Integration and Better Care Fund

Appendix 1

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1	
HWB	**Herefordshire**	
ICB	**Herefordshire & Worcestershire**	

Section 1: Overview of BCF Plan

This should include:

- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process.
- Specifically, alignment with plans for improving flow in urgent and emergency care services.
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

Executive Summary

This document sets out Herefordshire's Better Care Fund Plan for 2025/26. It aligns with the BCF Planning Template and the Demand and Capacity Template which will be submitted together with this narrative.

The BCF has been a key contributor for a number of years towards building partnerships and integration between partners and stakeholders of health and social care.

Despite system pressures, partners continue to make a difference to the way services are organised and delivered.

Priorities for 2025/26

Herefordshire's Better Care Fund (BCF) Plan for 2025-26 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 2025-26 include:

- Hospital Discharge Support
- Adult Social Care Services
- Community Health Services

Key changes since previous BCF Plan

Our BCF plan for 2025/26 has a number of changes compared to the 2023/25 plan. Some of these changes are driven by changes in priorities, others by the need to make difficult financial choices due to the real-terms reduction in BCF funding, particularly in relation to discharge services. In order to maintain discharge flow and consolidate the progress we have made in integrating discharge services, partners have tried to maintain levels of spending on hospital discharge. The lack of any increase in discharge funding for 2025/26, coupled with costs of care that have increased by more than 10% in each of the last three financial years, means that maintaining funding for hospital discharge leads to funding reductions in other areas, and some services funded by BCF will have to be decommissioned.

The most significant changes made in this year's plan are:

- Removal of all operational social work teams from BCF- these services will be funded by adult social care base budget, with the BCF funding repurposed towards long-term ASC placements.
- Removal of Talk Community services - these services are focussed on community resilience and prevention. Responsibility for them has transferred to public health and they will be funded by base budget, with the BCF funding repurposed towards long-term ASC placements.
- No funding available to increase investment in prevention, community resilience or admission avoidance.

A rapid review will focus on identifying cost-effective schemes to achieve any savings.

Patients overstaying the 6-week BCF funded reablement period in one of the 'contracted' D2A providers (Home First, Hillside or LICU) continue to be the financial responsibility of the BCF rather than financially contributing themselves or funded by the council or health.

This does lead to a material financial pressure on the BCF and accordingly this issue needs to be resolved this financial year. This issue will not be easily resolved by cross charging those deemed responsible for the delay and will ultimately create a financial pressure for one or more of the One Herefordshire partners. It is important that partners work together to prevent overstays in the first place and by doing so reduce the overall financial burden on the BCF and release capacity of others to access in a timely way.

Approach to development of plan and of joint system governance to support delivery (and where required engage with BCF oversight and support process).

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.

The 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) was agreed for 23-25 plan and has been approved and agreed to continue for the 25-26 plan. Signed by the four partners this will continue 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 partners are Herefordshire Council, Herefordshire General Practice, Herefordshire and Worcestershire Health and Care NHS Trust and Wye Valley Trust. Herefordshire Healthwatch, and Herefordshire and Worcestershire ICB 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 report to 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 2025-26 BCF Plan, metrics and capacity & demand data following approval at relevant leadership and committee meetings.

Governance decisions regarding the BCF for Herefordshire are endorsed by Herefordshire Council and Herefordshire and Worcestershire ICB (HWICB) with final accountability for signing off BCF commitments made by Herefordshire Health and Wellbeing Board.

The successful recruitment has taken place for a new role, Partnerships and BCF Manager, to support collaborative practice and system-wide working which will be supported through matrix management agreements.

Alignment with plans for improving flow in urgent and emergency care services.

Integration of discharge services are a key priority of the One Herefordshire Partnership. We have chosen to maintain levels of investment in discharge services to continue the progress made in previous years.

Priorities for developing intermediate care (and other short-term care).

Working with our strategic partners, we plan to further develop Home First services to build on the improvements we have made in pathway one. We will seek to increase capacity by increasing more reablement workers and improve flow by reducing lengths of stay.

We have plans to restructure operational social care to increase capacity for assessments under the Care Act, and to increase capacity in community therapy.

We also plan to improve capacity in our strategic partners for pathway two beds, to reduce reliance on the care market for discharge placements.

We have made great strides in improving our data around discharge services and plan to build on that work to fully understand the whole patient journey from prior to admission to after exit from intermediate care, using the information and learning to improve efficiency and effectiveness throughout the pathway.

Section 2: National Condition 2: Implementing the objectives of the BCF.

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money.
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans.
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care.
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

Objective 1: reform to support the shift from sickness to prevention.

Local areas must agree plans that help people remain independent for longer and prevent escalation of health and care needs, including:

- timely, proactive and joined-up support for people with more complex health and care needs
- use of home adaptations and technology
- support for unpaid carers

Herefordshire Council is embarking on a joint piece of work to develop an accommodation and care at home strategy. The strategy will be a signal to the housing and social care markets on requirements in the coming 15-20 years for people with a range of needs. The guiding principle of this work is to ensure in-county accommodation is available for vulnerable people, so funding is retained within the Herefordshire system.

Accommodation is purpose built with design features that support the growth and maintenance of independence for as long as possible, and where digital technologies enhance the built environment. This work is being arranged to include systems partners and is directly related

to several other pieces of work; Herefordshire Council and Herefordshire and Worcester ICB are collaborating to jointly commission new care facilities tailored for children and adults with complex needs. This initiative is designed to offer a comprehensive support system that integrates both social care and health wrap-around services, along with digital technologies in the built environment which will significantly enhance the quality of care and delivery on-site for individuals with the highest levels of need.

This joint effort aims to ensure that the support provided is seamless and holistic, addressing not only the social care requirements but also the health-related needs of the individuals we serve. By working together, we can create a more cohesive and effective support structure that will greatly benefit those in our community who require the most intensive care and prevent further escalation of need.

This joint work is being done in the context of the development of an accommodation and care at home strategy and a review of supported living, both areas of work involving a multiagency approach which provides a positive foundation for BCF initiative to support.

In addition to the development of additional capacity in the system, reviews are being carried out with systems partners on existing accommodation-based services i.e. supported living and respite to ensure both the accommodation and service models are fit for current and future needs to support timely and safe discharge from hospital and the changing needs of existing residents.

The Carers Partnership Board is overseeing the delivery of the Carers Strategy Action Plan with multiple stakeholders, including health and social care professionals. The action plan seeks to understand the carers population and support them to continue providing services to the Cared for by the collection of robust data sets.

Health, Public Health and other preventative services play a key role in identifying carers who may not yet be known to social care and whose needs for social care could be delayed if the right interventions are made available in a timely way and by ensuring sources of information, advice and guidance are readily available across systems partners.

The ICB supports carer breaks through the BCF, including respite care for people with life-limiting conditions in clinical settings. The NHS contribution will continue to support the Care Act by providing assessment, advice, and support to carers. Carer engagement and support are integral to the strengths-based reablement approach, ensuring carers are informed, supported, and have access to equipment and aids. Additionally, addressing social isolation, fuel poverty, and carers' wellbeing remains critical.

Re-commissioning has recently taken place on Herefordshire's telecare contract, the new service which commences on 1 April 2025, focuses on improved integration between delivery of the service and service monitoring. An aim throughout 2025/26 is to expand a small scale pilot that took place within 2024/25 of proactive and preventative monitoring, enhancing the preventative approach within Herefordshire. The Partnership continues to work proactively to embed technologies as a system first approach alongside home first. The system-wide Integrated Community Equipment Contract (known as ICES) as has also recently been re-commissioned, following expiry. The new service will commence on 1 April 2025 and the existing contract has been developed and streamlined to provide enhanced outcomes for individuals and greater monitoring capabilities within the system.

Throughout 2025/26, commissioners will be working closely with providers of care services to further develop the care market within Herefordshire. Timely and proactive engagement with providers to build relationships, understand the workforce and provider challenges will enable us to further ensure we are best placed to facilitate timely, proactive and joined-up support. The possibility of further joint commissioning and contracting across the wider provision of care outside of BCF will be fully explored where there are opportunities that arise from contract expiry, to ensure integration is central across the Partnership.

Objective 2: reform to support people living independently and the shift from hospital to home.

Local areas must agree plans that:

- help prevent avoidable hospital admissions
- achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
- reduce the proportion of people who need long-term residential or nursing home care

The system utilises a primary provider where possible to provide the Home First Service, this service also supports the wider discharge to assess process. A service review of delivery of this support for Pathway 1 has recently taken place, with an aim to improving and increasing capacity working collaboratively with the service provider through robust key performance indicators that embed the principles of the home first approach. The review has explored all parts of the patient journey through pathway 1 and a number of improvements to the service specification and to system processes have been made. Through these improvements the

Service has increased capacity without further financial investment and significantly reduced the number of bed days lost to pathway 1.

We will continue ongoing arrangements for Home First 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 system wide Discharge to Assess Board has been developed to support the review of all pathways and to work collaboratively with providers to ensure improvements are sustained.

The system will continue to support the contract to provide a range of advocacy services for adults is via Onside Advocacy (Scheme 151). 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

The advocacy contract ensures that individuals have the right support to make decisions and the most appropriate care solution.

Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans.

The table below shows the metrics for 2025-26 and associated targets with explanatory notes on the ambitions.

Metric	Ambition	Comments
Emergency admissions to hospital for people aged 65+ per 100,000 population.	To reduce admissions of this cohort by 5% over the financial year	Provide increased support to those with long term conditions to prevent avoidable admissions and a more responsive health and/or care service to provide a safe alternative to hospital admission.
Average length of discharge delay for all acute adult patients, derived from a combination of: - proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) - for those adult patients not discharged on DRD, average number of days from DRD to discharge.	To reduce the number of discharge delay days by 5% over the year	This will be achieved by working with main providers and removing common causes of delay.
Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population.	The ambition will remain as previous year.	2024/25 admissions are forecast to be much lower than planned. 2025/26 plan is to maintain that improved performance despite demographic pressures and increasing complexity of service users.

System partners are ensuring robust metrics are in place and working collaboratively to maintain performance in each area. The Integrated Care Executive (ICE) is responsible for monitoring performance against these metrics throughout the year. ICE will set and assess local metrics, such as falls outcomes, D2A capacity utilisation, Length of Stay targets, and the impact of DFGs and expenditure.

Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care.

We will continue to utilise the discharge bridging team to support patients to be discharged, if there are any delays with our Home First service starting.

There has been a review of contract process with the Home First provider and newly established contract management processes will now also include partners from health. The arrangements will ensure that the improvements in the service are sustainable and consider further improvements.

Benchmarking on Home First services is underway in order to identify if further improvements can be made within our Home First delivery.

A full review of therapy resource is underway to ensure reablement offer is available and supports the relevant pathways. Findings will be presented to the D2A Board for discussion on agreement on next steps.

Our aim is to continue to improve our position related to patients being discharged home on the day that they become medically stable for discharge. Our discharge to assess pathways have been reviewed and amended to further improve us achieving this aim.

Service reviews of commissioned services across the D2A pathway have taken place to ensure that the services are aligned to key performance indicators and that improved outcomes for D2A are overseen and monitored closely to reduce delays to discharge.

In 2024/25 the Right Care, Right Place, Right Time programme within which discharge from hospital and improved alignment of community-based resources and responses is a core feature. Partners, we have embedded a home first approach in line with the government's hospital discharge and community support guidance, and ongoing actions continue to support recruitment and retention of staff working within discharge pathways. 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.

Adult social care has wrapped significant support around hospital discharge and D2A including:

- The establishment of the Care Act and Assessment Team (CAAsT) who are responsible for assessing all patients discharged under D2A to pathways 1 2 and 3.
- The appointment of a hospital discharge worker in Housing Solutions to address the challenges faced by individuals and partners when people are discharged from hospital and their accommodation is no longer suitable for them.
- The establishment of a new post of Hospital Team Manager to manage the existing hospital team, as part of the Integrated Discharge Team, to ensure timely escalation regarding delays and immediate actions required

Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

The consolidated local authority discharge fund will continue to support the same activity as previous years.

Our Frailty Same Day Emergency Care (FSDEC) bridging team will continue to provide rapid support to those patients seen in FSDEC who could be cared for at home to prevent admission to an acute bed.

We will continue to maintain strong links with our Virtual Ward (VW) to ensure, where appropriate, patients can remain at home. In addition, step up VW beds are now available for primary care to access, and the system works closely with the team to provide care and support where needed including care support via bridging team and our reablement provider. 2025/26 will see us building on this pathway to maximise opportunity.

The Care Home Practitioner role is currently being reviewed to ensure we are maximising the opportunity for avoiding admission or to reduce discharge delays. This team have developed strong links with our care home providers over previous years, and our aim is to involve these staff directly in liaising with providers to ensure patients can remain in their home unless necessary to receive secondary care.

We will continue to review provision of the trusted assessors system throughout 2025/26, focused on where they add value across the system to reduce discharge delays.

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

How 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)

The 2025/26 plan is based on 2024/25 demand and capacity actuals. Activity for the 12 months to January 2025 were used as the baseline for the 2025/26 plan; January 2025 being the most recent completed month available when planning began.

The 2024/25 actual demand has been adjusted for expected increases in demand for discharge to assess, based on experience of 2024/25, tempered by expected reductions in emergency admissions to Hereford County Hospital due to planned actions by members of One Herefordshire partnership.

Capacity plans have been adjusted from 2024/25 levels to reflect improved performance in key strategic partners which both introduce further capacity, improve occupancy levels, and reduce length of stay in pathways one and two. These improvements will reduce but not eliminate spot purchase of discharge capacity in the social care market. This reduction generates savings which partly offset the cost pressures caused by the there being real terms cut in funding for the BCF for 2025/26.

How capacity plans take into account therapy capacity for rehabilitation and reablement interventions

A recent demand and capacity review around therapy support has taken place and has highlighted a significant gap related to therapy roles. Our aim is to ascertain how, by investing in additional therapists will not only support financial savings elsewhere in the system but will provide better outcomes for our residents.

The system will also review reablement training across the system to ensure that all services required to provide high level of reablement are up to date with the latest principles, to ensure we provide our residents with the best opportunity to maintain independence.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

All partners remain dedicated to upholding equality and diversity as outlined by the Equality Act 2010, ensuring that due regard is given in decision making concerning the design and delivery of services. It is essential that individuals are placed at the centre of all activities and services. Partners continue to strive towards enabling universal access to services, particularly for those requiring additional support due to conditions such as learning disabilities and/or autism, ensuring these individuals have equal access to services and are supported to achieve maximum independence within 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.

In relation to proposed plans to review some of the existing schemes within the BCF, consultations will take place with affected staff groups and stakeholders and service users where appropriate.

In addition, Herefordshire Council Community Wellbeing Directorate are developing the approach around co-production. Initial work has been completed and includes guidance for staff and teams on implementing co-production into commissioning and adult social care and has introduced a payment system to recognise the valuable time contribution of people with lived experience. There are plans to develop this approach further, but recent examples include lived experience panels for recruitment to key commissioning posts.

The system also has a range of forums and boards to consult and gain views of patients and people with live experience. One such example is the Making It Real Board hosted by the Council, which is a board of lived experience individuals with which the system can regularly engage. Senior leaders from the system participate in the Board and the agenda is set by those with lived experience.

Our Person's Voice questionnaire, co-produced with people with lived experience, provides individuals with the opportunity to tell us more about their recent experience with Adult Social Care. Feedback is shared with staff members and is used to inform and improve our services.

The Joint Strategic Needs Assessment (JSNA) has just been refreshed in 2024 and reflects the position for Herefordshire. The system continues to use the JSNA to inform the evidence base for commissioned services and service improvements. Further strategic work is planned to consider the needs of the county in future years considering the ageing population.