Herefordshire Council

Cover

Health and Wellbeing Board(s)

Herefordshire

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

Ongoing 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 including; Wye Valley NHS Trust (WVT) Integrated Discharge Team, WVT Integrated Care Division, Herefordshire and Worcestershire Health and Care Trust, Primary Care Networks, Herefordshire Healthwatch, voluntary and community organisations along with Herefordshire council stakeholders. 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 developing the Integrated Care System in Herefordshire and Worcestershire, and through sharing of data and wider documentation.

Executive Summary

This should include:

- *Priorities for 2021-22*
- *Key changes since previous BCF plan*

The BCF guidance 2021-22 sets out national conditions, which are the key requirements for the better care fund plan 2021-22.

a. a jointly agreed plan between local health and social care commissioners, signed off by the HWB
b. NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
c. invest in NHS-commissioned out-of-hospital services
d. a plan for improving outcomes for people being discharged from hospital

The BCF also has key national metrics for 2021-22.

Avoidable admissions to hospital	Unplanned admissions for chronic ambulatory care sensitive conditions
Admissions to residential and care homes	Annual rate of older people whose long term support needs are best met by admission to residential and nursing care homes
Effectiveness of reablement	People over 65 still at home 91 days after discharge from hospital with reablement
Length of stay	Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days or more
Discharge destination	Improving the proportion of people discharged home using data on discharge to their usual place of residence

The proposed targets and ambitions against these metrics include;

Admission avoidance

The BCF plan includes a new investment of £500k in admission avoidance as well as continuing and increasing investment in community strengthening and resilience via Talk Community. Achieving improvements in this metric in this financial year will be difficult as new upstream interventions take time to have an impact and up to now the Herefordshire BCF has been focussed much more on hospital discharge.

The ambition for reducing the percentage of hospital inpatients with a long length of stay is based on improving performance with a target of 11.1% by quarter 4 for 14 days and 5.7% for 21 days or more; current performance is 11.7% and 6.3% respectively.

The ambition for improving the percentage of people who return to their normal place of residence on discharge from acute hospital is set at 92.4%. Current performance is 91.5% with the ambition to capture data more effectively and understanding the relationship with D2A. The integrated discharge teams and strength-based assessments will continue to assist improvement.

We feel we can achieve moderate improvements in performance for length of stay and discharge destination. More significant improvements will be challenging for 2021/22 given that less than five months of the financial year remain and significant winter and COVID-19 pressures are being experienced throughout the system. Hospital Discharge funding for COVID-19 and Discharge to Assess continues to be of huge benefit; Herefordshire health and social care partners are planning for continuation of discharge to assess services funded through BCF, but this will require diversion of resources from other parts of the plan.

For long-term support needs of older people (age 65 or over), the ambition is to increase capacity in the Home First and Hospital at Home teams, leading to an increase in reablement and reducing permanent admissions to residential care homes. Maintaining the reduced levels of placements seen in 2020/21 will be difficult because COVID-19 depressed demand for care home placements considerably, but the Herefordshire health and social care plan remains focussed on citizens living well at home.

Associated with these developments, the reablement metric of increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, will be achieved by increasing capacity in the teams. This will enable delivery of the 80% target. The investment in Talk Community projects will contribute to this target by strengthening and supporting community resilience.

Recruitment and retention of health and social care workers, and the sustainability of home care and care home providers are major challenges across the country and in Herefordshire they are exacerbated by rurality and by a small working age population. The challenges will be increased by social care reforms and the uncertainty about future funding for social care.

Key to the successful delivery of the plan is to continue developing services that work in a more integrated way; redesigning services around the needs of individuals in a locality / place presents the best opportunity to improve health and well-being and reduce health inequalities. The system aim is to provide sufficient support in the community to enable people to remain independent in their own homes for longer, thereby reducing, hospital admissions and support discharges.

The priorities for 2021-22 are:

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

In addition to the main BCF resources and plans, the Improved Better Care Fund (IBCF) allocation for Herefordshire adult social care in 2021-22 includes funding to be spent on the following:

a) meeting adult social care needs;
b) reducing pressures on the NHS including seasonal winter pressures;
c) supporting more people to be discharged from hospital when they are ready; and
d) ensuring that the social care provider market is supported

Partners have agreed to the following principles in relation to the allocation of the iBCF and are continuing to work together to implement robust spending plans:

a) to support market development and sustainability for social care providers in Herefordshire;
b) to support short term health initiatives that demonstrate future benefit to residents, and across the health and social care system;

BCF funding is used for key core social care and NHS community services - operational social work, brokerage, integrated discharge, community health and care services, DoLS, short-term and long-term placements in home care and care homes, and discharge to assess; it is central to the delivery of health and social care in the community. It is acknowledged that in due course, the legislative changes which will introduce Liberty Protection Safeguards (LPS) to replace DoLS, will require a review of the cost profile of those operational services.

Herefordshire is investing in a number of services to help 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.

Talk Community has emerged as one of the council's primary approaches to demand management and admission prevention.

Talk Community is bringing Herefordshire together to encourage residents, businesses, community leaders and our Council to play their part in making Herefordshire a better place to live and work. The aims of Talk Community are:

- Delivering the right support, in the right place at the right time
- Developing partnerships that inspire and impact through collaboration
- Coordinated community based support that:
    - Promotes and facilitates independence and wellbeing inevitable for all across all ages
    - Puts wellbeing, social value & strengths bases approaches in all practice, policy & decision making
    - Ensures that prevention & early intervention are prioritised by connecting people into communities
    - Applies a whole population approach that targets & reduces health & social inequalities
    - Help to bridge the gaps in health & wellbeing; care & quality; funding & finance
    - Robustly connects formal services & community support
    - Helps to improve the environment for the residents of Herefordshire

The Herefordshire system has put itself in a strong position to realign resources at a local level. This transformation began with the development of the Adults and Wellbeing Blueprint, which was adopted in 2015 and since has been developed into an agreed system integration blueprint which is now being updated to reflect the maturing of the integration relationship through the One Herefordshire Partnership. It has a focus on integrated care and support as the guiding approach to prevention and to supporting vulnerable people and continues to be integral. It places the individual at the centre and focuses on early intervention and upstream prevention to keep people as well as possible, remaining safely in their own homes as long as possible, and supporting people with eligible needs to be as independent as possible. This has evolved through comprehensive application of strengths based approaches in social work and wider practice, the continuing development of system wide relationships, and the implementation of Talk Community which is supported by all partners in the system as being core to our approach to community resilience.

Key changes since the previous BCF Plan

The main changes to the previous plan include funding for admission prevention (up to £500k) and for equipment loans. A number of services and schemes have also been consolidated under Talk Community. Overall, the BCF plan remains focussed on supporting hospital discharge but it is evolving to bring in more activities to prevent admissions to hospital and to long-term care placements.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

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

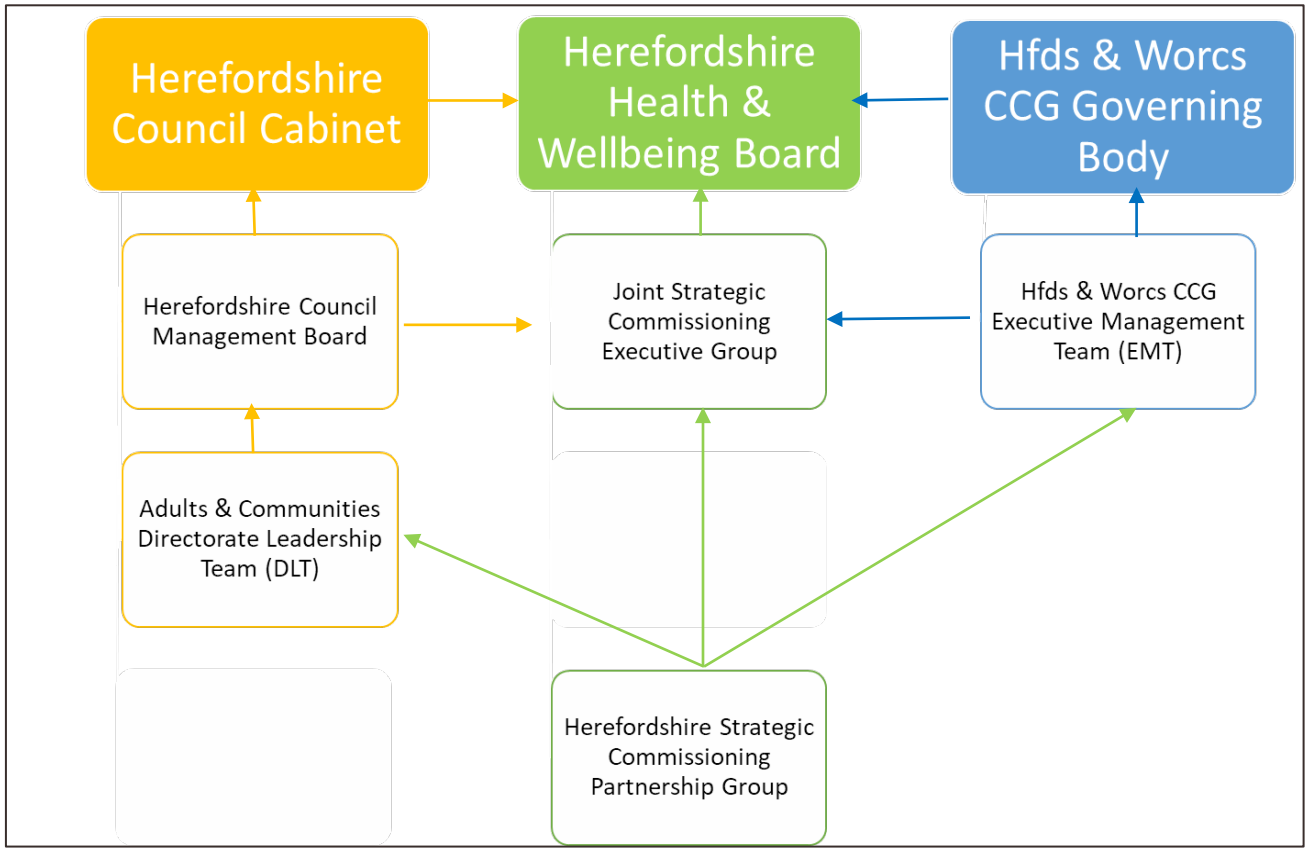
Oversight and responsibility for the BCF is embedded within the Senior Leadership Teams of both Adults and Communities within the council and the Herefordshire and Worcestershire Clinical Commissioning Group. In each organisation, this is led by chief officers and their senior leadership teams, who are 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 "County Plan"

The senior leaders of the two organisations have formed the Joint Strategic Commissioning Executive Group (JSCEG) which meets on a monthly basis to review progress on delivery and to agree next steps. This group links into the One Herefordshire Partnership to ensure that we continue to build an ambitious approach to integration as our system develops. JSCEG provides quarterly reports to the H&WB Board.

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

The governance arrangements will continue to be reviewed as the Integrated Care System and the role of "Place" develops.

Herefordshire Joint Commissioning Governance Structure:



Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- *Joint priorities for 2021-22*
- *Approaches to joint/collaborative commissioning*
- *Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.*

How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

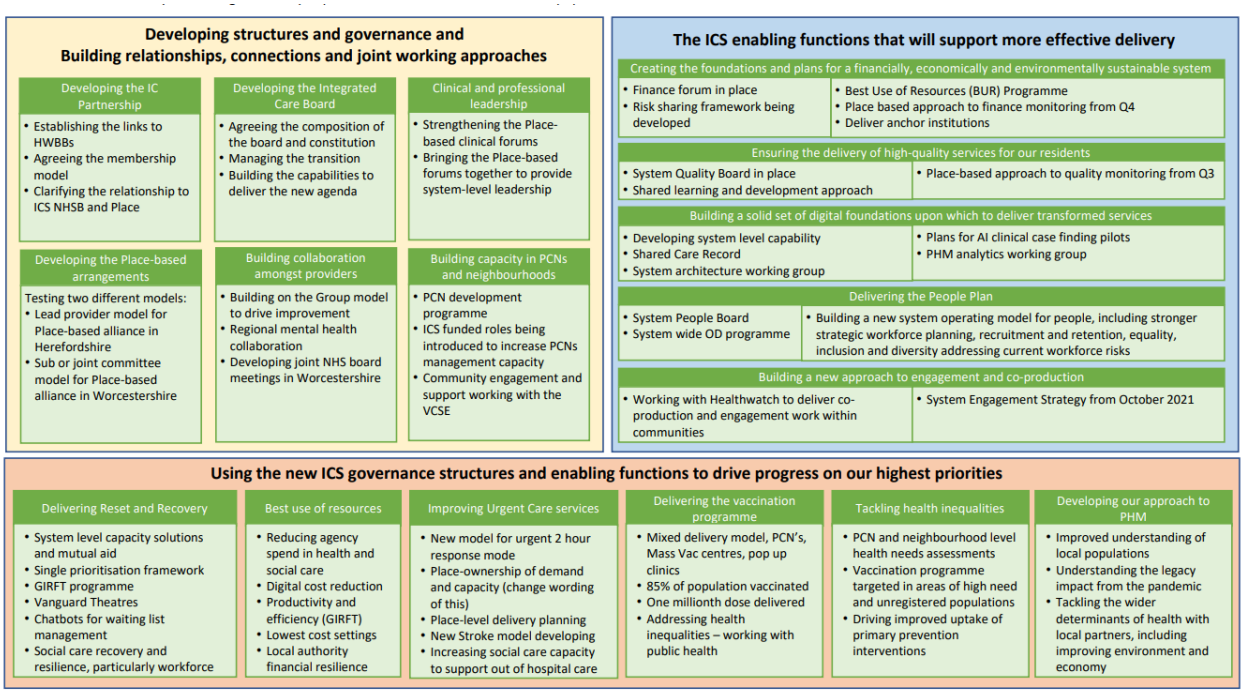
The integrated care system (ICS)

The Herefordshire and Worcestershire system has built a strong record of delivery and improvement over the last three years. The system has stable leadership across our two places and our primary care networks, with excellent support from our local authority and voluntary sector partners. Continuity of staff and an increasing number of joint posts contribute to a mature relationship between health and social care partners, including primary care and the voluntary sector. Organisations in Herefordshire have formed into the One Herefordshire Partnership and commissioning and operational changes and strategy are discussed at regular meeting of the One Herefordshire Partnership Board. For operational health and social care Herefordshire is divided into four localities co-terminus with four primary care

networks and the fifth locality made up of two primary care networks. Community social work teams are organised to mirror the locality structure.

Integration has enabled the delivery of a successful COVID vaccination programme, which has proactively targeted reducing health inequalities by working with patient representatives, communities, PCNs, local authorities and NHS providers to increase uptake. By working collectively, it has been possible to develop mutual aid and secure Vanguard Theatres in both counties, which support a Reset and Recovery Programme. With a commitment to improve clinical productivity through implementing 'Getting it right first time' and deliver an ambitious Best Use of Resources programme.

The plan on a page shows a summary of the development plan. The top left section describes the key six strategic development initiatives that will shape the overall operating model for the ICS going forward. The top right describes the enabling functions that are required to support delivery of this operating model and the bottom section is the way in which this new way of working will be used to deliver improved services and outcomes for the local population.



Joint priorities for 2021-22 include:

- Discharge facilitation;
- Recovering from COVID; and
- Admission avoidance and prevention.

Response to the coronavirus pandemic has seen greater integration of discharge, intermediate care and reablement services. While reforms to NHS structures bed-in and reforms to social care take shape, Herefordshire continues to integrate services at an operational level. Service developments are discussed by all partners at the One Herefordshire Partnership Board before any changes are made. New integrated developments include redesigning and recommissioning falls prevention services, developing a business case for investment in technology enabled living and developing discharge to assess services into a recurrently-funded and financially sustainable model.

One Herefordshire partnership identified '**Falls'** as a key priority area in 2020/21. The partnership recognised the importance of ensuring that organisation's across the health and social care sector in

Herefordshire work together to provide a single and effective system wide Falls Prevention Approach, to keep residents safe and well and maintain their independence and to reduce the pressures on the county's health systems.

The Falls Responder Service continues to work well, with community teams referring to therapy where appropriate.

Joint options are currently being scoped for a joined up falls service delivery model. Services continue to be delivered, and extra elements are added via Talk Community, including; a toolkit being made available to anyone at risk or prone to falls or anyone who comes into contact with vulnerable adults who are at risk of or prone to falling. The falls prevention toolkit is available on the Talk Community website; a free booklet is also available.

The **Community Interface Team** (CIT) (WVT) is a new umbrella term for five responding assets that have integrated to provide a unified response in line with newly mandated two-hour crisis response targets.

The five responding assets of the CIT are:

- Hospital at Home Therapy – (Wye Valley NHS Trust) Established Admission Avoidance and early support discharge service. Joint/interdisciplinary working with nurses, support workers and therapists is commonplace for patients requiring both routine monitoring and 2-hour response interventions.
- Hospital at Home Nursing - (Wye Valley NHS Trust)
- Home First - (Local Authority service) provides 'reablement' social care and therapy support at home.
- Virtual GP (vGP) - (Taurus Healthcare)
- Community Advanced Clinical Practitioners (ACPs) - (Wye Valley NHS Trust)

In addition, all components of the CIT work closely with District Nurses, aiming to integrate working whenever possible for those patients shared across both caseloads. Duplicate visits will be minimised by effective communication and information sharing.

Planned funding is directed towards the implementation of **Care Act** related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF; these include

1) Independent Mental Health Advocacy; DoLs/AMHPs – professional staff for liberty protection and mental health assessments and advocacy for users of social care.
2) Carers advice, respite and support

The **Care Home Clinical Practitioners** are working within the Integrated Care Division, Wye Valley Trust (WVT) and in close partnership with Herefordshire Council (HC) Quality Assurance Division.

The team has been working to identify individual provider needs to inform day to day activity; enhance individual care through collaborative working using evidence based education as a resource to broaden knowledge and skills to ensure the successful delivery of clinical support and advice to Residential and Nursing Homes across Herefordshire.

Visits and support calls are based around consolidating knowledge, embedding practice and learning around Infection Prevention and Control (IPC), PPE, Hand Hygiene, Brass Bands England (BBE) and social distancing guidelines.

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

- Recognising the Deteriorating Patient
- Respiratory Support
- Slips, Trips and Falls
- Continence
- Tissue Viability

Integrated Care Home Support and Development

Throughout 2020/21 the Integrated Care Home Support and Development Programme consisted of 2 key workstreams – the Herefordshire Care Home Tactical Plan and the Directed Enhanced Service (DES) and the Enhanced Health in Care Homes specification.

The purpose of this delivery plan is to enable partners to continue to work collaboratively to support and further develop the care home market throughout Herefordshire and to bring the previous 2 workstreams together into a single plan. The plan will be in place from April 2021 to March 2023 with an annual review.

Health and social care partners are committed to working together to provide an integrated approach to supporting the care home market throughout Herefordshire to:

- provide demand management through strength based approach and developing models and services that will support the principle that “home and family can be best”;
- create a versatile, cost effective and sustainable market at a Primary Care Network (PCN) level;
- increase and improve services that support complex and challenging behaviours such as autism or dementia;
- enhance support for those who fund their own care;
- work across health services, children and young people and adult services to integrate our commissioning and market management approach where appropriate;
- invest in early help prevention and community services;
- improve and embed mental health and wellbeing in all services design;
- support and develop the health, family support and social care workforce;
- embed technology where it delivers benefits across pathways and services; and
- promote an inclusive customer focus to ensure fair access to services.

To support these intentions, the delivery plan focuses upon 5 key work stream areas:

1. Outbreak Prevention
2. Workforce
3. Market Management
4. Health and wellbeing
5. Technology and digitalisation

Integrated Community Equipment

Herefordshire Council and NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG) have statutory requirement duties under various legislation to provide community equipment for people with an assessed eligible social or health care need. The Integrated Community Equipment Service is central to the delivery of the prevention and wellbeing priorities of the council and its partners with changing demand in social and health care, this service continues to evolve to meet the demands of stakeholders.

The service continues to see an increase in both client numbers and overall equipment spend compared to monthly averages in 2020/21. The increase evidences the ongoing focus to provide equipment to enable people to remain in their own homes, to reduce the need for the interventions of domiciliary care, care home placements and avoidable hospital admissions, whilst facilitating hospital discharge.

An element of the **IBCF Minor Investments** fund has been utilised to redesign the Herefordshire Care Heroes website to 'Herefordshire Cares'. This has been undertaken through a new approach co-produced with the local care market. The new marketing campaign will be delivered to promote the local (Herefordshire) care market and job opportunities, through a new look website and social media engagement strategy. The new approach will improve local recruitment and entrants to the local care sector. The new approach aims to engage 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.

A **Postural Support** training pilot, which follows the Later Life model, 1-hour sessions over 24 weeks' is currently in place. The agreement is for the delivery of 12 courses across the county, with a review upon completion. Referrals are currently via the WVT falls service, but discussions have taken place at PCN level and further referrals with also be taken via this route.

A Management of Deterioration Pilot in Supported Living Settings East – Pilot site NHSE/ADASS

Herefordshire is part of a regional pilot programme that will provide an evidence base to support national planning for a wider strategy for the improvement of care and outcomes for people with learning disabilities who reside in supported living environments.

The Learning from Lives and Deaths of People with a Learning Disability and/or Autism (LeDeR) programme and reports, have highlighted significant difference in life expectancy between people with learning disabilities and the general population. There is evidence that health deterioration is not always detected promptly and that people with learning disabilities die prematurely from conditions that could have been prevented or treated.

The programme is facilitated by the East and West Midlands Academic Health Science Network (AHSN) and the Association of Directors of Adult Social Services (ADASS) and funded by NHS England/Improvement (NHSE/I), the pilot's key partners are the Local Authority and Health in Nottinghamshire and Lincolnshire for the East Midlands and Walsall and Hereford in the West Midlands.

The **Tackling Health Inequalities Board** (Herefordshire and Worcestershire) continues to work collaboratively with the draft LeDeR Strategy submitted to NHS England and completion and publication of LeDeR annual report for 2020/21.

LeDeR reviews - Reviewers have been trained and 93% of reviews undertaken within a 6-month timeframe. The 3-year NHS plan improvement target of 100% for Learning Disability Mortality Reviews to be completed within a 6 month timeframe.

Health Actions Plans - All GP practices within the county ensure that all people with learning disabilities are invited to attend an annual health check to an agreed standard. The current performance is 85%. The NHS plan has extended this now to include people with autism, which will increase the population by 10%.

Developing Services for Autistic people Group (Herefordshire and Worcester)

To enable access to mainstream healthcare, we are working collaboratively with CCG to establish up to 15 (one per PCN) clinic space which is low stimulus and sensory integrated, with accompanying

guidance for practices to ensure the whole experience is reasonably adapted to meet sensory needs. The CCG will part-fund adaptations and equipment.

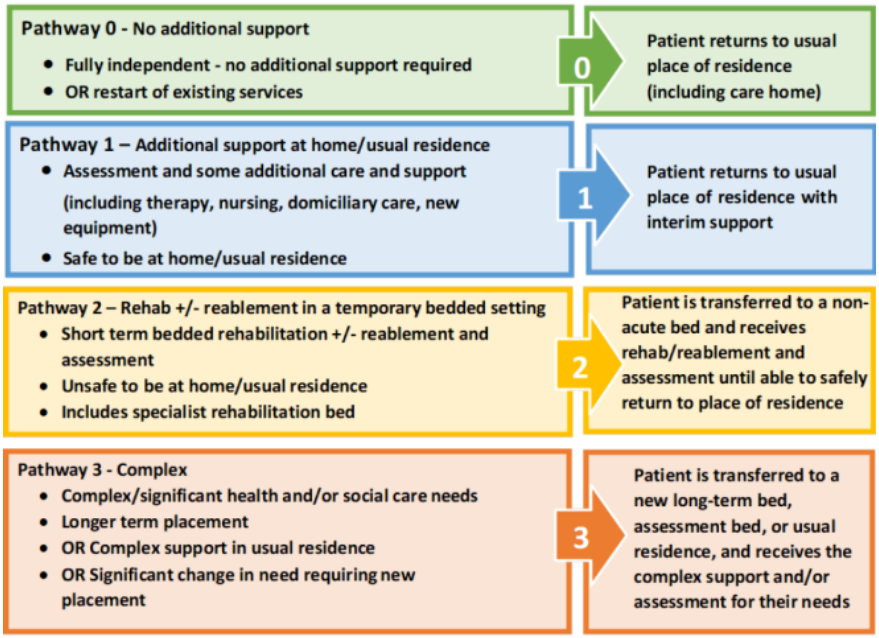
Plans are in place to commission an autism support service from April 2022 for age 16 years upwards. The specification is being co-produced across the sector.

A jointly commissioned Framework for Complex Needs is now in place across the Herefordshire/Worcestershire footprint. The complex needs pathway is for people that have a diagnosis of a Learning Disability and/or Autistic Spectrum Condition whose needs are assessed as complex, due to comorbidity. Individuals on the pathway will require support and intervention that is over and above support offered within a supporting living specification. These people present with behaviours that have challenged services and led to multiple placement breakdowns and/or in-patient admissions. The pathway is being developed to support this group of people and the provision will be inclusive of a multi-disciplinary team. This pathway will aim to develop and provide services to people with complex needs identified on our Dynamic Support Register (DSR). This will be across the health and social care footprint.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital? How is BCF funded activity supporting safe, timely and effective discharge?

Herefordshire Council provides a Reablement service, funded by BCF, which offers therapy-led services aligned with a Reablement model. People are discharged from a hospital setting by a fully integrated discharge team who provide a proportionate assessment in line with the Discharge to Assess (D2A) model.



Pathway 1 (Home) being the optimum pathway for patients who need additional support.

Herefordshire is expanding Pathway 1 services to enable more people to return home, where safe to do so, and reduce the number of people sent to a bed-based facility.

Awareness across the services of the high risk of Hospital Acquired Functional Decline underpins our practice. A recruitment drive is scheduled, to commence 26th October 2021, to increase the reablement workforce.

Outcomes continue to be measured for people who are in the Reablement service, in terms of levels of independence and requirements for ongoing care following the discharge to assess period. The integrated working with health colleagues has been improved with regards to therapy and access to longer term service provision to ensure people maximise opportunities for independence.

Improvement of the access to therapy has been made for those people discharged via Pathway 2 and 3, by changing the referral route through an integrated therapy hub; this ensures equity across the pathways.

Equipment continues to be readily available to support the person's journey and opportunity for independence.

Locality teams within adult social care provide the assessments for ongoing care within the D2A period.

Strengthening integration of social care and health teams has been the aim of the Herefordshire partners throughout. We now have a number of joint management roles, which provides more opportunity for joined up ways of working.

Length of Stay

A snapshot of the integrated teams' actions currently being undertaken to reduce 21 days are listed below.

- Twice weekly Length of Stay reviews on all 7 day stranded patients
- Daily ward/board rounds
- Integrated discharge team providing 7 day services
- Escalation daily of "criteria to reside"
- Capacity meetings – 4 daily meetings to escalate barriers to discharge
- System escalation through specific joint roles for health and social care
- Out of county discharge staff on site daily
- Daily huddle WVT and ASC community response teams
- Access to Early Supported Discharge pathway

WVT is an integrated acute and community provider and has set the 21-day target based on all beds. The BCF metric is based on acute beds where current performance is slightly worse than the national average and the ambition is to improve performance to meet the national average for acute beds by the end of the year.

Trusted Assessors

The 'Trusted Assessor' is an initiative driven by the NHS to reduce the number of delayed discharges. The underlying principle of the approach is to promote safe and timely discharges from NHS Trusts to adult social care services. The approach allows adult social care providers to adopt and use assessments carried out while people are still in hospital, as long as the assessment is carried out under a suitable 'Trusted Assessor Agreement'.

The Trusted Assessor model was implemented in Herefordshire during 2018-19, and continues to be a valued resource in helping to reduce the number of delayed discharges.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

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.

The strategic direction for DFG is to continue to work to deliver the goal of maximising independence and people living well at home. The council's Independent Living Service is to be restructured and strengthened, and in conjunction with the integrated Telecare service will work to increase the use of technology in home adaptations, telehealth and telecare. The council and CCG are working on a joint 'Technology Enabled Living' business case to maximise the use of digital technology in overcoming Herefordshire's challenges around workforce, rurality and ageing population. Working with the councils' Housing services we look to use DFG to help increase the amount of suitable available housing in Herefordshire to enable more people to remain at home, living well for longer.

<u>Plan for DFG 2022/23</u>

Implementation of a new Home Adaptations & Assistance Policy is currently under review. Consultation is taking place with key stakeholders to ensure that the policy includes key priorities for stakeholders, and maximises contribution of discretionary options to help meet priority needs.

A new Independent Living Service staffing structure is proposed that will assist the OT service to ensure assessments are allocated and completed in a timely manner, and ensure that the HIA can progress and complete adaptations requests within agreed performance targets.

During 2022/23 the use of the dynamic procurement system put into place during 2021/22 will be extended to allow competitive pricing, works allocation and design by contractors for most works, with certain exceptions of larger building works.

Works are ongoing with RSL partners to review and streamline the existing landlord applications process, RSL's contribution towards maintaining accessible homes register and maximising use of adapted properties to ensure longer-term effective use of DFG funds within social housing stocks.

Targets include:

- 100% OT/AEO assessments started within a maximum of 20 days
- 100% DFG requests received at Home Improvement Agency allocated to a caseworker within 10 working days
- Minimum of 60% major adaptations <£15K completed within 30 weeks of receipt of request
- 200 DFGs and 20 Discretionary Grants completed
- Memorandum of Understanding agreed and in place with RSL partners
- Home Adaptations & Assistance Policy to enable adaptations to properties sourced for the relief of homelessness

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- *Changes from previous BCF plan.*
- *How these inequalities are being addressed through the BCF plan and services funded through this.*
- *Inequality of outcomes related to the BCF national metrics.*

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.

The main challenges for Herefordshire are rurality, sparsity of population, and ageing population. The BCF metrics bear this out as older adults are more likely to have longer lengths of stay and 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.

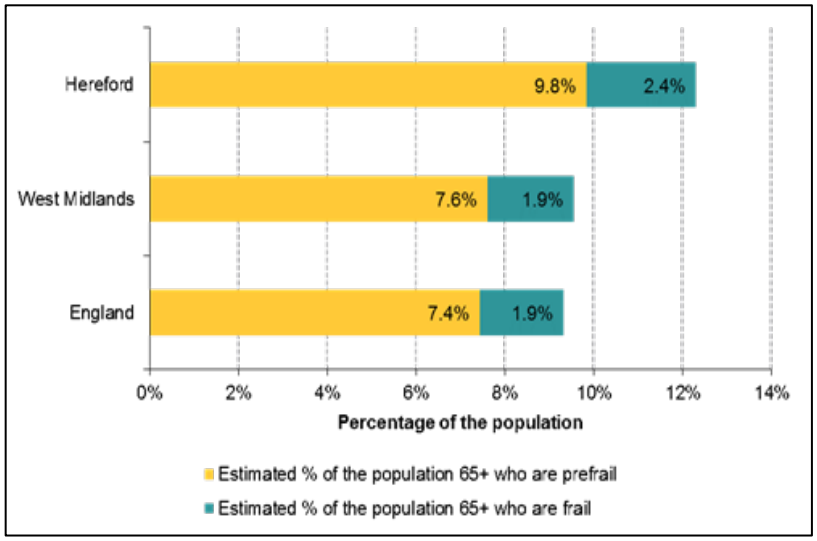
The current estimate of the county's resident population is 193,615 (mid-2020), an increase of 4,115 people (2.17 per cent) since mid-2016. There are 36,029 children and young people (0-17 years old) and 157,586 people (aged 18 to 64 years old) in our county.

Herefordshire's age profile is markedly older than that of England and Wales as a whole. People aged 65 and over constitute 25 per cent of the county's population (48,458 people), in comparison with 18 per cent nationally. There are 6,463 people aged 85 and over. By 2031, there is projected to be 50,180 65-84-year-olds (nearly 33 per cent more than in 2016) whilst the number age 85+ will rise to 9,316.

The trajectory for population growth suggests that a significant proportion of our population could be impacted by frailty. Frailty is "a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves". Frailty is not an inevitable part of ageing, but an under recognised health state. Older people with frailty are more vulnerable to minor illnesses and are at an increased risk of hospitalisation, admission to a care home and death.

It was estimated that in 2016 there were 4,600 people aged 65 and over with frailty living in the community in Herefordshire. However, the total number is likely to be higher as this calculation did not consider the number of people with frailty living in care homes. By 2025, the number of people aged 65 and over with frailty living in the community in Herefordshire is estimated to rise by approximately 28 per cent to approximately 5,900 people. There are also estimated to be around 18,600 with pre-frailty living in the community in Herefordshire. The prevalence of frailty increases with age with 4% of those aged 65 to 69 estimated to be frail, rising to 26% among those aged 85 and over.

Estimated percentage of the population aged 65 and over who had pre-frailty and frailty in 2016:



All partners are committed to equality and diversity using the scope of the Equality Act 2010 to eliminate unlawful discrimination, advance equality of opportunity and foster good relations, and demonstrate that we are paying 'due regard' in our decision making in the design and delivery of services.

All partners in the Integrated Care System are members of the Inequalities Collaborative Board which has developed a framework to support our system in working together to address inequalities. Implementation of this framework will be at "Place" level.

It is fundamental that individuals are at the heart of all activities and services. The CCG and the Council will work together with wider partners to ensure vulnerable people such as those with a learning disability and/or autism have equal access to services. Collaborative working is undertaken to implement the council's learning disability and autism strategy.

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, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

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

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

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

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

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

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

On this sheet please enter the following information:

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

2. Scheme Name:
- This is a free 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.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

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

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

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

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

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

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB 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 average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

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.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service 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.

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

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

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 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 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- 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:	Adrian Griffiths
E-mail:	adrian.griffiths@hotmail.com
Contact number:	01432 383 809

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

Job Title:	Paul Walker / Simon Trickett
Name:	Chief Executive Herefordshire Council / Accountable Officer Heref

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Mon 06/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Pauline	Crockett	Pauline.Crockett3@herefordshire.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Mr	Simon	Trickett	simon.trickett@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	N/A	Not Applicable	Not Applicable	Not@Applicable
	Local Authority Chief Executive	Mr	Paul	Walker	Paul.Walker@herefordshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Paul	Smith	Paul.Smith@herefordshire.gov.uk
	Better Care Fund Lead Official	Mr	Ewen	Archibald	Ewen.Archibald@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 -->	Joint Strategic Finance Lead	Mr	Adrian	Griffiths	adrian.griffiths2@herefordshire.gov.uk
	Senior Commissioning Officer	Ms	Marie	Gallagher	Marie.Gallagher1@herefordshire.gov.uk

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

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

Template Completed

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Herefordshire, County of

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,268,653	£2,268,653	£0
Minimum CCG Contribution	£14,321,369	£14,321,369	£0
iBCF	£6,583,421	£6,583,421	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£23,173,443**	**£23,173,443**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£4,069,727
Planned spend	£8,163,907

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,157,462
Planned spend	£6,157,462

Scheme Types

Assistive Technologies and Equipment	£292,938	(1.3%)
Care Act Implementation Related Duties	£1,226,823	(5.3%)
Carers Services	£478,314	(2.1%)
Community Based Schemes	£8,119,252	(35.0%)
DFG Related Schemes	£2,268,653	(9.8%)
Enablers for Integration	£610,645	(2.6%)
High Impact Change Model for Managing Transfer of C	£1,400,897	(6.0%)
Home Care or Domiciliary Care	£298,523	(1.3%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£3,453,041	(14.9%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£2,667,256	(11.5%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£424,696	(1.8%)
Residential Placements	£1,518,607	(6.6%)
Other	£413,798	(1.8%)
Total	**£23,173,443**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	513.7	729.4

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	LOS 14+	11.7%	11.1%
	LOS 21+	6.3%	5.7%

Discharge to normal place of residence

	0	21-22 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)	0.0%	92.4%

Residential Admissions

		20-21 Actual	21-22 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	435	408

Reablement

		21-22 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: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Herefordshire, County of

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

iBCF Contribution	Contribution
Herefordshire, County of	£6,583,421
Total iBCF Contribution	**£6,583,421**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

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

CCG Minimum Contribution	Contribution
NHS Herefordshire CCG	£14,321,369
Total Minimum CCG Contribution	**£14,321,369**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£14,321,369**	

	2021-22
Total BCF Pooled Budget	**£23,173,443**

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

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Herefordshire, County of

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,268,653	£2,268,653	£0
Minimum CCG Contribution	£14,321,369	£14,321,369	£0
iBCF	£6,583,421	£6,583,421	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£23,173,443**	**£23,173,443**	**£0**

Required Spend

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

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£4,069,727	£8,163,907	£0
Adult Social Care services spend from the minimum CCG allocations	£6,157,462	£6,157,462	£0

Checklist

Column complete:

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

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
51	Falls First Response	First responder for non-injury falls	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£41,420	Existing
51	Community Development	Commissioning & Development of Community Based	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum CCG Contribution	£281,473	Existing
52	Integrated Discharge Lead	Joint post to manage integrated discharge team	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			NHS Acute Provider	Minimum CCG Contribution	£32,684	Existing
52	Home First Service	Home First Reablement	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,384,210	Existing
52	Admission Prevention	Schemes to prevent admission to hospital or to long-term social care	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£284,523	New
52	Community Equipment	Community Equipment Loan Store- Hospital Discharge	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum CCG Contribution	£127,926	New
52	Residential Care	Long-Term Residential Placements	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Private Sector	Minimum CCG Contribution	£200,000	Existing

52	Housing Hospital Discharge	Service to assist with discharges delayed by housing issues	High Impact Change Model for Managing Transfer	Housing and related services		Social Care		LA			Local Authority	Minimum CCG Contribution	£79,520	Existing
52	Brokerage	Service to commission care placements	High Impact Change Model for Managing Transfer	Monitoring and responding to system demand		Social Care		LA			Local Authority	Minimum CCG Contribution	£217,777	Existing
52	Social Care Urgent Care	Social work professionals focussed on hospital discharge	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£787,489	Existing
53	Partnerships & Integration	Staff to support and develop joint commissioning,	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum CCG Contribution	£247,714	Existing
54	DoLs / AMHPs	Professional staff for liberty protection and mental health	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Local Authority	Minimum CCG Contribution	£833,928	Existing
54	Social Care Complex Needs	Social care professionals for specialist assessments and	Other		Social workers assessing specialist or	Social Care		LA			Local Authority	Minimum CCG Contribution	£413,798	Existing
54	Carers Support Contracts	Carers respite and support	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£225,000	Existing
51	Falls First Response	First responder for non-injury falls	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£122,551	Existing
52	Discharge to Assess Beds	Intermediate Care beds-D2A pathway 3	Residential Placements	Discharge from hospital (with reablement) to		Community Health		CCG			Private Sector	Minimum CCG Contribution	£837,198	Existing
52	Admission Prevention	Schemes to prevent admission to hospital or to long-term social care	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£125,173	New
52	Community Equipment	Community Equipment Loan Store- Hospital Discharge	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			Private Sector	Minimum CCG Contribution	£165,012	New
57	Acorns Children's Hospice	Carers Respite placements	Carers Services	Respite services		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£31,617	Existing
57	St Michael's Hospice Carer's Support	Carers Respite placements	Carers Services	Respite services		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£256,976	Existing
60	Integrated Community Care	Community Healthcare services	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£6,296,786	Existing
60	Hospital at Home Physiotherapy (2020/21 Inflation)	Physiotherapy support to hospital at home service	Reablement in a persons own home	Preventing admissions to acute setting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£239,046	Existing
60	Head of Integrated Care Services (2020/21 Inflation)	Manager of Integrated Community and Discharge teams	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£89,548	Existing
33	DFG	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£2,268,653	Existing
151	Talk Community	Support to and development of communities and	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	iBCF	£1,377,022	Existing

151	Care Navigator Frequent Fallers	Assessment of and support to frequent fallers	Reablement in a persons own home	Preventing admissions to acute setting		Social Care		LA			Charity / Voluntary Sector	iBCF	£44,000	Existing
151	Advocacy	Advocacy for users of social care	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Charity / Voluntary Sector	iBCF	£167,895	Existing
152	Trusted Assessors	Trusted assessment for care home placements	High Impact Change Model for Managing Transfer	Trusted Assessment		Social Care		LA			Private Sector	iBCF	£102,875	Existing
152	Additional Costs of D2A	Intermediate Care beds-D2A pathway 3	Residential Placements	Discharge from hospital (with reablement) to		Community Health		LA			Private Sector	iBCF	£218,783	Existing
153	Joint Strategic Finance Lead	Finance business partner for joint commissioning and integration	Enablers for Integration	Integrated models of provision		Social Care		LA			CCG	iBCF	£102,704	Existing
153	Minor Investments	Small grants and investments in health promotion and	Prevention / Early Intervention	Other	Miscellaneous small grants and payments to aid	Social Care		LA			Local Authority	iBCF	£15,000	Existing
154	Locality Social Work Teams	Social work professionals aligned to PCNs	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£3,453,041	Existing
154	Social Care Business Delivery & Practice	Professional development for social care staff- strengths-	Enablers for Integration	Workforce development		Social Care		LA			Local Authority	iBCF	£260,227	Existing
154	Shared Lives	Social care staff commissioning Shared Lives placements	Residential Placements	Other	Shared Lives	Social Care		LA			Local Authority	iBCF	£142,720	Existing
156	Care Home Practitioners	Nurses to support care homes	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Social Care		LA			NHS Community Provider	iBCF	£91,004	Existing
401	Block Nursing Home Beds (Leominster)	Long Term Care Home Placements	Residential Placements	Nursing home		Social Care		LA			Private Sector	iBCF	£119,906	Existing
401	Hard to place Home Care (Katherine Harriet)	Home Care placements	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£298,523	Existing
401	Additional short-term respite placements	Short Term Care Home Placements	Carers Services	Respite services		Social Care		LA			Private Sector	iBCF	£189,721	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Herefordshire, County of

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	513.7	729.4	2020/21 actuals based on local data. It will be difficult to deliver significant improvement with less than half of the current year remaining. Target set to maintain 2019/20 levels because admissions artificially depressed in 2020/21 by COVID-19.

>> link to NHS Digital webpage

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	11.7%	11.1%	Ambition is based on improving performance to match the national average. Specific actions include: • Twice weekly Length of Stay reviews on all 7 day stranded patients • Daily ward/board rounds • Integrated discharge team providing 7 day services • Escalation daily of "criteria to reside"
	Proportion of inpatients resident for 21 days or more	6.3%	5.7%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.4%	Ambition is based on improving performance to match the national average. Better data capture will lead to some improvement, as will understanding the relationship between this target and D2A. Practical improvements will stem from

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	550	543	435	408	Increasing capacity in Home First and Hospital at Home teams as part of discharge to assess should increase reablement and reduce permanent admission to residential care homes. However the 20-21 actual is artificially low due to COVID-19 depressing demand for care home placements.
	Numerator	260	259	211	202	
	Denominator	47,301	47,666	48,458	49,541	

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

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	76.9%	80.0%	Increasing capacity in Home First and Hospital at Home teams should maintain current good performance. Talk Community projects will strengthen and support community resilience
	Numerator	80	93	320	
	Denominator	100	121	400	

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

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Herefordshire, County of

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			