Better Care Fund 2019/20 Template

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

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

1. This section helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Clicking on the corresponding 'Cell Reference' column will link to the incomplete cell for completion. Once completed the checker column will change to 'Green' and contain the word 'Yes'

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

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we collect email addresses to communicate with key individuals from the local areas for various purposes relating to the delivery of the BCF plans including plan development, assurance, approval and provision of support.
We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.
Please let us know if any of the submitted contact information changes during the BCF planning cycle so we are able to communicate with the right people in a timely manner.

4. Strategic Narrative (click to go to sheet)

This section of the template should set out the agreed approach locally to integration of health & social care. The narratives should focus on updating existing plans, and changes since integration plans were set out until 2020 rather than reiterating them and can be short. Word limits have been applied to each section and these are indicated on the worksheet.

1. Approach to integrating care around the person. This should set out your approach to integrating health and social care around the people, particularly those with long term health and care needs. This should highlight developments since 2017 and cover areas such as prevention.
2 i. Approach to integrating services at HWB level (including any arrangements at neighbourhood level where relevant). This should set out the agreed approach and services that will be commissioned through the BCF. Where schemes are new or approaches locally have changed, you should set out a short rationale.
2 ii. DFG and wider services. This should describe your approach to integration and joint commissioning/delivery with wider services. In all cases this should include housing, and a short narrative on use of the DFG to support people with care needs to remain independent through adaptations or other capital expenditure on their homes. This should include any discretionary use of the DFG.
3. How your BCF plan and other local plans align with the wider system and support integrated approaches. Examples may include the read across to the STP (Sustainability Transformation Partnerships) or ICS (Integrated Care Systems) plan(s) for your area and any other relevant strategies.

You can attach (in the e-mail) visuals and illustrations to aid understanding if this will assist assurers in understanding your local approach.

5. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund (BCF) plan and pooled budget for 2019/20. On selected the HWB from the Cover page, this sheet will be pre-populated with the minimum CCG contributions to the BCF, DFG (Disabled Facilities Grant), iBCF (improved Better Care Fund) and Winter Pressures allocations to be pooled within the BCF. These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from Local Authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be utilised to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact England.bettercaresupport@nhs.net

6. Expenditure (click to go to sheet)

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

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.
On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- While selecting schemes and sub-types, the sub-type field will be flagged in ‘red’ font if it is from a previously selected scheme type. In this case please clear the sub-type field and reselect from the dropdown if the subtype field is editable.
5. Planned Outputs
- The BCF Planning requirements document requires areas to set out planned outputs for certain scheme types (those which lend themselves to delivery of discrete units of delivery) to help to better understand and account for the activity funded through the BCF.
- The Planned Outputs fields will only be editable if one of the relevant scheme types is selected. Please select a relevant unit from the drop down and an estimate of the outputs expected over the year. This is a numerical field.

6. Metric Impact
- This field is collecting information on the metrics that a chem will impact on (rather than the actual planned impact on the metric)
- For the schemes being planned please select from the drop-down options of ‘High-Medium-Low-n/a’ to provide an indicative level of impact on the four BCF metrics. Where the scheme impacts multiple metrics, this can be expressed by selecting the appropriate level from the drop down for each of the metrics. For example, a discharge to assess scheme might have a medium impact on Delayed Transfers of Care and permanent admissions to residential care. Where the scheme is not expected to impact a metric, the ‘n/a’ option could be selected from the drop-down menu.
7. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “CCG minimum” then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
8. Commissioner:
- Identify the commissioning entity for the scheme based on who commissions the scheme from the provider. If there is a single commissioner, please select the option from the drop-down list.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.
9. Provider:
- Please select the ‘Provider’ commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

10. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop-down list
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
11. Expenditure (£) 2019/20:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
12. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2019/20 and will inform the understanding of planned spend for the iBCF and Winter Funding grants.

7. HICM (click to go to sheet)

National condition four of the BCF requires that areas continue to make progress in implementing the High Impact Change model for managing transfers of care and continue to work towards the centrally set expectations for reducing DToC. In the planning template, you should provide:
- An assessment of your current level of implementation against each of the 8 elements of the model – from a drop-down list
- Your planned level of implementation by the end March 2020 – again from a drop-down list

A narrative that sets out the approach to implementing the model further. The Narrative section in the HICM tab sets out further details.

8. Metrics (click to go to sheet)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2019/20. The BCF requires plans to be agreed for the four metrics. This should build on planned and actual performance on these metrics in 2018/19.

1. Non-Elective Admissions (NEA) metric planning:
- BCF plans as in previous years mirror the latest CCG Operating Plans for the NEA metric. Therefore, this metric is not collected via this template.

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

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

4. Delayed Transfers of Care (DToC) planning:
- The expectations for this metric from 2018/19 are retained for 2019/20 and these are prepopulated.
- Please include a brief narrative associated with this metric plan.
- This narrative should include details of the plan, agreed between the local authority and the CCG for using the Winter Pressures grant to manage pressures on the system over Winter.

9. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2019/20 for further details.

The Key Lines of Enquiry (KLOE) underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

10. CCG-HWB Mapping (click to go to sheet)

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity figures.

Better Care Fund 2019/20 Template

2. Cover

Version 1.2

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2019/20.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Richmond upon Thames
Completed by:	Anna James
E-mail:	Anna.James@richmondandwandsworth.gov.uk
Contact number:	0208 891 7050
Who signed off the report on behalf of the Health and Wellbeing Board:	Mark Maidment
Will the HWB sign-off the plan after the submission date?	No
If yes, please indicate the date when the HWB meeting is scheduled:	

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Piers	Allen	Cllr.P.Allen@richmong.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Tonia	Michaelides	Tonia.Michaelides@swlondon.nhs.uk
	Additional Clinical Commissioning Group(s) Accountable Officers		Sarah	Blow	Sarah.Blow@swlondon.nhs.uk
	Local Authority Chief Executive		Paul	Martin	Paul.Martin@richmondandwandsworth.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Liz	Bruce	Liz.Bruce@richmondandwandsworth.gov.uk
	Better Care Fund Lead Official	NOTE: The BCF Lead Officals are Joint Chairs of the Health and Care Integration Group (BCF oversight)	Sydney Sue	Hill Lear	Sydney.Hill@richmondandwandsworth.gov.uk Sue.Lear@swlondon.nhs.uk
	LA Section 151 Officer		Mark	Maidment	Mark.Maidment@richmondandwandsworth.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

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

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

Checklist

2. Cover ^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes

Sheet Complete	Yes

4. Strategic Narrative ^^ Link back to top

	Cell Reference	Checker
A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	Yes

Sheet Complete	Yes

5. Income ^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure ^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes
Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete	Yes

7. HICM ^^ Link back to top

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete	Yes

8. Metrics

^^ Link back to top

	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

Sheet Complete	Yes

9. Planning Requirements

^^ Link back to top

	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes
PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes

Sheet Complete	Yes

^^ Link back to top

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Richmond upon Thames

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,697,204	£1,697,204	£0
Minimum CCG Contribution	£11,830,372	£11,830,372	£0
iBCF	£92,793	£92,793	£0
Winter Pressures Grant	£660,842	£660,842	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£14,281,211	£14,281,211	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£3,361,856
Planned spend	£5,740,420

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£4,561,522
Planned spend	£5,127,799

Scheme Types

Assistive Technologies and Equipment	£653,282
Care Act Implementation Related Duties	£579,048
Carers Services	£404,869
Community Based Schemes	£0
DFG Related Schemes	£1,697,204
Enablers for Integration	£0
HICM for Managing Transfer of Care	£1,394,756
Home Care or Domiciliary Care	£1,400,185
Housing Related Schemes	£0
Integrated Care Planning and Navigation	£5,529,898
Intermediate Care Services	£660,842
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£0
Prevention / Early Intervention	£668,649
Residential Placements	£1,292,478
Other	£0
Total	£14,281,211

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Mature
Chg 2	Systems to monitor patient flow	Mature
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature
Chg 4	Home first / discharge to assess	Mature
Chg 5	Seven-day service	Mature
Chg 6	Trusted assessors	Established
Chg 7	Focus on choice	Mature
Chg 8	Enhancing health in care homes	Mature

Metrics >>

Non-Elective Admissions
Delayed Transfer of Care

Go to Better Care Exchange >>

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	351.7576193

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.916666667

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
	PR8	Yes
Metrics	**PR9**	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: Richmond upon Thames

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes Your approach to integrating care around the person, this may include (but is not limited to): - Prevention and self-care - Promoting choice and independence	
Remaining Word Limit:	795

The Richmond Health and Care Plan 2019-2021 sets out the key priorities for "Start Well, Live Well and Age Well" and the BCF will predominately support "Age Well" priorities. The Health and Care Plan describes key actions we plan to deliver across health and social care over the next two years. A key focus of the health and care plan is to integrate health and social care around the person, which has overarching focus on prevention. Through the Health and Care Plan we have agreed a set of actions that will be taken that will have a positive impact for residents in the borough. Across the borough of Richmond, we are committed to understanding and identifying where we have inequalities in health most notably we will focus on reducing health inequalities for people with a learning disability. We will increase the uptake of GP annual health checks, support the delivery of the Mencap Treat Me Well campaign and address the physical health needs of this cohort of people to minimise years lost to ill health.

1) Encourage active, resilient and inclusive communities that promote healthy ageing and reduce loneliness and isolation:
We will explore and build opportunities for social connections / community hubs that bring people together in their community. We have made a commitment to promote wellbeing and healthy lifestyles for all older people, including through the rollout of the "Making Every Contact Count" initiative. We have plans to improve access to health and care information and advice for people and their unpaid carers; as well as to improve access for older people and their carers to outreach and community-based services, including though the delivery of Community Independent Living Services (CILS) and social prescribing. There will be investment in the training and provision of the voluntary sector throughout plans for social prescribing and development in IT connectivity. The underpinning philosophy is that 'money follows activity' to support what individuals need and to deliver positive outcomes for our residents.

2) Support people to live at home independently, for as long as possible including people with dementia:
We will identify and proactively support older people with complex health and care needs by bringing health and care professionals together around the individual – through primary care networks, across the borough. We have plans to increase the number of shared care plans developed with older people who have complex needs and their unpaid carers. We have plans to redesign the pathways for integrated community based urgent care services and implementing a "home first" principle for people leaving hospital. This will be complimented by an increase in older people who receive reablement support and recover at home on discharge from hospital.

3) Support people to plan for their final years so they have a dignified death in a place of their choice:
We will support people to plan for their old age and have sensitive conversations to include talking about death and dying. We will improve end of life care by progressing delivery of our End of Life Care Strategy to ensure that end of life issues are addressed. We will support people to take up health and social care personal budgets to enable them to receive personalised care to meet their needs, including for their end of life care by 2021. We have plans to improve care coordination and information sharing across health and social care at the end of life, including rolling out access to the integrated 'Coordinate My Care' system.

4) Supporting Carers:
We have made a commitment to improve our practice in identifying and recognising carers of all ages, ensuring that they are linked into support options, enabling carers to reduce the emotional, social, financial and health impacts they face. We have made a commitment to implement the recommendations from the consultation on the Richmond Carers Strategy and work with Richmond Carers Hub to review how carers' needs are assessed and responded to in their own right to ensure they are 'not forgotten'. We have plans to improve the approach and practice in relation to carer assessments and support planning and improve the recognition of young carers and develop a range of support options.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements - Alignment with primary care services (including PCNs (Primary Care Networks)) - Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

^^ Link back to top

Remaining Word Limit:	27

A core transformation programme is the establishment of Locality/Networks focused on 50k populations aligned to GP practices which facilitates multi-disciplinary working between primary, community, secondary care, social care and the voluntary sector to develop and deliver care plans to support people with complex care needs in managing their conditions, avoid crisis and reduce unplanned care needs. GP teams will use the SOLLIS risk stratification tool to identify those patients who are most vulnerable to admission.

The teams are configured from existing practitioners from primary, community, acute, mental health and voluntary sector working together to plan and manage the care for patients within their locality area. The multi-disciplinary teams will work with the Primary Care Networks (PCN's) to co-ordinate the care within a network population. Providing PCN's with population health profiles and information on health and care utilisation to support them in the planning of care for their populations. Developing a robust social prescribing model engaging with the voluntary sector to provide support to local communities.

There is an integrated Response and Rehabilitation Team within Richmond funded jointly by RCCG and LBRuT through the BCF. This team consists of therapists, nurses and social care staff working together to provide an urgent community response for people experiencing sudden deterioration in their condition. The aim is to maintain people in their usual place of residence by tailoring support to their individual needs. The service provides:

- A rapid response, urgent care assessment, observation and support in the community for people whose health needs may otherwise lead to an admission to hospital or an extended stay in hospital
- Improving the transition from acute hospital admissions to community services through facilitating safe and timely discharge from hospital
- A range of short-term interventions, which help people recover their skills and confidence after an episode of poor health, admission to hospital, or sudden deterioration of their functioning
- Providing short-term intensive support to people to regain independence and wellbeing
- A person-centred package of support to people in their own homes, in hospital or in a care home setting which is jointly delivered by health and social care professionals
- Ensuring an effective referral process to district nursing and/or other specialist teams as appropriate
- Maintaining effective communication with GPs and other referrers to the service
- Provide short term rehabilitation support to people in the community who are currently not as independent as possible. This is either from a community referral, routine or rapid response, or following a hospital discharge from either secondary care or from community hospitals.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the

^^ Link back to top

Remaining Word Limit:	266

Under the provisions of the Housing Grants, Construction and Regeneration Act 1996, the Council provides mandatory means tested Disabled Facilities Grants (DFG) to assist residents with the cost of providing adaptations to dwellings or common parts of buildings containing flats where the adaptation is considered 'necessary and appropriate' and 'reasonable and practical'. The Regulatory Reform Order (RRO) 2002 provides local authorities a broader freedom and opportunity to address living conditions in their area including to provide, directly or indirectly, assistance to adapt or improve living accommodation and repair living accommodation.

The RRO (2002) allows local authorities to create assistance schemes using the DFG funding which help people to meet their needs without going through the full DFG process. Additional funding under the BCF has expanded the scope of help available to include discretionary DFG schemes. This widening of funding enables more people to remain independent and prevents the need for care and support for longer.
The BCF has created new opportunities for the Local Authority to develop and fund joint commissioning plans with Clinical Commissioning Groups to meet the needs of residents across care groups. The Discretionary DFGs and Housing Assistance Policy supports the development of these plans by providing the policy context for how commissioning partners will use the funding available to develop a range of DFG funded services. The broad priorities of the policy are to improve outcomes for disabled and older people, reduce admissions or re-admissions through prevention, help people remain independent for as long as possible, reduce care costs where possible and help facilitate more efficient discharge from hospital.

More specifically, the funding for discretionary DFGs sits within the BCF and funding for services is prioritised and targeted at initiatives which:

- Reduce or eliminating hospital admissions;
- Allow speedier discharge from hospital;
- Consider the long-term needs of individuals and reductions in associated treatment and social care costs; and
- Provide for works, adaptions or provision of equipment that is not provided by any other service.

The Local Authority implemented a Discretionary DFG and Housing Assistance Policy in early 2019. The policy sets out how the discretionary funding can be used, and it includes the local agreed approach for funding in the following areas:

- Speeding up the delivery of adaptations: additional staff and/or training
- Funding adaptations over the maximum mandatory DFG limit
- Relocation funding
- Hospital Discharge Grants
- Fast Track non-means tested assistance
- Preventative outreach and independence assistance
- Telecare and Telehealth services
- Adaptation of temporary accommodation

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	
Remaining Word Limit:	814

^^ Link back to top

Richmond has a long history of working together to deliver improved health and care to our local people. The CCG and the Local Authority work in partnership across health and social care, with our local population, to prevent ill health, reduce inequalities and support people to start well, live well and age well, both physically and mentally.

The BCF in 2019-20 will build on the existing 2017-19 Plan and reflect the "Age Well" priorities of the Richmond Health and Care Plan 2019-20. It will continue to support and facilitate the strategic direction in Richmond to meet the requirements of the NHS Long Term Plan as set out in the vision of the SWL Health and Care Partnership to deliver integrated services, to give people the care they have told us they want.

The Richmond Health and Care Plan 2019-20 has been developed alongside local health and care plans of the other boroughs in the South West London Health and Care Partnership. It describes the vision, priorities and actions to meet the health and care needs of local people in the borough, in themes of Start Well, Live Well and Age Well. The plan focuses on where health, social care and the voluntary sector can work together to have the biggest impact on what a single organisation cannot achieve alone.

In response to the South West London Sustainability and Transformation Plans (2016), there was a recognition that a local approach works best for planning and it was agreed that local health and care plans would be developed across the six boroughs in SWL Health and Care Partnership. Richmond's Health and Care Plan has been developed in partnership with the Local Authority, CCG, NHS Providers, Healthwatch and representatives from the voluntary and community sector with consultation and engagement from local people in the borough.

Richmond Health and Care Plan is informed by the borough's Joint Strategic Needs Assessment (JSNA) outlining the key challenges and pressures across health and social care for the whole population of the borough. The plan reflects the whole life cycle and sets out priorities for Start Well, Live Well and Age Well acknowledging that there is transition between these stages. Richmond Health and Care Plan reflects the key priorities for improving health and wellbeing for the local population, and where we can have the biggest impact by working differently across health, social care and the voluntary sector.

The six borough plans will form an overall SWL Health and Care Partnerships Plan and will form part of the SWL response to NHS England in relation to achieving priorities set in the NHS Long Term Plan.

Richmond is part of a "complex system" with LBRuT and RCCG working across different geographies. Richmond Council has been part of a Shared Staffing Arrangement (SSA) with Wandsworth Council since 2016 and Richmond CCG have a shared Local Delivery Unit with Kingston CCG. NHS Community Services are largely provided by Hounslow and Richmond Community Healthcare, which also provide community services in Hounslow. Richmond has no acute hospitals in the borough, and most acute admissions are into Kingston Hospital and West Middlesex Hospital with a small flow to other hospitals. Working across CCG, Council and Provider boundaries offers benefits to how we engage with acute Trusts outside the borough. There is close working with Kingston Social Services and Kingston's Community Health Provider on developing aligned discharge pathways from Kingston Hospital, and we have established an integrated Joint Assessment and Discharge Team. There will be further opportunities through SWL on how we engage with acute hospitals across the system.

The BCF Plan and Health and Care Plan need to be set in the context of the wider strategic landscape for health and care integration for adults in the borough. This is supported by other joint plans, including:
Carers Strategy
Dementia Strategy
Health and Wellbeing Strategy
End of Life Care Strategy

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Richmond upon Thames

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Richmond upon Thames	£1,697,204
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,697,204**

iBCF Contribution	Contribution
Richmond upon Thames	£92,793
Total iBCF Contribution	**£92,793**

Winter Pressures Grant	Contribution
Richmond upon Thames	£660,842
Total Winter Pressures Grant Contribution	**£660,842**

Are any additional LA Contributions being made in 2019/20? 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 Richmond CCG	£11,830,372
Total Minimum CCG Contribution	**£11,830,372**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Addition CCG Contribution	**£0**	
Total CCG Contribution	**£11,830,372**	

	2019/20
Total BCF Pooled Budget	**£14,281,211**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
No further comments

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Richmond upon Thames

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,697,204	£1,697,204	£0
Minimum CCG Contribution	£11,830,372	£11,830,372	£0
iBCF	£92,793	£92,793	£0
Winter Pressures Grant	£660,842	£660,842	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£14,281,211	£14,281,211	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£3,361,856	£5,740,420	£0
Adult Social Care services spend from the minimum CCG allocations	£4,561,522	£5,127,799	£0

Link to Scheme Type description

						Planned Outputs		Metric Impact				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Outcome Based Commissioning	This is the scheme within the previous BCF plan which was designated Model of Care and includes, going forward, schemes which are to be subsumed within the wider Outcomes Based Commissioning approach; these include the Falls Prevention Service, the Early Supported Discharge for Stroke Survivors, the COPD Respiratory Team and Community Services including locality teams, Cardiac rehab, Tissue Viability.	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	Medium	Medium	Medium	Community Health		CCG			Local Authority	Minimum CCG Contribution	1842254	Existing
2	Carers	The Council and the CCG are continuing to invest in services for carers through the Carers' Hub contract. These provide a range of services for carers such as , Adult Carer Support / information and advice services; Adult Carer Breaks and Leisure activities; Communication and Information4; Adult Carer Training and Learning; . Debt and Financial Advice; Caring Café7 ; Events; Carer Engagement; Young Carer Support and Breaks; Leadership and Management and Carer in Mind	Carers Services	Respite Services				Low	Low	Medium	Low	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	404869	Existing
31	Richmond Response and Rehabilitation Scheme	This service is a key service in the achievement of a number of the national conditions, particularly joint assessment and care planning, seven day working, NHS investment in out of hospital services, preventing unnecessary admissions and reducing delayed transfers of care. Investment is being maintained in this service area	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Medium	High	Social Care		LA			Private Sector	Minimum CCG Contribution	782570	Existing
4	Richmond Response and Rehabilitation Scheme	The RRRT team provides person-centred support with clear rehabilitation and independence goals delivered by an integrated health and social care team. Rehabilitation may take place in the person's home, in a community hospital, in rehabilitation beds at a contracted care home or in the smart flat. The service is available seven days a week and is available regardless of eligibility for social care	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				Medium	High	Medium	High	Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	1394756	Existing
5	GP and Multi-disciplinary Team	This model includes identification, using risk profiling and/or clinical judgement, of the 3% of the practice population who are most at risk of emergency hospital admissions. It makes GPs the accountable professional for patients aged 75+ and adults with complex needs, offers longer appointments to at risk patients, joint assessment and care planning where appropriate, signposting or making onward referrals to other relevant services and encouraging routine multi-disciplinary meetings to discuss patients at high risk of emergency hospital admission. The community geriatrician complements this service with specialist information and advice to GPs and A&E departments	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	Medium	Medium	Not applicable	Other	Multiple Support services from Primary care, Community Health & social Care	Joint	82.0%	18.0%	Private Sector	Minimum CCG Contribution	1920319	Existing
6	Improved Mental Health OOH Services	This includes the formerly funded Psychiatric Liaison Service which, like the GP led service, has benefited from learning. The new specification incorporates new funding (outside the BCF) to increase hours of operation from 9am to 9pm to 24/7. Also in this section, we have used increased BCF funding to contribute to investment in a Crisis Café.	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Not applicable	Not applicable	Not applicable	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	275467	Existing
7	Equipment and Assistive Technologies	This includes equipment provision through a joint equipment service to support people to continue to live in their own homes.	Assistive Technologies and Equipment	Community Based Equipment				Low	High	Medium	High	Community Health		CCG			Private Sector	Minimum CCG Contribution	653282	Existing
8	Protection of Adult Social Care	This continues to maintain existing social care services, homecare and Care Homes services to meet the ever increasing demand from a growing population.	Home Care or Domiciliary Care			Hours of Care	73,694.0	Medium	High	Medium	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	1400185	Existing
9	DFG	The Council is committed to assisting older people and the disabled to maintain their ability to live independently in their own home and uses the Home Improvement Agency (HIA) and Disabled Facility Grants to achieve this.	DFG Related Schemes	Adaptations				Low	Low	High	Medium	Social Care		LA			Local Authority	DFG	1697204	Existing
10	Richmond Response and Rehabilitation Scheme	To support & enhance the Integrated community rehabilitation service	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Medium	High	Social Care		LA			Local Authority	iBCF	92793	Existing
3	Richmond Response and Rehabilitation Scheme	Provides support to ensure prompt service delivery that is service user and carer focused and supports the single assessment process, person-centred planning and Self-Directed support (SDS).	Integrated Care Planning and Navigation	Other	Support Services			Medium	High	Medium	High	Community Health		LA			NHS Community Provider	Minimum CCG Contribution	616495	Existing
11	Additional Responsibilities Care Act	Implementation and delivery of the transformation work resulting from new duties as a result of the Care Act	Care Act Implementation Related Duties	Other	Covering a range of diferent servcies			Not applicable	Medium	Medium	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	579048	Existing
12	Services Commissioned by the Voluntary sector	Investing and protecting social care servies that enables service users to be living indpendently and stay longer in their homes. This includes CILs and Nightingale services	Prevention / Early Intervention	Other	Physical Health and Wellbeing Servcies			Low	High	Medium	High	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	668649	Existing
13	Winter Pressures	The Winter Pressures funding will enable further reductions in the number of patients that are medically ready to leave hospital but are delayed because they are waiting for adult social care services. The expectation is that the spending is focused on reducing Delayed Transfers of Care (DTOC), helping to reduce extended lengths of stay, improving weekend discharge arrangements and speeding up the process of assessing and agreeing what social care is needed for patients in hospitals.	Intermediate Care Services	Reablement/Rehabilitation Services		Hours of Care	32,362.6	Medium	High	High	Low	Social Care		LA			Local Authority	Winter Pressures Grant	660842	Existing
8	Protection of Adult Social Care	This continues to maintain existing social care services, homecare and Care Homes services to meet the ever increasing demand from a growing population.	residential Placements	Care Home		Placements	1,390.5	Low	Medium	High	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	1292478	Existing

Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board: Richmond upon Thames

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including:
- Current performance issues to be addressed
- The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan
- Anticipated improvements from this work

National condition four requires health and social care partners in all areas to work together to agree a clear plan for managing transfers of care and to continue to embed the High Impact Change Model (HICM). The HICM identifies eight system changes which will have the greatest impact on reducing delayed discharges.

In Richmond, we are "established" or "mature" across most areas of the HICM and have plans in place to develop in four of the areas:

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Chg 1	Early discharge planning	Mature	Mature	
Chg 2	Systems to monitor patient flow	Mature	Mature	
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature	Mature	
Chg 4	Home first / discharge to assess	Established	Mature	
Chg 5	Seven-day service	Established	Mature	
Chg 6	Trusted assessors	Plans in place	Established	
Chg 7	Focus on choice	Established	Mature	
Chg 8	Enhancing health in care homes	Mature	Mature	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Richmond upon Thames

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative	
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	In 2018-19, there were 18,447 non-elective admissions for RCCG patients against the 2018-19 Operating Plan expectation of 18,379 non-elective admissions. Richmond CCG (RCCG) was 68 non-elective admissions above plan (0.37%) by March 2018. RCCG is working collaboratively with partners across acute, community and primary care, and the LBRuT to adopt a co-ordinated and systematic approach to understanding the cohort of people, who are at risk of admission, where this can be manged in the community and delivering a co-ordinated response.	**Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative	
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	12.2	Richmond has been set a DToC target for 2019-2020 of 12.2 delayed transfers of care per day (daily delays) from hospital. This includes people who are delayed for reasons attributable to the NHS, social care or both. Whilst a daily target has been set, performance will be monitored on a monthly basis. Richmond is part of a complex system with no acute hospitals in the borough, with the majority of residents being admitted to Kingston Hospital or West Middlesex Hospital. One of the main aims of the 2017-2019 BCF Plan was to reduce the number of DToCs and the BCF has contributed to Richmond making significant improvements in managing delays both in acute and non-acute (including mental health) settings. Over	**Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.**

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	341	352	In 2018-2019, there were 107 new permanent admissions into care homes, which exceeded the target of 105. Richmond has set a higher target for 2019-20 (110 new placements compared to 105 last year), taking into consideration demographic pressures of the borough. Richmond has a high population of residents over the age
	Numerator	105	110	
	Denominator	30,749	31,272	

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 2016 based Sub-National Population Projections for Local Authorities in England;

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.1%	91.7%	Richmond has over achieved the BCF targets set in 2017-2019 Plan, and a more stretching target of 91.7% has been set for 2019-2020. There has been a reduction in referrals to reablement, and this is something that is currently being reviewed to understand the causes. It is a priority for Richmond that people have access to the right
	Numerator	143	143	
	Denominator	166	156	

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 merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Richmond upon Thames

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes	Richmond upon Thames BCF Summary Plan 2019-20		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes			
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on? Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box) Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter? **Has funding for the following from the CCG contribution been identified for the area?** - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Yes			
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes			
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes			