service provision.

19. In response to this report from the PCC, the Chairman of the West Mercia Police and Crime Panel subsequently wrote to the leaders of the Member Authorities of the West Mercia Police and Crime Panel (Bromsgrove District Council, Herefordshire Council, Malvern Hills District Council, Redditch Borough Council, Shropshire Council, Telford and Wrekin Council, Worcester City Council, Worcestershire County Council, Wychavon District Council, Wyre Forest District Council).

20. This letter acknowledged the reservations about the MAA Policy, including the speed at which it has been implemented but asked each of the Councils within the West Mercia area to consider making a commitment to engage with and support the MAA policy. The letter also confirmed that the PCC would welcome their engagement and that any information required could be supported by the Office of the Police & Crime Commissioner.

21. In addition to established force governance arrangements set out an Appendix A, the PCC will continue to monitor the implementation of MAA using his statutory A&A framework to hold the Chief Constable to account.

22. The PCC is also exploring opportunities for joint governance / scrutiny activity with partners impacted by the policy. This includes engagement with the IOPC

(national oversight body for complaints and death and serious injury referrals) and partners on local Health & Wellbeing Boards.

What the PCC is seeking from Partners at the Health & Wellbeing Board

23. The PCC welcomes partners engagement in providing feedback on the force's MAA policy as set out at Appendix A, and the concerns set out by the PCC above.

24. In particular, the PCC would invite partners to consider the following areas in respect of MAA:

- Are partners satisfied that they fully understand the implications of the policy for themselves from both a strategic and an operational perspective?
- Do partners understand what Police are doing and do they endorse it?
- Are partners clear on the threshold for police involvement if no crime is committed and there is no threat to safety?
- Are partners aware of the Police's approach to welfare calls?
- Partners assessment/concerns of resource gaps in service provision and how this gap will be filled to ensure the prevention of avoidable harm?
- Appetite for ongoing shared / co-ordinated governance of MAA
- Partner views on raising awareness off MAA/RCRP with the public to increase awareness and help better manage demand and improve outcomes?
- How partners locally may learn from the approach taken in Humberside since May 2020 to inform any dedicated response and community-based mental health services
- Any other concerns/advice we feel we should include?

25. The PCC also wishes to determine if partners would find it beneficial to establish a forum to facilitate partnership governance of the force's MAA policy. This could be a new multi-agency board or utilisation of existing governance boards such as local Health and Wellbeing Boards.

26. The PCC's office has undertaken research on the most effective forum to facilitate partnership governance of police-led MAA policies and has identified that a multi-agency governance structure could be created.

27. Within the Right Care, Right person policy paper published by the Government on the 26th July 2023 it is advised that cross-agency partnerships could be set up in each area in conjunction with the ICBs to implement the RCRP approach for people with mental health needs work together on achieving the following:

28. *"Agreeing a joint multi-agency governance structure for developing, implementing, and monitoring the RCRP approach locally. People with lived experience of the urgent mental health pathway, including those from ethnic minorities, should form*

part of the governance structure and be actively engaged in considering how RCRP is implemented. In addition, from a health system perspective, Integrated Care Boards will play a key role in coordinating the approach to supporting the implementation of RCRP.

29. *Reaching a shared understanding of the aims of implementing RCRP locally and the roles and responsibilities of each agency in responding to people with mental health needs. Given that 'mental health needs' covers people with a broad spectrum of needs, this should include agreeing what is the remit of health services (primary care and secondary mental health services), local authority services (including social care and substance misuse services), and voluntary, community and social enterprise organisations.*

30. *Enabling universal access to 24/7 advice, assessment, and treatment from mental health professionals for the public (via the NHS111 mental health option), as well as access to advice for multi-agency professionals, including the police, which can help to determine the appropriate response for people with mental health needs. Plans should be put in place to communicate the availability of this advice to the public and other organisations/professionals locally, who may otherwise call the police as their first point of contact".*

31. There is no contention with the central premise of Right Care, Right Person / MAA; that people in mental health crisis require an expert healthcare response first and foremost. The PCC remains committed to working with partners to ensure a solid working relationship is in place between the police and health services to reduce inappropriate police involvement in care and support better access to mental health specialists for the public.

Financial Implications

32. None.

Legal Implications

33. See above.

Equality Implications

34. None in relation to this report.

Supporting Information

Appendix A – Summary of West Mercia Police Most Appropriate Agency Policy and Implementation.

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Contact Points

Gareth Boulton, Police and Crime Commissioner Chief Executive

Appendix A: West Mercia Police Most Appropriate Agency (MAA) Policy

Summary of Policy

1. On the 3rd of April 2023 West Mercia Police introduced a new policy and procedure referred to as 'Most Appropriate Agency' (MAA). A precis of the force's policy and relevant background are provided within this briefing. This information has been taken from West Mercia Police briefings and policy documents to best set out the force's rationale and position in respect of MAA.

2. The force's MAA policy is based on Humberside Police's Right Care Right Person (RCRP) policy and procedure.

3. Humberside Police identified that before the introduction of RCRP an average of 1,566 incidents per month were being reported to the police relating to issues such as concerns for welfare, mental health incidents or missing persons.

4. Humberside Police were concerned that by attending these incidents, they were not providing the most suitable intervention to vulnerable members of the public who required specialist support. This was putting both the public and their officers at more risk. It also meant that the public were not receiving the most effective response to incidents from public services.

5. Humberside Police made the conscious decision to refocus on core policing duties, as set out by Sir Robert Peel. These still form the basis of policing in the UK today. The core duties under common law are:
    a. preventing and detecting crime
    b. keeping the King's peace
    c. protecting life and property

6. Following this decision, Humberside Police sought advice to understand where duty of care responsibilities lie and where other agencies would be more appropriate to attend calls for service. This advice was used as a basis to support the development of the RCRP initiative.

7. RCRP is a programme of work that has been carried out over a three-year period involving partners in ambulance, mental health, acute hospitals and social services. The premise of the initiative is that these partnerships ensure RCRP can achieve its aim to provide the best care to the public by ensuring the most appropriate response to calls for service.

8. RCRP and MAA as it has been introduced locally is intended to ensure that everyone, including the most vulnerable within the community, receive the correct service, by the most 'Appropriate Agency' – first time and every time.

9. The policy is underpinned by case law and legislation that specifically defines the parameters of the police role & purpose; and provides the legality, jurisdiction and legitimacy in which the police should be operating.

10. Whilst the policy is underpinned by relevant legal precedent and statutory guidance relating to police powers, discretion will always exist for operational commanders. If, or where, West Mercia Police choose to attend an incident where there is no statutory policing role, consideration would need to be given as to whether some potential actions from attending officers would be within the lawful execution of their duty. It therefore follows that the decision to attend must be clearly recorded, with the rationale and a clear tactical plan as to what is expected of the attending officers. This is a consideration for the Force around implementation of the new policy.

11. Policing powers are not always appropriate to resolve many of the situations that officers are requested to attend by the public. In many cases, a legal precedent has already ruled that the police service is not the most appropriate agency to act.

12. The majority of calls for service that will fall within the new policy are those that relate to “Medical, Health & Social Care”. The police service rarely have the qualifications, training, or experience to respond to these calls as effectively as trained medical professionals, and rarely have the legal basis, jurisdiction or legitimacy to act.

13. The type of calls that this procedure is intended to address generally fall under the following headings.
    a. Medical/Health related calls for service
    b. Safe & Well or Welfare checks
    c. AWOL mental health patients
    d. Patients with full capacity who leave health facilities (A&E, GP etc) unexpectedly
    e. Police support to voluntary mental health cases
    f. Requested use of Police attendance for security at premises occupied by or attended by partner agencies
    g. Requested use of Police for transportation of patients in the care of other agencies
    h. Police use of emergency powers to mitigate incidents being managed by other agencies which have escalated

14. The Force policy sets out that all calls for service will be assessed and only those where there is an identified statutory policing role or where the call handler has confirmed that it is the most appropriate agency, will an incident be created. In all other situations the call will be closed as a contact record.

15. West Mercia Police will continue to utilise the THRIVE assessment model for those calls for service where an incident has been generated; on the basis that

the creation of an incident will denote that a police response has been agreed. The THRIVE assessment tool will allow for the appropriate decision making in relation to the grading and allocation of these calls for service; as below.

T: Threat
What is the overall threat posed by the report, not only to the victim, but to the immediate family, children, community and location?

H: Harm
What is the impact of the threat? Consider not just the victim or witnesses, but also the community impact.

R: Risk
What risks are obvious or yet to be determined?
What resources and specialist assets are needed to safeguard the victim or community?

I: Investigation
What is the legality, necessity, proportionality in relation to the offence being reported?

V: Vulnerability
What are individual or community vulnerabilities?
Identify how police and partners best safeguard against harm.

E: Engagement
What is the safest means of engagement for the victim and what is the most effective means?

16. During the THRIVE assessment, there is an assessment as to whether there is an immediate risk to life or serious harm to an identified person and determine who is the most appropriate agency to mitigate that risk.

17. Even where a response from the most appropriate agency would be delayed, the Force's position is that it is always preferable that a qualified person from the most appropriate statutory agency, in possession of all the relevant facts, should attend to the person in need. The only exception would be that where there is an immediate, unconditional and real threat to life.

18. This procedure allows WMP to be clear on its policing propose and service delivery prior to deploying available resources.

19. The MAA policy seeks to define a consistent relationship between the Force and all other public authorities, statutory partner agencies and those commissioned to provide services on their behalf. Similarly, it seeks to present greater transparency for members of our community who are often confused as to the roles they can expect from health and social care providers and from the police service.

20. The Force is routinely contacted by partner agencies and members of the community to carry out a “welfare check” on a person whom they have concerns for, in the belief that police are the most appropriate agency and are responsible or liable for the welfare of identified individuals deemed to be vulnerable or at risk.

21. Consequently, partner agencies should therefore only have a need to call the Operations and Communications Centre (OCC) where there is an unforeseen, immediate, unconditional, and real threat to life; or where they are reporting an ongoing or imminent breach of the peace; or when reporting that a criminal offence has occurred, and they are requesting us to investigate it.

22. Call handlers at the OCC now recognise that there is no lawful power of entry for police officers in this situation. The provisions contained within Section 17 of the Police and Criminal Evidence Act 1986 (where there are grounds to suspect entry is necessary to save life or limb or prevent serious damage to property) have been significantly restricted and abolished all other general, common law powers to enter premises without a warrant, except the general power to prevent a breach of the peace. Parliament expressly defined and limited police powers of entry into domestic premises without a warrant.

23. By adopting this approach, the Force believes that the most vulnerable members of our community can be assured of a consistent approach and that decisions relating to their care are based on the most up to date facts by qualified and experienced staff and they are attended to by the most appropriate agency.

Implementation of the Policy

24. In June 2022 Chief Officers considered adopting the principles of RCRP (known locally as the MAA) policy. The policy was approved in principle and the Force began working on implementation, to include stakeholder engagement.

25. In August 2022, ACC Rachel Jones outlined the proposed policy to the West Mercia Vulnerability Partnership Executive Group (VPEG). VPEG brings together partners from across West Mercia involved in safeguarding and public protection. Members of VPEG were provided with a presentation outlining the policy and given an opportunity to ask questions. Several partners indicated that they would need to go back and consider the implications of the policy.

26. The Force began to formally consult with partners after the August VPEG meeting. West Mercia Police engaged with over 60 organisations holding a series of workshops and engagement events in addition to inviting stakeholders to take part in a formal consultation exercise.

27. As part of the consultation exercise the Force sought direct feedback from over 60 partners via a survey questionnaire. Executive leads and senior members of organisations were asked to cascade the survey and communication to their workforce. The Force anticipated in the region of 600 responses, (representing approximately 10 responses per agency) but received just 19 (approx. 2% of the

expected returns). Most of the responses received indicated that the change in policy wouldn't have an impact on their organisation / service.

28. On the 9th of November 2022, ACC Jones wrote to members of VPEG thanking members for their contribution and outlining that the Force would be moving towards implementing the policy. In addition, ACC Jones set out how the policy would be monitored, and management information would be brought back to VPEG for review.

29. While West Mercia Police were in the process of implementing MAA, the Home Office, College of Policing (CoP) and the National Police Chief's Council (NPCC) were in the process of reviewing RCRP as a policy to be adopted nationally by all forces.

30. In February 2023 the Home Secretary (HS) wrote to each Police Chief and Police and Crime Commissioner outlining the work carried out by Humberside Police. In the letter the HS outlined how the CoP and the NPCC were developing a toolkit along with a range of products to assist Forces in implementing RCRP.

31. The toolkit was released in July 2023 with the CoP recommending that Forces begin to implement the toolkit and Policy between July and December 2023. Part of the work being carried out by the CoP and NPCC includes a National Partnership Agreement between governing bodies, such as the Department of Health and Social Care, the NHS and Home Office.

32. In addition to the toolkit products being developed a national team funded by the National Police Chiefs' Council (NPCC), will also be available to support forces to implement the toolkit between July and December 2023.

33. West Mercia has adopted the policy before the availability of the national toolkit and associated products. The impact of this and whether it would have presented any further opportunities to aid consultation, development and implementation is unknown.

Oversight and Governance

34. Humberside Police (identified as an early adopter and best practice) is clear that several factors supported the successful implementation of RCRP. These included the following.
    a. Governance structure – the development of tight governance, providing staff with clear guidance regarding parameters, information sharing and briefing expectations with statutory partners. Humberside Police also embedded legal advice in every step of RCRP initiative. This supported buy-in when staff were anxious about not meeting their duty of care.
    b. Senior officer buy-in – having a chief officer lead who believed in RCRP and was prepared to drive it. Chief officer conversations are pivotal for gaining buy-in from other agencies and forming good partner relationships

c. Partnership working – RCRP benefits from close and effective partnerships with other agencies. Well-defined boundaries were created via MOUs, which also ensure all parties are updated about any intelligence that will be useful to them.
d. Systems – Humberside Police and partner agencies already benefit from the use of standardised risk and need rating tools that are now employed alongside RCRP.
e. Staff in police control rooms to identify the right agency to deploy at the outset when responding to 999 calls about individuals experiencing a mental health crisis.

35. Within West Mercia, governance is provided by a monthly scrutiny panel, chaired by the Head of Public Contact, which will report into the monthly Local Policing and Operations Board and Quarterly Performance Review meetings chaired by the ACC for Local Policing and Operations. Quarterly reporting will be provided to relevant partners, allowing insight and joint consideration of any necessary action needed to adjust policy or procedure.

36. In addition to existing governance arrangements, the PCC will monitor the implementation of MAA using his statutory A&A framework to hold the Chief Constable to account. This will be supplemented by the attendance of a PCC representative at the force's monthly MAA Governance scrutiny panels.

37. The PCC is also exploring opportunities for joint governance / scrutiny activity with partners impacted by the policy. This is explored in more depth in the substantive paper.

Herefordshire Council

Update on the work of the Oral Health Improvement Partnership Board

Meeting: Health and Well-being Board

Meeting date: 25th September 2023

Report by: Consultant in Public Health

Classification
This report is open.

Decision type

This is not an executive decision

Wards affected
All

Purpose
This report updates the Health and Well-being Board on the work of the Oral Health Improvement Partnership Board since the last report to Board (September 2022)

It seeks approval of its recommendations which focus on:

- Noting the comprehensive programme of work which is underway to improve oral health in Herefordshire
- Continuing to support a system approach to delivery of the action plan
- Support work to explore fluoridation of the water supply in Herefordshire.

Recommendation(s)
That members of the Health and Well-being Board:

a) **note the progress of the Oral Health Improvement Partnership Board;**

b) **Continue to support and deliver Herefordshire oral health action plan. (Appendix 1)**

c) **Support work to explore fluoridation of the water supply in Herefordshire.**

Further information on the subject of this report is available from
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Alternative options

1. The alternative would be non-delivery of the Oral Health Improvement Plan. This would be detrimental to the health and well-being of local people, whose poor oral health is already identified as a cause of concern. Good oral health is integral to individual health, well-being and quality of life.

2. Non-delivery of the Oral Health Improvement Plan would disproportionally affect those who already experience poorer health outcomes and would therefore widen health inequalities. Populations at greater risk of poor oral health include those people who live in areas of higher social deprivation; have learning disabilities; experience mental health problems; need adult social care; are part of black and minority ethnic groups; and are children looked after.

Key considerations

3. Oral health here is of concern. Directors of Public Health in Herefordshire have drawn attention to this for many years, through their annual reports, and through Joint Strategic Needs Assessments. The Corporate Plan of Herefordshire Council too has identified this as a priority area for action.

4. An Oral Health Needs Assessment was completed by the Public Health Team in 2019, bringing together data on oral health and developing recommendations for change which were drawn into an action plan. This is available at Oral health needs assessment - Understanding Herefordshire This work was halted for two years, due to Covid 19.

5. The Oral Health Improvement Partnership Board was re-started in 2021, and meets quarterly. It is well attended, with a public health consultant in the chair, and membership is drawn from system partners including Healthwatch and NHS England commissioners.

6. The Oral Health Improvement Partnership Board receives an updated action plan at each meeting, taken from the initial needs assessment. Reports from NHSE/ICS commissioners are also presented, as well as from the practitioner providers of training.

7. Attention is drawn below to recent and promising areas of progress, across the life course.

8. At system level, a new dental service has been procured for Hereford City by NHSE/ICS, and premises are currently being explored with a planned mobilisation date of December 2023. A ‘golden hello’ scheme has recruited an additional dentist to the South of the County.

9. The NHSE/ICS have secured funding for a new Oral Health Improvement team and public health staff from Herefordshire have been fully involved in drawing up the service specification for the team. Once recruited, the team will be hosted at the Herefordshire and Worcestershire Health and Care NHS Trust and work priorities for the team will be taken from the local action plans from each County, and drawn up in consultation with the local oral health public health consultant.

10. For children and young people, delivery of a comprehensive ‘Time to Shine’ programme to improve children’s oral health continues successfully as below:

11. Evidence based supervised tooth brushing programmes for young children is in place and has been enthusiastically taken up by early years settings. Funding has been secured for 40 settings and the first 37 of these are now live, with a focus on settings in areas of higher deprivation. This includes special schools who will be starting the programme in September 2023. Engagement sessions with parents take place as part of this programme, which evaluates well.

12. A ‘Brush, Book, Bed’ pack has been made available via libraries and this initiative aims to give every child aged 3 a pack including a toothbrush and book. 3,000 packs have been distributed to date.

13. Free online training for improving the oral health of children has been developed and is available for all to access. So far, this has been completed by over 300 parents and professionals. The training has evaluated well, and a review of impact on behaviour is to be carried out as a follow-up.

14. A 4-6 month oral health check for all babies, focusing on weaning and oral health, has been incorporated into the service specification for the 0-19s public health nursing contract, which is currently being recommissioned. This follows the successful piloting of the check which was introduced in 2021.

15. All primary schools in Herefordshire have received dental pack resources and are using them as teaching aids in delivering good oral health messages to children.

16. Additional funding from the NHS has enabled distribution of oral health resources to those at greatest risk of poor oral health, including via food banks, children’s centres, homeless shelters, and a range of other voluntary and community sector organisations.

17. Following an audit of care homes, a focused staff training package was developed and delivered during 22/23, and oral health champions in care homes were identified. The training package was developed through strong partnership working between public health, Wye Valley Trust, and the Adult Social Care Quality team. The aims of the training are to empower care staff in all care settings to be confident and competent to perform mouth care to a recognised standard, and to be able to recognise and escalate suspected changes in mouth health, so as to improve the oral and overall health and well-being of the residents. The training is followed up by evaluation considering changes in knowledge and practice, and on-the-day evaluation was promising.

18. However, oral health outcomes for children remain disappointing despite our focus on delivering evidence based programmes. The results from the most recent survey of five year olds in Herefordshire shows that the % of children with decay experience has risen from 33.6% in 2012 to 38.7% in 2022, and the average number of teeth affected by decay has risen from 1.1 in 2012 to 1.5 in 2022. .

19. Fluoridation of the water supply is a powerful tool in improving oral health and areas of the country with fluoridation have better outcomes than those without. It is also a powerful tool in reducing inequalities between populations Water fluoridation health monitoring report 2022 (publishing.service.gov.uk) This, the most recent national monitoring report, concludes that: ‘five-year-olds in areas with higher fluoride concentrations were less likely to experience dental caries, and less likely to experience severe dental caries, than in areas with low fluoride concentrations; five-year-olds in areas with a fluoridation scheme in place were less likely to experience dental caries than in areas without a scheme; children and young people in areas with higher fluoride concentrations were less likely to be admitted to hospital to have teeth removed (due to decay) than in areas with low fluoride concentrations; children and young people in areas with a fluoridation scheme in place were less likely to be admitted to hospital to have teeth removed (due to decay) than in areas without a scheme; and these effects were seen at all levels of deprivation, but children and young people in the most deprived areas benefitted the most.’

20. Legislative changes in 2022/23 have moved the statutory powers of local authorities in this context to central government and the processes now required to trigger a feasibility study into fluoridation here are currently being refined nationally. Full public consultation of the local

population is an early requirement of feasibility considerations. Herefordshire has no fluoridation of the water supply and it is clear that addition of fluoride would improve oral health outcomes for our young people.

Community impact

9. Distribution of the resources via libraries enhances their role as trusted sources of health information.

10. The Oral Health Improvement Plan addresses the needs set out in the Oral Health Needs Assessment.

11. The plan makes specific reference to engaging with children who are looked after by the Council.

Environmental Impact

12. This report is considered to have minimal environmental impact.

Equality duty

13. The detail in the Oral Health Improvement plan has due regard to this duty, and a programme of work is planned and underway which seeks to deliver appropriate support for those who share protected characteristics. (Appendix 1)

Resource implications

16. The Oral Health Improvement Plan includes elements of delivery with long-term funding implications. Accepting the recommendations of this report does not in itself have resource implications, but it is understood that full implementation has funding implications which will need to be considered by each organisation. Creative solutions will be needed including the re-prioritisation of existing budgets and applications for additional funding whenever opportunities arise, across the system.

Legal implications

17. This report is for noting the progress of the work of the Oral Health Improvement Partnership Board and supporting the objectives of the Oral Health Improvement Plan as set out in this report. There are no specific legal implications arising out of this report.

Risk management

18. Accepting the recommendations of this paper carries no risk for the constituent organisations of the Health and Well-being Board.

19. However, not endorsing the work of the Oral Health Improvement Board carries performance risk for the Council, which has identified children's oral health improvement as a priority, and reputational risk for the NHS and Council, who have responsibilities for the oral health of the local population.

Consultees

20. The Oral Health Improvement Plan was not subject to consultation. However, views of a recent Healthwatch engagement exercise have been taken into account in updating the Plan. This included an on-line survey of over 600 people and a number of focus groups. Healthwatch remain part of the Partnership Board.

21. Appendices:

    1. Oral Health Improvement action plan

Background papers

None identified.

Herefordshire Oral Health Improvement Action Plan (2023-2026)

Version – Final
Herefordshire Council - Public Health Team

Revised 2/6/23
For discussion Oral Health Improvement Partnership Board June 5th 2023

HEREFORDSHIRE ORAL HEALTH IMPROVEMENT ACTION PLAN (2023-2026)

1) BUILDING HEALTHY PUBLIC POLICY

Key action	Planned activity	By who	Milestone	Progress update
1A. Ensure the OHIP is endorsed by executive committees in Herefordshire Council and Health and Well-being Board partners	Share the plan with partners identified as key stakeholders for achieving the OHIP aim and objectives	HC PHT	Report to Health and Well-being Board Autumn 23.	June 23 Agenda item for Autumn 23 planned.
1B. Ensure oral health is included in the Joint Strategic Needs Assessment (JSNA)	Engage with HC Intelligence Unit, to ensure updated oral health data is included.	HC PHT	On-going	June 23 Last JSNA Dec 2021. Update data from 2022 survey shared.
1C. Advocate for inclusion of oral health promotion within all health and wellbeing policies, strategies and commissioning	In partnership with public health colleagues and wider professionals to identify opportunities for inclusion of oral health across relevant work streams e.g. smoking, substance use and NHS Health Checks	HC PHT	Determined by commissioning cycles.	June 2023 Oral health being worked into new contracts for 0-19s service. NHS health checks contract now under review.
1D. Influence early years and adult social care settings to adopt healthy food and drink policies	Share latest guidance (NICE/OHID) and online resources with early years and adult social care leads and providers to inform policy development and implementation	HC PHT	OHIG to review quarterly	Oral health champions contacts now established, identified through having received training. Schools food initiative with

				Environmental health is now established.
1E. Support the implementation of smoke-free policies across public, private and voluntary/sector organisations	Provide system-leadership and role modelling for smoke-free policies and ensure proactive communication of messaging around smoke-free settings.	All OHIG members	OHIG to review quarterly	June 2023 National Tobacco Control Strategy still expected, although targets have been set CBP-9655.pdf (parliament.uk) with local Strategy to be developed from that. In March 23 Herefordshire stop smoking group was set up and is now operationally focussed group on hospital in-patient work. A workshop to develop a local system plan to be discussed with new cabinet member for health and well-being.
1.F Support fluoridation of water supply in Herefordshire.	Provide leadership for bringing discussion to the Health and Well-being Board. To draw attention to current evidence base and processes (following legislative change) through annual report to HWB Board.	DPH and consultant in PH.	Report to HWB Board Autumn 23. OHIG to review quarterly	June 23 To be actioned with newly elected Cabinet member.

2) CREATING SUPPORTIVE ENVIRONMENTS

Key action	Planned activity	By who	Milestone	Progress update
2A. Increase the provision of healthy food and drink in early years, children's and all settings that the local authority reaches wider public sector settings	Influence key settings to reduce availability of sugar sweetened beverages/snacks in high sugar and increase offer of healthy alternatives (including provision of free plain drinking water) Develop healthy vending guidance for all settings that the local authority reaches Encourage primary and secondary schools to engage with the 'Healthy schools rating scheme' (Department for Education)	HC PHT HC EYT	OHIG to review quarterly	June 2023 Oral health promotion in selected nurseries and primary schools in progress. There will be an opportunity to input to a new leisure services contract.
2B. Introduce targeted supervised tooth brushing (STB) in targeted early years and children's settings	Deliver staff and parent training with follow up evaluation. Ensure materials are distributed to support intervention.	HC PHT	OHIG to review quarterly	June 2023 Oral health promotion in selected nurseries and primary schools in progress.
2C. Introduce targeted provision of toothbrushes and toothpaste (eg through health visitors and food banks)	Use any available funding to draw down additional resource to support. Link with regional networks to ensure learning is shared and full use is made of any supply opportunity.	HC PHT	OHIG to review quarterly	June 2023 Additional funding has now been approved on a one off basis from NHS to extend provision of materials to the harder to reach populations
2D. Support adult care settings to improve the oral health of their clients	Increase the number of settings adopting relevant NICE guidelines and complying with CQC standards for improving oral health in adult care settings Audit care settings annually	HC PHT/ HC QT	OHIG to review quarterly	June 2023 Programme of training sessions now underway and well-received, and

				embedded by ASC quality team.

3) STRENGTHENING COMMUNITY ACTION

Key action	Planned activity	By who	Milestone	Progress update
3A. Engage with individuals/groups to explore oral health needs and barriers and facilitators to good oral health	To coincide with introduction of oral health improvement programmes locally, conduct targeted engagement with the following priority groups (or those who work with or support these groups) – • Looked After Children • Children or adults with a physical or learning disability • Children who are home-schooled • Adults in social care settings	HC PHT HH	OHIG to review quarterly	June 2023 Minimal progress – contacts with groups have now been established, and the offer being shaped. **No significant progress in this quarter. New PH practitioner now in post.**
3B. Explore opportunities to develop oral health champions to promote oral health in key organisations and community settings.	Engage with multi-sector stakeholders* to identify options for developing oral health champions, who will receive training and support to be able to deliver evidence-based oral health messages to individuals, families and communities. Review on line information and ensure that Talk community hubs are fully engage, including call for Oral health champions in hubs.	HC PHT HH	OHIG to review quarterly	June 2023 Care home and early years in progress. **No significant progress in this quarter on rolling out. New PH practitioner now in post.**
3C. Explore the feasibility of a 'Oral Health Community Fund', to support the third sector to improve oral health and reduce oral health inequalities	To coincide with the introduction of oral health improvement programmes, identify opportunities for developing a grant based funding scheme or oral health resource programme for voluntary and community organisations.	HC PHT HH	OHIG to review quarterly	June 2023 Part of a developing discussion on PH prioritisation for 23/4.

4) DEVELOPING PERSONAL SKILLS

Key action	Planned activity	By who	Milestone	Progress update
4A. Increase the oral health literacy of children and adults across Herefordshire	Undertake social marketing campaigns to promote the importance of oral hygiene, access to dental services and applications of fluoride varnish Provide dental practices (both NHS providers and private) with guidance on improving the oral health literacy of patients. Consider CPD for practice staff.	HC PHT and Comms HC PHT NHSE/I LDC	OHIG to review quarterly	June 2023 Social marketing aimed at families continues. **No significant progress in this quarter on CPD. New PH practitioner now in post.**
4B. Increase oral health promotion and signposting to NHS dental services by front line professionals in early years and educational settings	Provide oral health training (according to PHE's 'Delivering better oral health') to wider professionals across early years and schools Share online resources and latest guidance (NICE/OHID) with key multi-agency partners in early years and schools	HC PHT	OHIG to review quarterly	June 2023 Work in progress through EY work. Embedded in new 0-19s contract. Training programme on going and evaluated.
4C. Increase the oral health knowledge and skills of professionals within adult social care settings	• Provide oral health training to (according to PHE's 'Delivering better oral health') professionals working in adult social care settings. • Ensure training is evaluated for increase in knowledge and subsequent change in practice. • Share resources on oral health with those receiving training and with a contact point in each setting	HC PHT	OHIG to review quarterly	June 2023 On-going with Council training team (QA team) delivering.

5) REORIENTING HEALTH SERVICES

Key action	Planned activity	By who?	Milestone	Progress update
5A. Engage with NHS England and NHS Improvement to ensure access to good-quality NHS dental services.	Review quarterly NHS Dental Statistics (obtained from NHS Digital and NHS Business Services Authority), to monitor access levels for children and adults in Herefordshire	HC PHT NHSE/I	OHIG to review quarterly	June 2023 Good engagement with NHSE and LDN. Data being reported at each OHIB meeting although most is 6 monthly update.
	Engage with the Local Dental Network (NHS England and NHS Improvement) to gain insight and understand best practice around improving NHS dental access.			
5B. Engage with NHS England and NHS Improvement to increase the use of fluoride varnish in local NHS dental practices across Herefordshire	Expectation to provide fluoride varnish is reiterated to NHS dentists as a core universal offer and monitoring of its delivery is undertaken at end of year review meetings with providers and contract monitoring visits.	HC PHT NHSE/I LDC HH	OHIG to review quarterly	June 2023 **No significant progress in this quarter.**
	Engage with the Local Dental Network (NHS England and NHS Improvement) to gain insight and understand best practice around increasing use of fluoride in dental practices.			
	Develop proof of concept business case for targeted community based fluoride varnish programme for children and young people at greatest risk of poor health.			
5C. Engage with dentists to increase awareness and support behaviour change related to common risk factors of smoking and substance misuse.	Deliver Making Every Contact Count (MECC) training for dental practices (both NHS providers and private).	HC PHT NHSE LDC	OHIG to review quarterly	June 2023 County smoking cessation pathway now revised. **No significant progress this quarter. New PH**
	Develop stronger referral pathways between dental practices (both NHS providers and private) and public health services in particular stop smoking and substance misuse services.			

				practitioner now in post.

KEY PERFORMANCE INDICATORS

To inform the performance management of the OHIP, as part of quarterly meetings the OHIG will routinely monitor, a range of key performance indicators (see table below). Measurable improvements in each of the key performance indicators listed, is deemed to contribute to the OHIP Objectives and longer term to the overall OHIP Aim.

Key performance indicators	OHIP Objectives	OHIP Aim
Rate (%) of fluoride varnish applications in children (3-16 years)	Increase the access of and exposure to fluoride	Improve oral health and reduce oral health inequalities in Herefordshire, particularly in children, older people in residential care settings and those in high risk groups. **Aim measured by –** • Local results of Public Health England's dental epidemiological programme i.e. % of 5 year olds with decayed, missing or filled teeth
Number of targeted settings providing a supervised tooth brushing programme		
Number (%) of targeted oral health packs distributed		
Number (%) of primary/secondary schools engaged with Healthy schools rating scheme	Improve dietary behaviours and reduce consumption of sugar, alcohol and tobacco	
Number (%) early years settings adopting healthy food/drink policies		
Number settings adopting smoke-free policies		
Number (%) of children (1-18 years) accessing NHS Dental Services	Improve uptake and access to NHS dental care	
Number (%) Looked After Children receiving NHS dental check		
Number (%) of adults accessing NHS Dental Services		
Number of dental practices who have received 'Making Every Contact Count training'		

Number (%) of NHS Dental practices who show an increase in their fluoride varnish rates each quarter	Ensure prevention is at the core of NHS dental services	• Local trends in dental extractions under general anaesthetic (aged up to 18 years)
Number of professionals (across children's and adults services) trained in oral health promotion	Ensure oral health is considered in all relevant settings and policies	
Number (%) residential care settings adopting relevant national guidelines/achieving CQC standards		

Herefordshire Council

Title of report: Launch of Herefordshire's Joint Local Health and Wellbeing Strategy

Meeting: Health and Wellbeing Board

Meeting date: Monday 25 September 2023

Report by: Director of Public Health

Classification
Open

Decision type
This is not an executive decision

Wards affected

(All Wards);

Purpose:

- This report presents a brief review of the launch of the Joint Local Health and Wellbeing Strategy event which took place on 12 July 2023

Recommendation(s)

- The Health and Wellbeing Board is invited to reflect on the conference and any lessons that can be learned to inform future events

Alternative options

- There are no alternative options - it is a function of the Health and Wellbeing Board (HWB) to produce and deliver a Joint Health and Wellbeing Strategy (HWBS) and engage partners and communities.

Key considerations

- Following ratification of the Joint Health and Wellbeing Strategy by the Health and Wellbeing Board on 27 April 2023, a launch event was held on 12 July 2023 to bring partners together to share the new strategy and to begin to identify actions for its delivery.

- The venue for the event was Hereford race course. This was chosen as it had the necessary audio-visual equipment for broadcasting the event, as well as being an accessible venue

- A stalls marketplace included representation from local voluntary and community sector organisations and service providers that offer advice and support to local residents. This included British Legion, Talk Community, Healthwatch, West Mercia Women's Aid, Age UK and Hereford Yoga

- Over 100 delegates attended the event which included representatives from the statutory sector and voluntary and private sector.

- The event was primarily promoted to partners and stakeholders rather than members of the public. There was positive coverage of the event within local media channels

- The event was launched by Councillor Jonathan Lester (Leader of the Council) in the absence of Cllr Carole Gandy with subsequent speakers involving Matt Pearce (Director of Public Health), Jane Ives (Managing Director of Wye Valley Trust and vice chair of the Health and Wellbeing Board) and Christine Price (Chief Officer for Healthwatch). Participants also took part in a creative session reflecting on what health and wellbeing means to them (see appendix 1)

- A video was shared with participants to showcase some of the past achievements in supporting people to be healthy (see appendix 2).

- The latter part of the event involved partners working together to identify key actions and outcomes for the two priority areas of the new strategy e.g. Best Start in Life and Good Mental Wellbeing

- A number of themes were identified from delegates for the best start in life which included a desire to build on existing good practice and build on those services that are delivering outcomes e.g. talk community hubs and children services. There was also commonality amongst participants to prevent and tackle adverse childhood experiences and utilise community development approaches to improve the outcomes in the early years. There was also a desire to provide better support for families with SEND Children,

- A number of themes were also identified from delegates around mental wellbeing including the provision of training, information/self-help, community support and collaboration and partnership working. Preventing suicide was also noted as an important area recognising the impact this had on individuals, families and communities. The importance of focusing on good mental wellbeing and prevention was also highlighted by delegates as something they wanted to do more on.

- Following the event, work is now underway to use the feedback and ideas from participants to inform the development of the delivery plans which will be finalised toward the end of the year.

- An easy read version of the new health and wellbeing strategy has now been completed and has been uploaded to Herefordshire Council's website.

Community Impact

The purpose of the strategy is to help improve the wellbeing of Herefordshire residents and for it to have a real impact on our communities. One of the key principles upon which the strategy has been developed is that of community empowerment, which in practice means that we must continue to involve our communities and partners in any action that is taken, so that the community own it and the impact on that community is maximised.

Environmental Impact

There are no general implications for the environment arising from this report; however the strategy does feature the reduction in our carbon footprint as one of its priorities, therefore further along in the delivery of the strategy it is expected that there could be some environmental impact. There will also be co-benefits to the environment through ambitions to reduce levels of obesity, eat more healthily and increase levels of physical activity through active travel.

Equality duty

- 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) Facilitate good relations between persons who share a relevant protected characteristic and persons who do not share it.

- 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 principles of equality and the reversal of health inequalities are key strands of the strategy
- To be effective in delivering good population outcomes and helping those most in need, the strategy calls for intervention by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale.

Resource implications

- There are no resource implications associated with this report. However, the resource implications of any recommendations made by the HWB will need to be considered by the responsible party in response to those recommendations or subsequent decisions

Legal implications

- 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.
- 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.
- The functions of the Health and Wellbeing Board are set out in paragraph 3.5.24 of the constitution.
- The production of a Joint Local Health and Wellbeing strategy is a statutory requirement and therefore its endorsement and support is required.

Risk management

- There are no risk implications identified emerging from the recommendations in this report

Consultees

Matt Pearce (Director of Public Health), Mary Knower (Public Health Programme Manager)

Appendices

Appendix 1 – Montage of participants creations on what good health and wellbeing means to them

Appendix 2 – Link to video celebrating past achievements

Herefordshire Council

Appendix 1- Montage of participant's creations on what good health and wellbeing means to them

#HealthyHerefordshire

The Launch of Herefordshire's Joint Health and Wellbeing Strategy

Hereford Racecourse, 12th July 2023

Further information on the subject of this report is available from
Matt Pearce email: Matthew.Pearce@herefordshire.gov.uk

Health and Wellbeing Board Forward Plan 2023/24

AGENDA ITEM	REPORT FROM	FREQUENCY	PURPOSE	ACTIONS
12 December 2022 – Public Board				
Joint Strategic Needs Annual Update	Charlotte Worthy	Ad-hoc	Information	
Mental Health and Suicide Update	Darryl Freeman/Matt Pearce	Ad-hoc	Information	
Joint Health and Wellbeing Strategy Update	ICS	Ad-hoc	Information	
Winter Plan/BCF	Ewen Archibald	Ad-hoc	Information	
Health Inequalities Plan	Frances Howie/Alan Dawson	Ad-hoc	Information	
Integrated Care Strategy Update	David Mehaffey	Ad-hoc	Information	
11 January 2023 - Private Development Session				
Herefordshire Health and wellbeing strategy	Lucky Beckett/Matt Pearce	Ad-hoc	Information	
Adult Safeguarding Thematic Review	Ivan Powell/Anne Bonney	Ad-hoc	Information	
Project Brave	Ewen Archibald/Lucy Beckett	Ad-hoc	Information	
13 March 2023- Public Board				
Joint Health and Wellbeing Strategy (Draft)	Matt Pearce	Ad-hoc	Decision	
Health Inequalties Plan	Alan Dawson	Ad-hoc	Decision	
Health Protection Assurance Group	Rob Davies	Ad-hoc	Information	
Adult Safeguarding Thematic Review / Project Brave	Ivan Powell	Ad-hoc	Information	
Child Death Overview Annual Report	Elizabeth Altay	Ad-hoc	Information	
Community Paradigm	Amy Pitt	Ad-hoc	Information	
27 April 2023 – Public Board				
DPH Annual Report	Matt Pearce	Annually	Information	
Joint Health and Wellbeing Strategy (Sign-off)	Matt Pearce	Ad-hoc	Decision	
Sexual Violence Strategy	Frances Howie	Ad-hoc	Decision	
Integrated Care Strategy update	David Mehaffey	Ad-hoc	Information	
14 June 2023 - Private Development Session				
Joint Forward Plan discussion	David Mehaffey/Alison Roberts	Ad-hoc	Information	
26 June 2023 – Public Board				
Children's Services Improvement Plan	Darryl Freeman	Ad-hoc	Information	
One Herefordshire Partnership Update	Chair of One Herefordshire Partnership	Annually	Information	
Better Care Fund End of Year 2022/23 report	Marie Gallagher	Annually	Information	

Joint Local Health and Wellbeing Strategy Update	Matt Pearce	Ad-hoc	Information	
July 12th 2023 – HWB Strategy Launch Event				
15 August 2023 - Private Development Session				
25 September 2023 - Public Board				
Better Care Fund Plan 2023-25	Marie Gallagher	Ad-hoc	Decision	
'Most Appropriate Agency'	West Mercia Police	Ad-hoc	Information	
Oral Health Update	Harpal Aujla (formerly Frances Howie)	Ad-hoc	Information	
Update on Joint Local Health and Wellbeing Strategy Event	Matt Pearce	Ad-hoc	Information	
November 2023 - Private Development Session TBC				
4 December 2023 – Public Board				
Health and Wellbeing Board Delivery Plans	Matt Pearce	Quarterly	Information	
Joint Strategic Needs Assessment	Public Health	Ad-hoc	Decision	
Mental Health Strategy/Mental Health Collaborative	ICS	Annually	Information	
Community Safety Partnership Update	Adrian Turton	Ad-hoc	Information	
Domestic Abuse Strategy 2021-24	Kayte Thompson-Dixon	Ad-hoc	Decision	
Community Paradigm	Hilary Hall/Christine Price	Ad-hoc	Information	
11 March 2024 – Public Board				
10 June 2024 – Public Board				
16 September 2024 – Public Board				
9 December 2024 – Public Board				