Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 15 January 2020

Committee:
Health & Adult Social Care Overview and Scrutiny Committee

Date: Monday, 25 January 2021
Time: 10.00 am
Venue: VIRTUAL MEETING

Members of the public will be able to listen to this meeting by clicking on this link:
https://shropshire.gov.uk/healthandadultsocialcareoverviewandscrutinycommittee25january2021/

- **Please note that this meeting will be made available through Microsoft Teams Live Events - your device will need to meet the minimum specification as detailed on the Microsoft website at this link: Device Specification**
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- **Use the link at 10.00 am on the day of the meeting and click on 'Join as Guest'**
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You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Head of Legal and Democratic Services (Monitoring Officer)

Members of Health & Adult Social Care Overview and Scrutiny Committee

Karen Calder (	Tracey Huffer
Madge Shineton	Simon Jones
Roy Aldcroft	Heather Kidd
Gerald Dakin	Paul Milner
Kate Halliday	Dean Carroll
Simon Harris	Rob Gittins

Your Committee Officer is: amanda.holyoak@shropshire.gov.uk 01743 257714

AGENDA

1 Apologies for Absence

2 Disclosure of Pecuniary Interests

3 Minutes

To confirm the minutes of the meeting held on 9 November 2020, to follow

4 Public Question Time

To receive any questions or petitions from the public, notice of which has been given in accordance with Procedure rule 14. The deadline for this meetings is 10.00 am on Thursday 21 January 2021

5 Member Question Time

To receive any questions of which members of the Council have given notice. Deadline for notification is 5.00 pm on Wednesday 20 January 2021

6 Improved Better Care Fund (Pages 1 - 40)

To receive an update on the Government's arrangements for funding and consider examples of work arising from Start funding.

Report of Executive Director, Adult Services, Housing & Public Health attached

7 Joint Strategic Needs Assessments (Pages 41 - 62)

To receive an update on plans to update the Joint Strategic Needs Assessments for commissioning health services and services for children and young people with a special educational need or disability.

To receive a report and hear from the Co-Chairs of the Health and Wellbeing Board and Director of Public Health.

8 **Domiciliary Care** (Pages 63 - 74)

To receive a report and hear from the Director of Adult Services, Housing and Health and from Shropshire Partners in Care, to understand the impact of Covid-19 on the provision of domiciliary services and understand through the brokerage system patterns of demand, and how changing patterns influence strategy.

9 **Work Programme** (Pages 75 - 82)

To consider the proposed work programme for the Committee, attached

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Shropshire Council	Health and Adult Social Care Overview and Scrutiny Committee 25 January 2021	Item Public

Improved Better Care Fund (IBCF) and Projects

Responsible Officer Patricia Blackstock

E-mail: Patricia.blackstock@shropshire.gov.uk **Tel:** 01743 257931

1.0 Summary

1.1 The Health and Adult Social Care Overview and Scrutiny Committee requested an update report on the Improved Better Care Fund (IBCF) and plans for the future in light of future IBCF funding allocations.

1.2 This report will give a further update on the government's arrangement for funding IBCF and will summarise the council's current position. This is a follow up of the previous reports that were presented to HOSC on 21st September 2020 and 9th November 2020.

1.3 As requested by HASC there will be supplementary presentations giving

- A further update on the government's arrangement for funding IBCF and will summarise the council's current position.
- A summary of examples of work arising from START IBCF funding

1.4 As previously discussed, the IBCF grant provided the funds that enabled Shropshire Council to pilot a series of schemes that would:

- provide extra capacity within adult social care
- reduce pressures on the NHS and
- ensure that the local social care provider market is supported

Summary of IBCF schemes

1.5 Meeting Adult Social Care Need

- Increased number of FTE social workers in the community social work teams (generating savings through reviews)

- Additional hours for Brokerage to work on a Saturday and Sunday
- Dedicated CHC social workers
- To increase MH prevention work

1.6 Reducing Pressures on the NHS

- Additional bed based capacity - 19 x nursing beds for pathway 3
- Rapid Response Team
- Additional SW capacity in ICS
- To improve early discharge planning at Redwoods S117 discharge liaison worker
- Hospital based Carers Lead/Link Worker
- A and E/minor injuries pathway to include a social work perspective as people self refer
- Social Work Practitioner in MDT for frailty.

1.7 Ensuring that the Local Social Care Provider Market is Supported

4 x Provider Independent Assessors

2.0 Recommendations:

Committee members to:

- Note that the Council have sight of guidance which confirms the additional Improved Better Care Fund will be rolled forward into 2021/22.
- Note that this will leave a funding gap of £700,000. This presents a budget risk as the Council cannot commit funding to make up the shortfall from base budget.
- Note confirmation of termination of the following 2 contracts on 31st March 2021
    - Independent Care Home Assessor (ICHA) contract
    - 9x Discharge to Assess (D2A) beds contract.

3.0 Risk Assessment and Opportunities Appraisal

(NB this will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

3.1 The IBCF has enabled this Council to embark on many new initiatives, which have resulted in positive outcomes for people needing care and support on discharge from hospital.

3.2 The IBCF was originally a three year grant which tapered down over the three-year lifespan of the grant.

3.3 There was extensive consideration of the current schemes and their positive impact on Delayed Transfers of Care (DTOC)

3.4 Of the 13 schemes currently funded by the IBCF the majority deliver staffing posts and additional hours which lead to significant reductions in DTOC and reduced pressures on the NHS, and in order to identify which schemes need to be retained and which would be at risk, consideration was given to the impacts of stopping schemes that deliver staffing resources in comparison to those that do not. The following issues were considered:

- Team Managers' report that reductions in staffing levels in Social Work Teams and the Brokerage Team would create a significant reduction in current levels of productivity; assessments and sourcing care would be slowed down which would in turn lead to increases in DTOC.

- Staff are currently under significant pressure due to the pandemic and even small cuts in staffing would have a significant impact on the wider teams' resilience and wellbeing.

- Reductions in staffing levels would require formal redundancy processes and consequent redundancy costs would need to be met which would actually increase costs.

3.5 The Council undertook a thorough governance process and impact assessment which determined the schemes for termination. The schemes identified for termination were the Independent Care Home Assessor (ICHA) and 9x Discharge to Assess (D2A) beds contract.

The decisions were based on reducing the two schemes which are not directly related to staff employment and which would have less impact on DTOC. – The Council undertook a thorough governance process and impact assessments (See Appendices A and B) which determined the schemes for termination. The schemes identified for termination were the Independent Care Home Assessor (ICHA) and 9x Discharge to Assess (D2A) beds contract.

The Independent Care Home Assessor (ICHA)

The Shropshire ICHA scheme was developed to enable a patient to be discharged safely from hospital, therefore reducing delays to transfers of care of people between hospital and home.

Historically, many patients have remained as a delay in hospital whilst waiting for the Care Home Provider to come in and assess them. In Shropshire, the ICHA provided an independent assessment in their Trusted Assessor role. This meant the Care Home Providers were no

longer required to undertake this assessment saving time and enabling patients to be discharged from hospital safely in a timely manner.

The Independent Care Home Assessor's role has been significantly different since the start of Covid in March 2020. The Government guidance around Covid directed that there should be no hospital-based assessments.

Therefore, since March 2020, patients have been stepped down from the hospital setting without the need for an assessment on the ward. All assessments now take place outside of the hospital setting, in a planned way, which mitigates against the urgency of conducting assessments within the acute setting.

Consequently, the ICHA have been working differently by supporting partners in the integrated hub to process activities around patients discharge.

Discharge to Assess Beds (D2A)

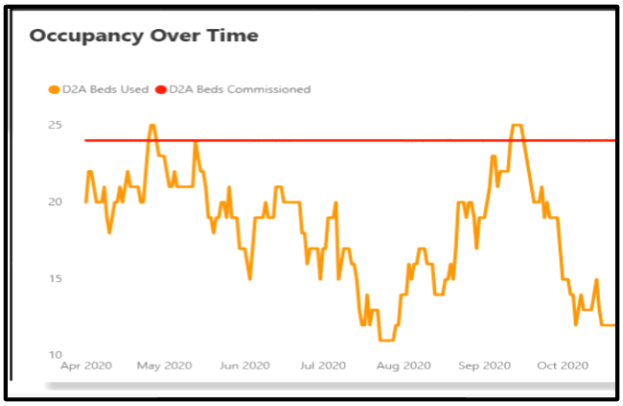
Shropshire Local Authority has a mature Discharge to Assess process which ensures that when a patient in a hospital bed is deemed as being medically fit for discharge, they are transferred from the acute hospital setting to the right destination, with the right support.

There are a total of 24 D2A beds of which 9 are funded through the IBCF investment. The D2A Beds enable patients to be discharged from hospital in a timely manner and allowed them to continue their rehabilitation in an appropriate bed based setting in the community, without having to use a hospital bed.

The Discharge to Assess (D2A) beds form a short term nursing service that focuses on rehabilitation and aims to:

- Reduce admissions and readmissions to hospital
- Support timely discharge from Hospital (SATH)
- Manage flow within the system
- Support the reduction of Delayed Transfers of Care (DToC'S).
- Provide an environment which helps people meet their rehabilitation and reablement potential and to become as functionally independent as possible,
- Provide a supportive care environment whereby some degree of recovery/recuperation can take place allowing a more accurate assessment of ongoing care needs

The charts below show there has been a significant underutilisation of the D2A beds. The IBCF funding allocation for 2021/22 will be insufficient to continue to fund all of the D2A beds. Given the underutilisation of these beds, the recommendation was presented to remove the 9 x IBCF funded D2A beds from the scheme on 31st March 2021. This would leave a total of 15 D2A beds.



3.6 The recommendations to cease the ICHA contract and to remove the 9 x IBCF funded D2A beds was presented to the Joint Commissioning Board on the 13th November 2020.

3.7 The recommendations were approved and subsequently confirmed by the Joint Commissioning Board on 2nd December 2020.

4.0 Financial Implications

4.1 Within the Spring Budget Statement 2017, it was announced that local authorities would receive additional Improved Better Care Funding (IBCF) over three financial years. Shropshire Council's allocation totalled £11,903,465. In the Autumn 2019 Budget Statement, it was announced that the 2019/20 allocations of the grant (Shropshire's allocation being £1,967,260) would be matched in 2020/21. In December 2020 it was announced that once again the grant would be matched for 2021/22 meaning that the Council has now received the grant for the last five financial years totalling £15,837,985.

4.2 The grant is short-term, time-limited, and is ring-fenced, and therefore does not change the Council's underlying funding gap.

4.3 The grant has been fully allocated over the five-year period, to new schemes and preventative services. The profile of the use of the grant over the first three years was set by the Council in a way that has smoothed the funding over this period.

4.4 As at 31st March 2020, the Council had spent £11,191,371 of the grant received in the first three years, leaving £712,094 to be added to the 2020/21 grant value to be spent within this financial year. As at quarter three we are projecting that we will utilise all of the grant, plus carry forward, by the end of the financial year.

4.5 The IBCF grant has enabled the Council to pilot innovative ways of working, which the Council would not have had the resources to pilot otherwise.

4.6 Anticipating that the grant would get rolled forward for 2021/22 as per the 2020/21 value Shropshire Council has worked hard to reduce budgeted expenditure for 2021/22 down to the grant level, assuming no carry forward and have set an expenditure budget of £1,967,260 as per the grant value.

4.7 Using the grant funding, Shropshire Council has piloted 33 schemes in total, starting with 26 in 2017/18. In 2019/20 the Council funded 24 schemes and there are now 13 schemes being funded in 2020/21. There will be 10 schemes that we have allocated funding for in 2021/22 which are required to continue in order to meet adult social care need.

4.8 In the medium term, the Council will be reliant on the outcomes of the Local Government Fair Funding Review to ensure that funding for adult social care is set on a more secure, sustainable, long-term basis in the future. It is hoped that the short-term funding for adult social care, which the Council is currently receiving, will be replaced by a long-term and ongoing grant, that is set at a level that addresses the increasing demand and cost of adult social care that the Council is facing. To date, there has been no assurance to the Council that this will be the case.

4.9 Should there be no further funding in 2022/23, and the Fair Funding Review is still outstanding, the Council will face the choice of ending all of the schemes or committing its own resources to the schemes, where it can be demonstrated that there is a need to keep the schemes operating. This would mean that alternative savings would need to be found elsewhere within the Council to be able to fund the schemes beyond March 2022.

4.10 The IBCF is monitored monthly by the Assistant Director of Adult Social Care and Finance Business Partner, who meet with each project lead to monitor the impact and performance of the schemes. The Local Government Association (LGA) and ADASS (Association of Directors for Adult Social Care) have made representation to central Government to stress the importance of long-term, sustainable funding for adult social care, and in particular have requested that the Government commits to

make the IBCF grant permanent so that the Council is able to make long-term plans.

5.0 Background

5.1 Since 2017 the council has implemented a series of new schemes funded by the IBCF grant to provide extra capacity within adult social care, reduce pressures on the NHS and ensure that the local social care provider market is supported.

5.2 Shropshire Council has piloted 33 schemes in total, starting with 26 in 2017/18. In 2019/20 we funded 24 schemes. There are now only 13 schemes remaining, and we face the prospect of ending a further two of these schemes if the grant gets rolled forward as per 2020/21 in order to balance expenditure to the anticipated £1,967,260 grant.

5.3 In a previous report to the committee, we evidenced that there have been some excellent outcomes from the IBCF pilot schemes; which have generated savings to the purchasing budget and enabled us to move some of the schemes into base budget funding.

5.4 As requested by the committee, this next section will spotlight the START service.

5.5 Rapid Response Team (START)

5.5.1 Reablement is a free time limited service which is used to support people who have either been discharged from hospital, or who are at risk of admission to hospital. The aim of reablement is to support people to regain lost skills, learn new ones, and increase ability and independence.

5.5.2 This IBCF investment enabled START to grow the service, in line with the increase in demand.

5.5.3 The investment provided additional staff within START which enabled the service to support more people to be discharged home from hospital

5.6 IBCF Investment outcome

5.6.1 People who have benefited from the START reablement programme, funded through the IBCF, have better outcomes and remain independent in the community for longer:

- Over 60% of people re-abled through START are discharged between 1 and 14 days. This shows that START takes people through reablement much faster.

- START provides better outcomes and leads to less dependence when compared to the market. 62% of people who had the benefit of START reablement where discharged with **no ongoing** services.

- This meant that there is significantly less financial pressure on the Adult Social Care budget for those being re-abled through START when compared to the market providers.

5.7 **Outcome of the combined IBCF investments schemes**

- By collectively implementing these innovative measures we have shown that we were able to support the reduction of DToC's and transform the service to get great outcomes for vulnerable people who needed to use our services.

- Between 2017 and 2018 we reduced delayed discharges from hospital by a staggering 98%

- In 2018 ICS won top prize and were **named the Team of the year** at the prestigious Social Worker of the Year Awards

- In 2019 we continued to exceed our targets in delayed transfers of care (DTOC)

6.0 Conclusion

6.1 Following presentation to the Joint Commissioning Board (JCB) on 13th November 2020, which outlined the IBCF funding shortfall of £700, 000, which equates to 2 IBCF schemes. The Council received final confirmation of approval to terminate 2 IBCF Schemes from Joint Commissioning Board Partners on 2nd December 2020.

6.2 Whilst we are awaiting confirmation of whether the IBCF grant will be rolled over into base budget, we are continuing to lobby Central Government via the LGA and ADASS to commit to make the IBCF grant permanent so that we make long term plans. We will also explore other means of addressing the shortfall through our continuing review of income and expenditure.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
None

Cabinet Member (Portfolio Holder) Cllr Dean Carroll

Local Member

Appendices

Appendix A - Impact asessment (E

Appendix B - Impact asessment (E

START Paper to HASC Jan 2021.pptx

IBCF Update January 2021.pptx

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Appendix A - Shropshire Council Equality and Social Inclusion Impact Assessment

IBCF Funded schemes review of impact of potential termination of ICHA Scheme

Part One Screening Record

A. Summary Sheet on Accountability and Actions

Name of proposed service change *Please use this box for the full formal name of the proposed service change, whether it is a policy, a procedure, a function, a project, an update of a strategy, etc. The term "service change" is used in this form as shorthand for whatever form the changes may take.*
Independent Care Home Assessors scheme started in May 2018, funded by IBCF and delivered through staff employed by ShropCom. The service employs assessors who are staff seconded from other roles, who deliver timely and quality assessments to Providers to enable patients to be discharged from hospital safely and quickly. The scheme was initially started to improve response times to delays created by providers being unable to do assessments in hospital wards in a timely manner and on occasion having to do more than one assessment. The scheme is part of a multi-scheme approach to reducing hospital DTOCs and the combined effect of all the schemes has been a reduction in DToC numbers and less delay in the waiting times of people awaiting discharge from hospital. The Trusted Assessors also has Provider benefits by fulfilling the CQC requirements for Providers to admit into their service. The proposed service change is that, due to funding from the IBCF team being insufficient to continue to fund the scheme that the scheme is stopped from March 2021

N**ame of lead officer carrying out the screening**
Deborah Webster/ Patricia Blackstock

Decision, review and monitoring

Decision	**Yes**	**No**
Part One ESIIA Only?	Yes	
Proceed to Part Two Full Report?		No

If completion of a Part One assessment is an appropriate and proportionate action at this stage, please use the boxes below and sign off as indicated. If a Part Two report is required, please move on to separate full report stage.

Actions to mitigate negative impact or enhance positive impact of the service change in terms of equality and social inclusion considerations
Impact on market - We have also sought to gauge the views of the Provider market to assess the impact of this new way of working and of the role of the ICHA role going forward.

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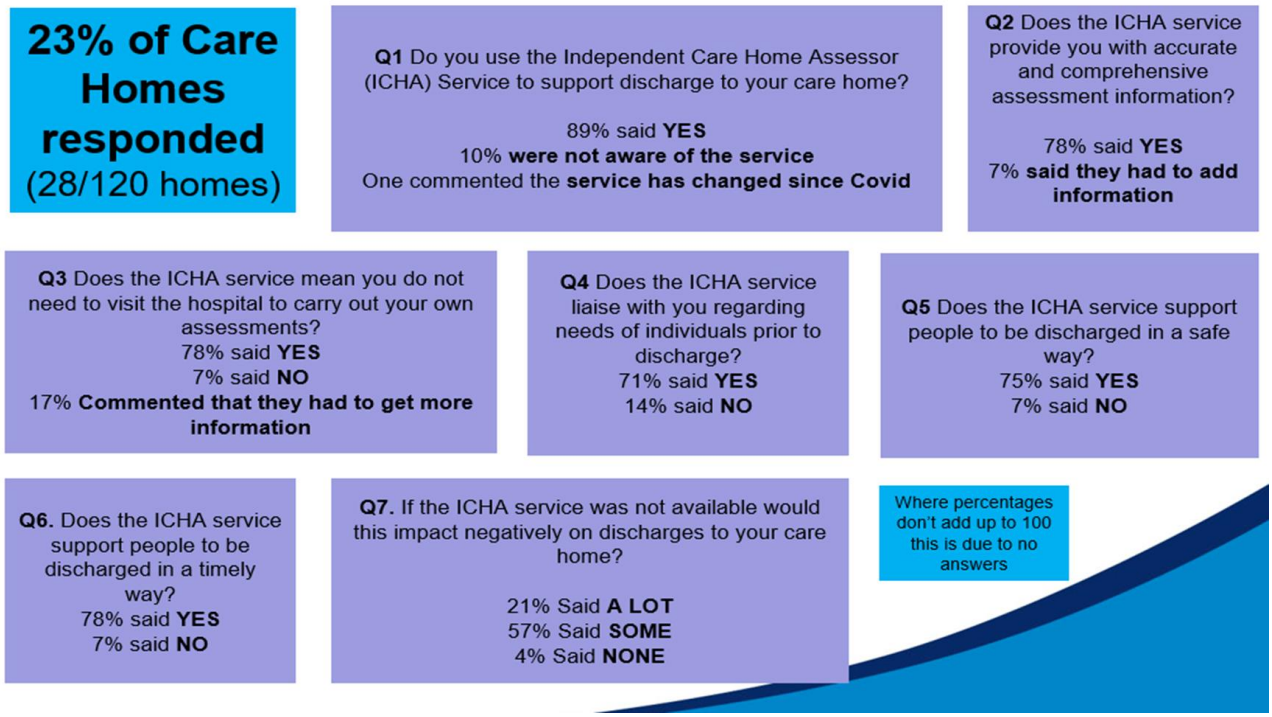

Provider feedback on the utilisation of the ICHA showed that 89% of those who responded to the survey had used the ICHA to enable them to save time on assessments and the service is valued by providers. Additionally, 78% of providers confirmed that they did not need to visit the hospital to undertake their own assessment. Comments from providers are included at the end of the document.

In considering whether there would be a negative impact on discharges to care homes if the ICHA were not available Providers responded as follows:
21% A LOT,
51% responding that there would be SOME negative impact.

The service is seen as a convenience by the providers who use it however some providers are still not aware of the service and the feedback received represents less than a quarter of the market.

Impact on system - It must be noted that Government guidance around Covid in March 2020, directed that there should be no hospital-based assessments. Therefore, since March 2020, patients have been stepped down from the hospital setting without the need for an assessment on the ward. All assessments now take place outside of the hospital setting regardless of who undertakes the assessment, in a planned way, which mitigates against the urgency of conducting assessments within the acute setting.

As a result of this, the Trusted Assessor role has been significantly different and since March 2020, they have been supporting partners in the integrated hub to process activities around patient discharge. **Consequently, the impact of the cessation of the scheme is significantly mitigated by this change in practice**

Impact on staff - staff are currently seconded from other roles within Shropcom therefore

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there is no redundancy impact as staff will return to substantive posts

Impact on patients – It is considered that every individual will still have an assessment in a timely manner and are not anticipated to experience any difference in service

Actions to review and monitor the impact of the service change in terms of equality and social inclusion considerations
This ESIIA has been created following the engagement and consultation with the providers in partnership with Shropshire Partners in Care (SPIC). Healthwatch – Healthwatch are currently in the process of completing a survey with patients It went live on 1/9/20 and will be ongoing until 31/12/20, the survey aims to gather views and experiences of patients who have been in hospital in the past 6 months and system partners are awaiting feedback. Consultation has not taken place with patients in the hospital setting as it is not considered an appropriate approach however it has also been considered that every individual will still have an assessment in a timely manner and are not anticipated to experience any difference in service

Associated ESIIAs
This is the initial ESIIA for this project consultation and will be reviewed and updated following final decision on next year's funding and discussion at the Joint commissioning board

Scrutiny at Part One screening stage

People involved	**Signatures**	**Date**
Lead officer carrying out the screening	Deborah Webster *Patricia Blackstock*	13.10.20
*Any internal support** N/A		
*Any external support***	Shropshire Partners in C4re independently conducted the provider survey	

This refers to other officers within the service area

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B. Detailed Screening Assessment

Aims of the service change and description
The change to the service would be to withdraw the separate Independent assessment service and return the responsibility for the assessments from 1st April 2021 to the care home managers.

Intended audiences and target groups for the service change
All residents in Shropshire who could have had a period of time in hospital and needs identified as going into a care home and are assessed as medically fit for discharge from hospital would receive an assessment and are eligible for Council funded care home placements. However It is expected that service users and families would not to see a difference to the service they receive with the revised arrangements. In the current circumstance due to Covid all assessments are away from the wards so impact will be low on patients but higher on providers.

Initial assessment for each group

Please rate the impact that you perceive the service change is likely to have on a group, through inserting a tick in the relevant column. Please add any extra notes that you think might be helpful for readers.

Protected Characteristic groups and other groups in Shropshire	**High negative impact** *Part Two ESIIA required*	**High positive impact** *Part One ESIIA required*	**Medium positive or negative impact** *Part One ESIIA required*	**Low positive or negative impact** *Part One ESIIA required*
Age (please include children, young people, people of working age, older people. Some people may belong to more than one group e.g. child for whom there are safeguarding concerns e.g. older person with disability)				✓
Disability (please include mental health conditions and syndromes including autism; physical disabilities or impairments; learning disabilities; Multiple Sclerosis; cancer; HIV)				✓
Gender re-assignment (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				✓
Marriage and Civil Partnership (please include associated aspects: caring responsibility, potential for bullying and harassment)				✓

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Pregnancy & Maternity (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				
Race (please include ethnicity, nationality, culture, language, gypsy, traveller)				
Religion and belief (please include Buddhism, Christianity, Hinduism, Islam, Judaism, Nonconformists; Rastafarianism; Sikhism, Shinto, Taoism, Zoroastrianism, and any others)				
Sex (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				
Sexual Orientation (please include associated aspects: safety; caring responsibility; potential for bullying and harassment)				
Other: Social Inclusion (please include families and friends with caring responsibilities; people with health inequalities; households in poverty; refugees and asylum seekers; rural communities; people for whom there are safeguarding concerns; people you consider to be vulnerable)				

Comments from providers in regards the service:

'We are not always able to go and assess and having this service enables individuals to access our services in a more timely manner '

'The nurses change so much and use agency so that when we ring for information it is different depending on who you talk to, the IA can read thorough notes and find what we need and lease with physio and OT'

'This would mean more traffic through the hospitals and especially in these times would be a concern.'

'At present time with COVID 19 it would mean I would have to visit hospital setting then come back to care setting'

'Since in the inception of ICHA it has been easy to get information prior to admission of a resident. That one point of call is very important. Unlike calling the ward, you never either to speak to the exact person who cares for the patient or even in some case a meaningful information. Communication prior to admission has been very good with ICHA.'

'The ICHA is essential to facilitate discharges from hospital in a timely way'

'Preventing having to go to hospital is the main reason but we still phone up the ward as a handover'

'My experience of the ICHA team is a very positive one. I have liaised with them a lot in the past, around potential discharges they have assessed on my behalf, to residents who have been admitted to the hospital from our home, gathering information and any changes in their condition. It can be difficult to speak with the ward due to workload etc, so it is great to have them on hand. It is also positive when they call the home post-discharge to ensure that everything is ok and that the resident is safe and happy'

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Appendix B - Shropshire Council Equality and Social Inclusion Impact Assessment

IBCF Funded schemes review of impact of potential termination of 9 X D2A beds

Part One Screening Record

A. Summary Sheet on Accountability and Actions

Name of proposed service change *Please use this box for the full formal name of the proposed service change, whether it is a policy, a procedure, a function, a project, an update of a strategy, etc. The term "service change" is used in this form as shorthand for whatever form the changes may take.*
Discharge to Assess (D2A) beds enable patients to be discharged from hospital in a timely manner and allow them to continue their rehabilitation in an appropriate setting, without having to use a hospital bed. Shropshire Council currently fund 24 D2A beds, 9 of these are paid form from the IBCF grant. Reduction in the grant funding for 21/22 has put these beds at risk. This impact assessment will look at who is impacted by the loss of these beds and what the impact will be on staff and the system The scheme is part of a multi-scheme approach to reducing hospital DTOCs and the combined effect of all the schemes has been a reduction in DToC numbers and less delay in the waiting times of people awaiting discharge from hospital. The Trusted Assessors also has Provider benefits by fulfilling the CQC requirements for Providers to admit into their service. The proposed service change is that, due to funding from the IBCF fund being insufficient to continue to fund 9 of the beds that the scheme is stopped from March 2021 or that funding be found from system partners for the continuation of the 9 beds if the risks and impacts are considered to be too high if they are terminated.

N**ame of lead officer carrying out the screening**
Deborah Webster/ Patricia Blackstock

Decision, review and monitoring

Decision	**Yes**	**No**
Part One ESIIA Only?	Yes	
Proceed to Part Two Full Report?		No

If completion of a Part One assessment is an appropriate and proportionate action at this stage, please use the boxes below and sign off as indicated. If a Part Two report is required, please move on to separate full report stage.

Actions to mitigate negative impact or enhance positive impact of the service change in terms of equality and social inclusion considerations
Impact on market - The nine beds currently considered to be at risk are provided by three

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separate organisations who are currently contracted until the end of March 2021. The contract can be extended if required. Providers who are delivering the service are currently not expecting the contract to be extended however would be willing to do so if this is required. Consequently, the impact on the providers should currently be anticipated by them due to the length of the contract. other providers are unlikely to be impacted by this decision

Impact on system - The 9 D2A beds that are funded through the IBCF are utilised for EMI and cognitive impairments assessments and are needed for individuals with complex needs. In some cases, use of these beds has prevented the need for people to be sectioned so the loss of them could also impact Redwoods.

- In summary although there is broader bed capacity across the system the loss of these D2A beds would result in an impact to System partners, to the Council and to individuals, and will potentially result in:
- Increased DToC numbers
- Reduced health outcomes (decompensation) for patients who will remain in hospital for longer, when there is no requirement for them to be in an acute hospital bed.
- Increase in the risk of hospital acquired infection
- Increase the pressure on hospital beds due to the impact of Covid/flu/winter surge
- Reputational damage to the Council and CCG and the risk of increased scrutiny with potential financial penalties.

Impact on staff – Due to the fact that providers should be fully prepared for contract cessation the impact on staffing with providers is unlikely to be significant. The impact on staff within the system however is likely to be reduced bed resources and internal staff may have to spend more time sourcing beds..

Impact on patients - There is the potential that patients will see a delay in discharge times if there are less discharge to assess beds in the system. It is also possible that there will be more significant delays for people with complex needs as the IBCF money pays for beds that focus on cognitive and EMI requirements

Actions to review and monitor the impact of the service change in terms of equality and social inclusion considerations

Healthwatch – Healthwatch are currently in the process of completing a survey with patients It went live on 1/9/20 and will be ongoing until 31/12/20, the survey aims to gather views and experiences of patients who have been in hospital in the past 6 months and system partners are awaiting feedback.

Consultation has not taken place with patients in the hospital setting as it is not considered an appropriate approach.

Associated ESIIAs

This is the initial ESIIA for this project consultation and will be reviewed and updated following

final decision on next year's funding and discussion at the Joint commissioning board

Scrutiny at Part One screening stage

People involved	Signatures	Date
Lead officer carrying out the screening	Deborah Webster *Patricia Blackstock*	13.10.20
*Any internal support** N/A		
*Any external support***		

This refers to other officers within the service area

B. Detailed Screening Assessment

Aims of the service change and description
The change to the service would be to withdraw the separate Independent assessment service and return the responsibility for the assessments from 1st April 2021 to the care home managers.

Intended audiences and target groups for the service change
All residents in Shropshire who could have had a period of time in hospital and needs identified as going into a care home and are assessed as medically fit for discharge from hospital would receive an assessment and are eligible for Council funded care home placements.

Initial assessment for each group

Please rate the impact that you perceive the service change is likely to have on a group, through inserting a tick in the relevant column. Please add any extra notes that you think might be helpful for readers.

Protected Characteristic groups and other groups in Shropshire	High negative impact *Part Two ESIIA required*	High positive impact *Part One ESIIA required*	Medium positive or negative impact *Part One ESIIA required*	Low positive or negative impact *Part One ESIIA required*
Age (please include children, young people, people of working age, older people. Some people may belong to more than one group e.g. child for whom there are safeguarding concerns			✓	

Page 3

e.g. older person with disability)				
Disability (please include mental health conditions and syndromes including autism; physical disabilities or impairments; learning disabilities; Multiple Sclerosis; cancer; HIV)				
Gender re-assignment (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				
Marriage and Civil Partnership (please include associated aspects: caring responsibility, potential for bullying and harassment)				
Pregnancy & Maternity (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				
Race (please include ethnicity, nationality, culture, language, gypsy, traveller)				
Religion and belief (please include Buddhism, Christianity, Hinduism, Islam, Judaism, Nonconformists; Rastafarianism; Sikhism, Shinto, Taoism, Zoroastrianism, and any others)				
Sex (please include associated aspects: safety, caring responsibility, potential for bullying and harassment)				
Sexual Orientation (please include associated aspects: safety; caring responsibility; potential for bullying and harassment)				
Other: Social Inclusion (please include families and friends with caring responsibilities; people with health inequalities; households in poverty; refugees and asylum seekers; rural communities; people for whom there are safeguarding concerns; people you consider to be vulnerable)				

Shropshire Counci

START

hort Term Assessment and Reablement Team

Mrs Amy Tipton - Registered Manager

Mr Andy Begley - Nominated individual

The purpose of this presentation is to show how IBCF funding enhanced the START service and will provide some examples

START (Short Term Assessment and Reablement Team) is Shropshire Council's inhouse domiciliary care provider which supports people to regain lost skills, learn new ones, and generally increase their ability and independence.

START offers

- A free Short-term assessment and re-enablement service (up to six weeks) to people who are discharged from hospital and to prevent admission to hospital.
- Support to Covid Positive people in their own homes.

START work with people, in their own home utilising a person centered, strength and asset based approach.

IBCF Funding Provided Additional Staffing

START Provision Pre IBCF

- Service Manager
- Registered Manager
- Countywide Organiser
- Assistant Organiser
- 6 Countywide Support Workers
- Admin officer

START Provision After IBCF Investment

- 1 Service Manager
- 1 Registered Manager
- 1 Countywide Organiser
- 2 Assistant Organiser
- 41 Countywide Support Workers
- 1 Admin officer
- 1 Admin Apprentice
- 3 Senior Support Workers

Creation of new Posts to ensure the service remains safe and CQC compliant

100% increas
to manage increa
referral activi
review servi
capacity and
rota's

58% increa
To provide perso
and support to
their own h

51% Total staffi
Increase, contribu
to the manage
of 350% increa
activity within

START Provision Pre IBCF

- A reablement service Countywide
- An Admission Avoidance Service
- Acknowledgement/outcome of all referrals within 1 hour
- Service could start within the same day
- START supported up to 20 people daily

START Provision After IBCF Investment

- Provide domiciliary care and or/bridging services that will facilitate prompt and timely discharges from hospital
- Provide short-term, individual and holistic rehabilitation programmes to help people improve their independence with everyday tasks such as washing, dressing, walking and eating
- Assess and Provide low level equipment through their specially trained Trusted Assessors
- Provide specialist Social Work/Occupational Therapist service in line with the Care Act.
- Develop time limited holistic independence plan enabling individuals and their carers to remain as independent as possible, for as long as possible
- Acknowledgement/outcome of all referrals within 20 minutes
- Service can commence within 2 hours at the persons home
- Provide advice, information and signposting Undertake Assessments for Care Act Eligibility

BCF Funding Has Enabled START To Support More People Leading To More Positive Outcomes

- Effective and efficient integrated partnership working
- Reduction in A&E attendances
- Reduction in LOS
- Significant reduction in the total numbers of Delayed transfer of Care for Shropshire patients
- Improves ambulance availability
- Reduction in inappropriate hospital admissions
- Improved health outcome for patient
- Reduction in the risk of hospital acquired infection
- Meets preference for home care over hospital
- Enhances patient choice
- Psychological and social benefits of comfort own home
- Reduction in functional disturbance
- Increased numbers of acute admissions prevented

a these programmes of care

- Hospital Discharge – Reablement
- Admission Avoidance countywide
- Bridging

Case Study Mr S – START 3 Week Complex Reablement Programme

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tion.
rged from
al to

s alone
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ds due to
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Week 1

Discharged home with 3 Care calls daily and some equipment

START Workers complete first call

IBCF Investment enabled Therapist to support pathway

IBCF Investment enabled START to train staff to be Trusted Assessors

START creates person centred reablement programme

- Make his own meals
- Manage his own personal care
- Confidence and understanding with new medication's

START makes Referrals to
Red Cross
Age UK
for shopping and cleaning.
Consent for community pendant alarm

START Trusted as
visits, assesses, l
provides further
equipment on sa

Week

Therapist has clinical oversight and monitors Mr S progress towards reablement goals

START First review
Mr S making excellent progress

Reablement calls reduced to 2 calls daily

Week 3

START Second review
Mr S making continues to make excellent progress

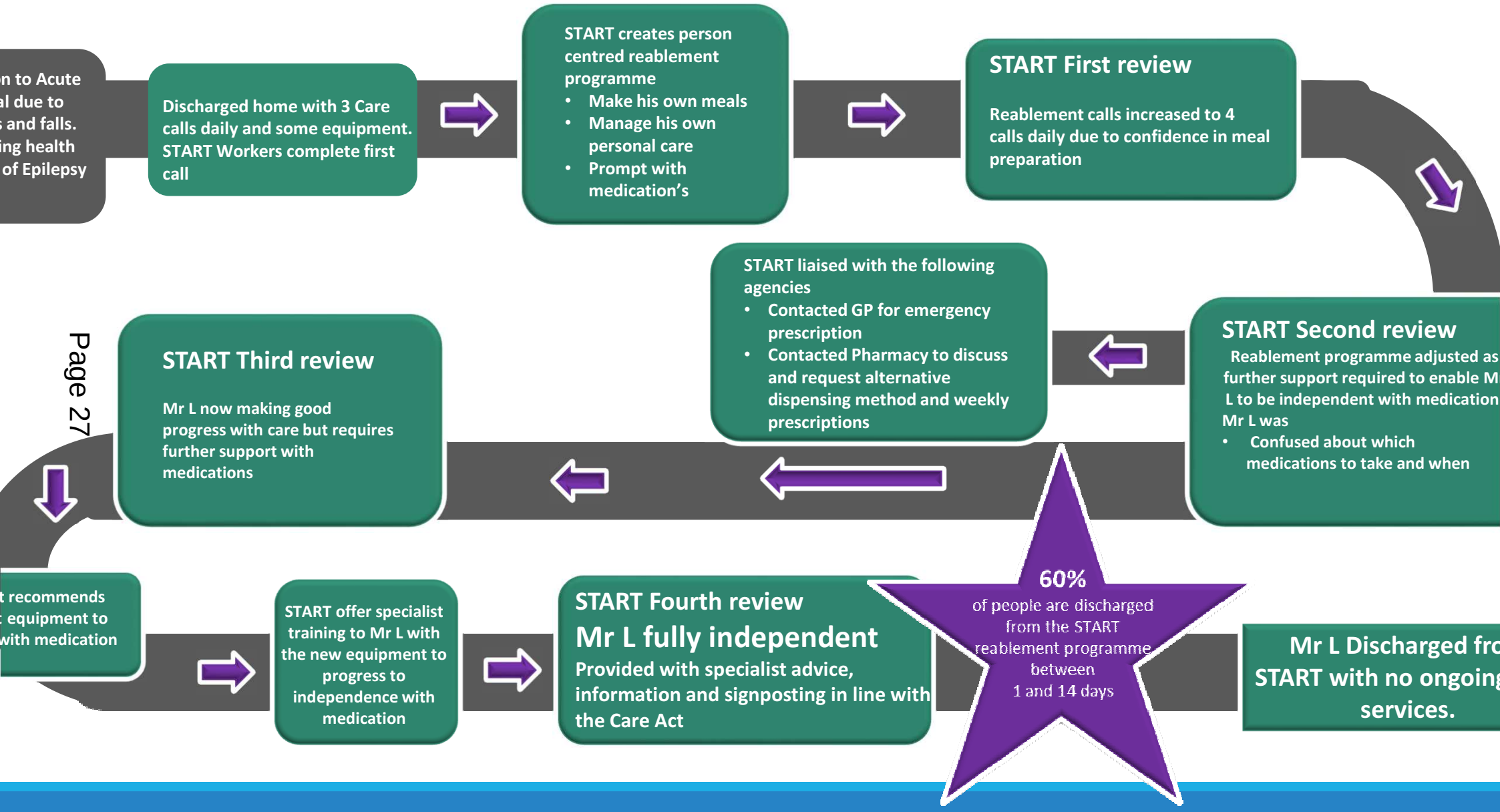
Reablement calls reduced to 1 calls daily

START Third review
Mr S fully independent
Provided with specialist advice, information and signposting in line with the Care Act

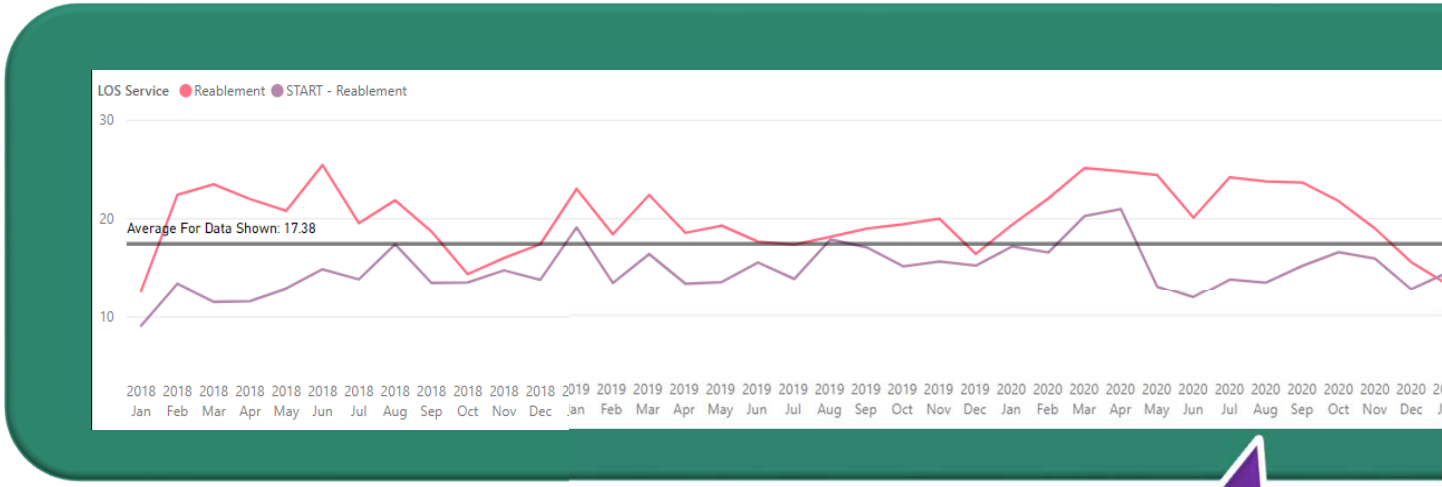
62% of people who complete a reablement programme with START were discharged with **no on-going services**

Mr S Discharged fro
START with no ongoing
services.

Mr L – Case Study START-Reablement programme



60%
of people are discharged from the START reablement programme between 1 and 14 days



IBCF Funding Has Enabled More People to have the benefit of START reablement leading to more positive outcomes

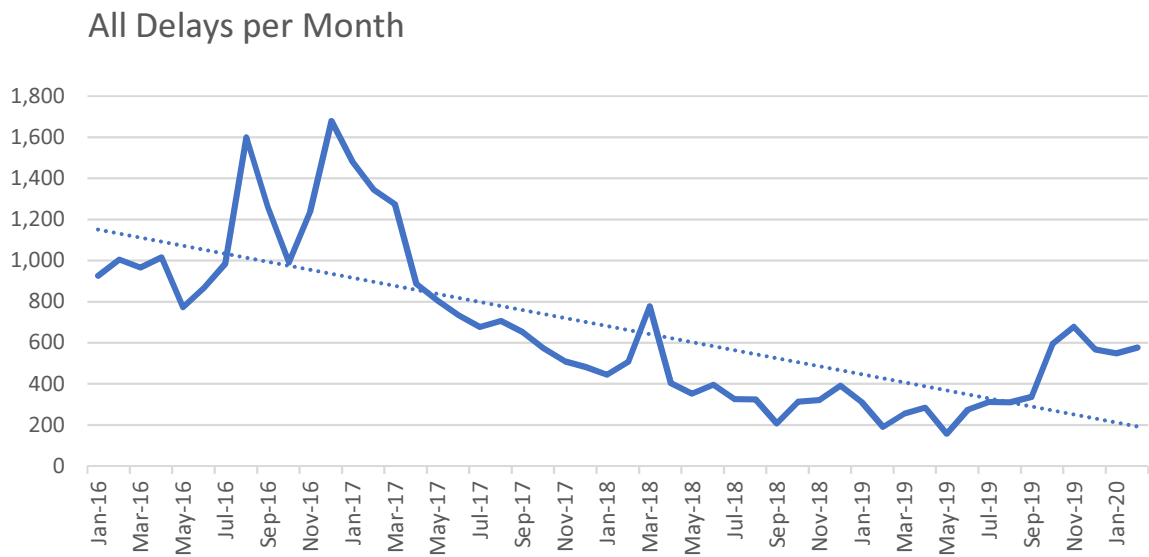
62%
of people who complete a reablement programme with START were discharged with **no on-going services**

There has been a 350% increase in the total number of people being supported within START
71 being supported
8/01/21

IBCF Funding supported the significant reduction in DTOC

elayed transfer of care (DTOC)is when an adult (18+ years) patient is ready to go home but is still occupying a pital bed.

e IBCF funding contributed to a significant reduction in the total numbers of Delayed transfer of Care for opshire patients, and this reduction is ongoing.



Meet some of the Award Winning START Team

START were voted Adult Social Care and Housing Team of Year 2019

Please note this photo was taken P
days.

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Update Report to Health and Adult Social Care Overview and Scrutiny Committee

IBCF update

This is a follow up on the previous reports that were presented to HASC on 21 September 2020 and 9 November 2020.

As requested by HASC this report will;

- Give a further update on the government's arrangement for funding IBCF and will summarise the council's current position.

- There will also be a supplementary presentation with a summary of examples of work arising from START IBCF funding.

Reminder of current IBCF schemes

We have aligned our IBCF schemes to

Provide Extra Capacity within Adult Social Care	Reduce Pressures on the NHS	Ensure that the Local Social Care Provider Market is Supported
Increased number of social workers in the community social work teams	Social Worker in A and E	4 x Provider Independent Assessors
Additional hours for Brokerage to work at weekends	Hospital based Carers Lead	
Dedicated CHC social workers to support MH prevention work	Additional SW capacity in ICS	
	Social Worker linked to frailty.	
	Enhance Rapid Response Team (START)	
	Additional bed based capacity 19 x nursing beds (D2A)	
	Discharge liaison worker at Redwoods S117	

The Committee is requested to

- Note that the Council have sight of guidance which confirms the additional Improved Better Care Fund will be rolled forward into 2021/22.

- Note that this will leave a funding gap of £700,000. This presents a budget risk as the Council cannot commit funding to make up the shortfall from base budget.

- Note confirmation of termination of the following 2 contracts on 31st March 2021
    - Independent Care Home Assessor (ICHA) contract
    - 9x Discharge to Assess (D2A) beds contract

Analysis of IBCF Contracts

There was extensive consideration of the IBCF schemes and their positive impact on Delayed Transfers of Care (DTOC)

Of the 13 schemes funded by the IBCF, the majority deliver staffing posts and additional hours. In order to identify which schemes were to be retained the Council undertook a thorough governance process and impact assessment which determined the schemes for termination.

Termination Process

The following 2 contracts will be terminated on 31st March 2021

- Independent Care Home Assessor (ICHA) contract
- 9x Discharge to Assess (D2A) beds contract

Following presentation to the Joint Commissioning Board on the 13th November 2020 the recommendations for termination for both of these schemes were approved.

This decision was confirmed by the Joint Commissioning Board on 2nd December 2020.

ct Assessment The Independent Care Home Assessor (ICHA)

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Provider Feedback

23% of Care Homes responded (28/120 homes)

Q1 Do you use the Independent Care Home Assessor (ICHA) Service to support discharge to your care home?

89% said **YES**
10% **were not aware of the service**
One commented the **service has changed since Covid**

Q2 Does the ICHA service provide you with accurate and comprehensive assessment information?

78% said **YES**
7% **said they had to add information**

Q3 Does the ICHA service mean you do not need to visit the hospital to carry out your own assessments?
78% said **YES**
7% said **NO**
17% **Commented that they had to get more information**

Q4 Does the ICHA service liaise with you regarding needs of individuals prior to discharge?
71% said **YES**
14% said **NO**

Q5 Does the ICHA service support people to be discharged in a safe way?
75% said **YES**
7% said **NO**

Q6. Does the ICHA service support people to be discharged in a timely way?
78% said **YES**
7% said **NO**

Q7. If the ICHA service was not available would this impact negatively on discharges to your care home?

21% Said **A LOT**
57% Said **SOME**
4% Said **NONE**

Where percentages don't add up to 100 this is due to no answers

Impact of termination

The Government guidance around Covid in March 202 directed that there should be no hospital-base assessments. Therefore, since March 2020, patien have been stepped down from the hospital settin without the need for an assessment on the ward.

All assessments now take place outside of the hospit setting regardless of who undertakes the assessment, a planned way, which mitigates against the urgency conducting assessments within the acute setting.

As a result of this, the Trusted Assessor role has been significantly different and since March 2020, they have been supporting partners in the integrated hub to process activities around patient discharge.

The impact of the cessation of the scheme is mitigated by change in practice and Government guidance around Covid.

mpact Assessment Discharge to Assess Beds (D2A)

Impact of termination

The 9 D2A beds that are funded through the IBCF will be terminated on 31st March 2021.

Impact on staff

Providers should be fully prepared for contract cessation and the impact on staffing with providers is unlikely to be significant.

Actions to review and monitor the impact of the service change in terms of equality and social inclusion considerations

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Healthwatch completed a survey with patients from 01/09/20 to 31/12/2020.

The survey aims to gather views and experiences of patients who have been in hospital in the past 6 months. Feedback and learning will be given to system partners.

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Health and Adult Social Care Overview and Scrutiny Committee **25 January 2021**	**Item** **Public**

Health and Adult Social Care Overview and Scrutiny Committee
Shropshire Joint Strategic Needs Assessment

Responsible officer
Rachel Robinson, Director of Public Health
rachel.robinson@shropshire.gov.uk

1.0 Summary

1.1 This paper presents to the Health and Adult Social Care Overview and Scrutiny Committee an update on Shropshire's JSNA; progress to date, future direction of the JSNA and revised timescales following a pause in progress due to COVID-19.

2.0 Recommendations

2.1 Committee members to:

- Endorse the current JSNA work programme, proposed JSNA refresh and move to a place based JSNA attached as **appendix 1**
- Note the current priorities attached as **appendix 2**
- Note the proposed work programme and resourcing

3.0 Background

3.1 The Local Government and Public Involvement in Health Act (2007) placed a duty on local authorities and PCTs (now CCGs) to undertake a JSNA, in three-yearly cycles. Local authorities and CCGs have equal and joint duties to prepare JSNAs and Joint Health and Wellbeing Strategies, through the health and wellbeing board. In practice, in Shropshire, these duties have been passed to Public Health to deliver on behalf of the Health and Wellbeing Board, leadership for the JSNA sits with the Director of Public Health 1.

3.2 The JSNA seeks to identify current and future health and wellbeing needs in the local population and identify strategic priorities to inform commissioning of services

[1] **Further guidance:** JSNA Toolkit: a springboard for action and Statutory guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

based on those needs. These priorities in turn inform the Health and Wellbeing Strategy, a key document as a basis for commissioning health and social care services in the local area. The JSNA aims to:

- Define achievable improvements in health and wellbeing outcomes for the local community;
- Target services and resources where there is most need;
- Support health and local authority commissioners;
- Deliver better health and wellbeing outcomes for the local community;
- Underpin the choice of local outcomes and targets.
- Importantly, the JSNA is not an end in it itself, rather a framework of tools that are produced to inform commissioning.

3.3 Shropshire's original JSNA was completed in 2008/09, a further review was published in 2009/10 and the most recent report was published in July 2012. These JSNA reports were structured in four key areas following a Marmot approach: Starting Well, Living Well, Aging Well and Vulnerable groups. Within those groups several priorities were identified and described following a review of local intelligence and stakeholder engagement. Subsequently, updates have been published on the Shropshire Together webpages, giving updated profiles and needs assessments for key themes http://www.shropshiretogether.org.uk/jsna/.

3.4 Changes to the health and social care landscape, the requirement to produce an updated Health and Wellbeing Strategy and emerging priorities meant in 2019 there was an urgent need to update the JSNA, deliver several theme-based needs assessments and consider a new approach to the JSNA moving forward.

4 Phased of the JSNA

4.1 Proposals for a refreshed JSNA were taken to Shropshire Council Directors and the Health and Wellbeing Board during July and September 2019 to move the JSNA to a new approach which whilst meeting immediate needs to refresh the JSNA priorities and deliver on urgent and outstanding needs assessments. An underpinning principle of any new model upon which the emerging STP, Councils approach to place-based working, social care, children's, public health and community services transformational models within Shropshire is based is the differentiation made between service delivery at four spatial levels, namely STP, Local Authority, Primary Care Network and Neighbourhood/Place Plans.

- Phase 1: Between July and December 2019, to complete three specific outstanding needs assessment to meet priorities identified by the Health and Social Care system and Shropshire Council; Ageing Well; Older Peoples Needs Assessment (Care Closer to Home), MSK and SEND.

- Phase 2: Running parallel to phase 1, through the Autumn, Public Health to lead a piece of work with the Health and Wellbeing Board to identify health and wellbeing priorities for Shropshire moving forward. This would have strong synergies with the priorities already identified within the Corporate Plan, the STP, CCG priorities and the DPH annual reports, providing an interim position statement for the local system.

- Phase 3: To move towards a JSNA place based JSNA approach. This would be a tiered approach, depending on resources. Step 1 would be to ***agree geographies***, the proposal is that these would be aligned to the Place Plan Areas building on *Shropshire Councils place plans* and *Community and Rural Strategy*. Step 2 would be to pull together data sources into one place, using the work already existing through the IT transformation and the STP Population Health Management programme. This could include an ***online profiling tool***. The tool would have a variety of features including the ability to view data in mapped form. The web-based tool should provide a useful addition to the evidence base for the commissioning of place-based services. The final step would be to produce detailed needs assessments for each locality, ***engaging with stakeholders and communities*** in each area to understand local needs and develop recommendations to address those needs moving forward.

4.2 To support the delivery of the JSNA and ensure correct governance and oversight. The proposal is to develop a simple governance structure for the JSNA process, responsible for putting together proposals for the JSNA, delivery of the JSNA and reporting to the health and wellbeing board. This would include a virtual strategic group to develop the direction of travel, agree priority areas and sign off the work programmes and a working a working group to practically support and write elements of the JSNA. This would require the pooling of analysts to create the geographies, profiles and needs assessments aligned to the population health agenda.

4.3 Information would be shared via the HWB website. Shropshire Council would maintain the site, but partners have a collective responsibility to input and keep the information up to date.

4.4 The benefits of a place-based approach to the JSNA moving forward were approved by HWB and directors.

5.0 Initial Timeline and Resources 2019/2020

5.1 Take a phased approach - Respond to the existing requests for themed needs assessment, a strategic overview and profiling data, but contextualise this as part of an evolving offer that will extend beyond basic health profiles and specific

localities. Positioning this as the first of a number of iterations and phases which build over time is critical. Therefore any material produced now needs to be able to contribute to future needs. By responding reactively, we risk having to work with what we have, which will perhaps tilt any outputs to be more health based and towards certain geographies, rather than truly joint.

1. Initially the focus will be dealing with several urgent outstanding three Health Needs Assessments. These will be a light touch, pragmatic approach within current limited resources. The aim was to complete these by December 2019.

2. At the same time a piece of work will be considered with Health and Wellbeing Board partners to consider strategic priorities based on the information available from DPH annual reports, STP, Public Health Profiles (fingertips) and profiling data through a local workshop. It was anticipated this would be undertaken and completed during Autumn 2019.

3. March 2019 onward –The ambition initially, was in 2019 was to have in place the new place-based approach, ready to launch by March 2020 with full delivery within 18 months to two years depending on resource capacity.

5.2 Put the JSNA front and centre - Within Shropshire the JSNA should be established as the single and accountable reference point for this work, linking directly to the population health management work as the local source of evidence. This strengthens the role of the JSNA and HWB Strategy.

5.3 Agree a coherent set of geographies - These geographies would form the basis of the JSNA and STP evidence base to 2020/21. The proposal is that these are based on Council Place Plan Areas to align to other strategies and data collection. This will be agreed by partners.

5.4 Pool analytical resource - The most effective way to deliver intelligence which is useful for health, wellbeing and social care, indeed all stakeholders who would draw from a shared intelligence base, is to commit analytical resource from individual partners to a collaborative exercise and create a truly joint approach to working towards joint outcomes. This will involve conversations with partners and internally.

1. Invest in Modelling expertise - To understand future needs, demands and potential savings areas through scenario modelling. This would include modelling for future demographic, planning and economic changes and their impact on workforce planning and service provision. The minimum could be a desktop exercise using readily available data, with limited engagement and basic interactive modelling tools. The more complex models could involve significant engagement and development of bespoke

locally adaptive model tool for the stakeholders. This might be an area of work that would require additional support externally and links to conversations already taking place in Shropshire, utilising external expertise and methodologies.

2. JSNA work programme - Develop an annual work programme driven by place-based need, which has the ability to scale up and show community, PCN, locality county wide need. Profiles are then developed over the next 1-2 years, building up detail and content over time.

6.0 Update, Next Steps and Revised Timescale 2021

6.1 Due to the COVID-19 pandemic, resources were diverted to deal with the emerging issues and capacity pressures from February 2020. By March 2020 Public Health was operating in full business continuity mode with other service areas following in April 2020 resulting in the pausing of the JSNA place based work programme, however, mapping and monitoring of vulnerable communities and services has taken place to support the COVID-19 response.

6.2 A update on progress prior to COVID and the next steps is described below:

- The Initial focus of addressing the resetting strategic priorities was complete in November 2019 to January 2020 and presented back to the HWB.

- The urgent MSK, Older People and SEND Health Needs Assessments were partially complete. The first two reports were finalised, and a structure agreed for the SEND report, however due to the pandemic further work was paused. As at December 2020, it has been agreed to restart the SEND JSNA bringing in resources from business intelligence and commissioning an external provider to complete the needs assessment report and engagement. The aim is to complete this now in the Spring 2020.

- April 2021 onward – The ambition is to restart the JSNA place based programme to have in place the new place-based approach, ready to launch by September 2021 with full delivery within 18 months to two years. The pace of the place JSNAs will depend on resource capacity; delivery of each need's assessment requires a small team. The ambition will be to prioritise the Counties 18 Place Plan areas and divide the County into 3 waves of JSNAs. In parallel developing a new online profiling tool led by the Business Intelligence team to enables users to profile a variety of different geographical areas but was developed particularly with the JSNA in mind.

- Leadership will remain with the Director of Public Health while working closely with system partners in the CCG to align the Population Health Management Needs and the Associate Directors for Business Intelligence, Communities and Head of Partnerships to align to the data infrastructure and community engagement elements. Engagement and leadership from local members, the community and voluntary sector and key stakeholders are critical to the process and will be a key element of Governance Structures.

- Resources to support the role out of the programme will be through the Business Intelligence Team within Shropshire Council, including the Public Health Intelligence Team and a new Joint Population Health post with the CCG working with the system

6.3 ***Key timescales*:***

January 2021 – Restart the SEND JSNA

January 2021- March 2021 – Planning and detailed resource mapping. Update of Prioritisation matrix (appendix 2). Development of profiling tool.

March 2021 - Update and prioritisation matrix to the HWB Board

May 2021 – Formal restart of the JSNA Place Based Programme

*subject to change in agreement with HWB

7.0 Financial and capacity Implications

In response to the above, it is proposed that a single, coordinated approach is taken to the development of place-based profiles and needs assessments which in turn support place-based working. This will take time to develop and is intrinsically linked to the refresh of the HWB Strategy.

Therefore, this paper seeks agreement to the approach and the sets out the anticipated direction of travel for the development of a coordinated evidence base for the whole system, delivered under the JSNA umbrella.

To deliver needs assessments at scale across the place plan areas, additional project support would be required, upskilling of analysts across the system (currently being rolled out through the CSU academy and analyst network) and the support of colleagues in planning and partners in local communities. The support of these will impact the scale and pace of delivery.

8.0 Interlinkages to other programmes of work

1.1. Population Health Management
1.2. Transforming Insight Function
1.3. Health and Wellbeing Board
1.4. Business Intelligence Function Shropshire Council
1.5. Community and Rural Strategy

List of background papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Appendix 1:HWB Workshop report January 2020 Appendix 2: JSNA Draft prioritisation framework March 2020
Cabinet Member (Portfolio Holder) Adults, Public Health and Climate Change Childrens
Local Member All
Appendices

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Health and Wellbeing Board
Meeting Date: 16th January 2020

HWBB Joint Commissioning Report – Health & Wellbeing Board 'Place Based Working and Priority Setting.' Second Workshop report

Responsible Officer: Val Cross, Health and Wellbeing Officer/Healthy Lives Co-ordinator

Email: val.cross@shropshire.gov.uk

1.0 Summary

1.1 Following a half-day Health & Wellbeing Board (HWBB) workshop held on the 22nd October 2019, for which the focus was 'Place Based Working and Priority Setting', a further workshop to discuss, agree and conclude the interventions and outcomes was held on the 5th December 2019.

1.2 The workshop was well attended with 20 people represented from; the Voluntary and Community Sector, Adult and Childrens' Services, Shropshire CCG, Shropshire Community Health Trust, Shropshire STP, Education, Elected Members and Public Health.

1.3 Participants were mixed across three tables, to enable a good cross section of discussion and balance of views.

1.4 This report provides the findings from that workshop.

2.0 Recommendations

Based on the evidence and workshop outcomes, the Health and Wellbeing Board is asked to endorse the key identified key priorities of;

- Adverse Childhood Experiences
- Workforce
- Healthy Weight and Physical Activity

The board is also asked to recognise the ongoing prioritisation and work happening which includes; Smoking in Pregnancy, Social Prescribing, Domestic Abuse, Dementia, Alcohol, Mental Health - wellbeing support, suicide prevention, County Lines and Air Quality.

REPORT

3.0

3.1 The aims of the workshop remained the same as the October workshop:

- To discuss and agree the role of the Health & Wellbeing Board in place based care/working, drawing in the 10 areas of the STP, Long Term Plan and cross-pollinating good practice happening across both
- Use intelligence from the JSNA to agree ongoing priorities

- Embed agreed priorities from the workshop in the refreshed Health & Wellbeing Strategy

3.2 The outcome of the workshop was that the role of the Board in place based care/working and priorities would be agreed, and embedded in the refreshed Health & Wellbeing Strategy

3.2.1 A recap of the previous session was provided including key themes which had emerged;

- *Workforce:* including elements such as: a healthy informed workforce, who have an awareness of prevention and looking at embedding behaviour change (a technique which help to put people back in control of their own lives, through making positive choices around their own health and wellbeing).
- *Children and young people:* Adverse Childhood Experiences (ACE); starting early and building ambition.
- *Weight Management/Diabetes*

also

- *Wider determinants of health* - use of green spaces, planning policy and housing etc.
- *Role of the VCSE* as a core element of our system
- *meeting the needs of seldom heard groups* and those of the nine protected characteristics
- *How Place Based Working and Priority Setting* is part of developing our integrated working, trusting, developing and designing collectively.

3.2.2 As requested at the October workshop, more data and detail from sources was provided which included;

- Public Health England (PHE) Fingertips data
- Draft JSNA prioritisation matrix (see appendix 1) which: evaluates level of need and strength of evidence; attempts to be more transparent, robust and objective on a subjective issue; has criteria outlined based on information available and has weighting for level of need and economic cost. This had started to be populated with the different priorities including; weight management, smoking in pregnancy, ACE, school readiness and alcohol. The draft, which will need to be discussed and ratified by the Joint Commissioning Group (JCG) can be seen in appendix 2.
- The PHE 2019 Prioritisation Framework process for health and wellbeing "interventions" (see appendix 3) which supports making the most of budgets and reviews programmes that could offer the greatest value. Use of this framework links to work with the Commissioning Support Unit (CSU) and to the STP System Design and Prioritisation and Quality Assurance Groups.
- Shropshire Council data, Place based data, Office of National Statistics (ONS), and specific sources such as www.adversechildhoodexperiences.co.uk.

3.2.3 Following the presentation of data, workshop participants were asked to work in smaller groups to answer the following;
'Based on the evidence and our organisational/own knowledge, do we agree these are our priorities'? Information which included; HWBB strategy and priorities, ACORN and place based data was placed on the tables to aid discussion.
Participants were also asked to consider:

- A life course approach - Starting Well, Living Well, Ageing Well
- The needs of our vulnerable communities
- Using a Place Based approach
- The Wider determinants of health

3.2.4 The PHE 2019 Prioritisation Framework (appendix 3) was provided, and participants were invited to score the priorities against this, and discuss potential enablers for change.

3.3 The table below provides a summary of the table discussions:

Scoring for key priorities

N.B. two of the three groups specifically scored the criteria as below. The third group did not. The discussion captured however, demonstrates a similar scoring to the other groups and can be considered as valid.

Adverse Childhood Experiences (ACE)

Criteria	High score – 10	Medium Score 6	Low Score 3	Weighting
Strength and quality of evidence	(Score from 2 groups) - good evidence of importance of work - good evidence that supports need for trauma informed workforce			
The size of the health benefit	(Score from 2 groups) - Potential to address 50% of the population -Opportunity to support specific families			
The prevention of future illness	(Score from 2 groups) - Good evidence to support prevention -Intervening early can break the cycle - Life course approach			
Addresses health inequality or inequity	(Score from 2 groups) Good evidence to support this			
Delivers national or local priorities or targets	(Score from 1 group) STP Mental Health, Early Help, HWBB	(Score from one group)		
The financial costs and benefits	(Score from 2 groups) Significant return on investment			

Potential enablers for change	
System wide approach	Champions, informed about trauma, holistic approach
Prevention	• Using opportunities throughout a person's life journey, and intervening earlier to break the cycle. • Pilot interventions to enable measurement • Understand why children are behaving as they are and put in place appropriate support
Targeting	Consider if prioritisation should be on poor outcome areas, or on impacts/actions that could improve outcomes across multiple areas.
Training	Develop trauma informed workforce
Data	• Understand the data – risk stratify • Identify parents – work with troubled families and all services

Policy development	• Should be firmly in the HWBB strategy
Involving everyone	• Create peer support (like compassionate communities but for younger people) • Consider role of grandparents and friends • Understand what is needed in communities that will help • Connect schools (including nursing service), voluntary and community sector and families together

Workforce

Criteria	High score – 10	Medium Score 6	Low Score 3	Weighting
Strength and quality of evidence	(Score from 2 groups) - Good evidence. Skills, lower employment, sufficient workforce			
The size of the health benefit	(Score from 2 groups)			
The prevention of future illness	(Score from 2 groups) Healthy workforce. THRIVE model.			
Addresses health inequality or inequity	(Score from 2 groups)			
Delivers national or local priorities or targets	(Score from 1 group)	(Score from 1 group)		
The financial costs and benefits	(Score from 2 groups) Immediate; wellbeing day, Couch25K, digital			

Potential enablers for change

Healthy workforce	• Leading by example in our organisations • Targeting our workforces • Adopting the THRIVE model across sectors. https://www.wmca.org.uk/what-we-do/thrive/thrive-at-work/ • Wellbeing Days, Couch25K, use of digital • Evaluating impact of interventions
Workforce improvement – influencing factors	• skills • lower unemployment • income and better wages • career progression • Terms and Conditions of employment
Using workforce as an influence on others	• Voluntary and Community Sector • Nudges/opportunity for stimulating change

Weight and Physical Activity

Criteria	High score – 10	Medium Score 6	Low Score 3	Weighting
Strength and quality of evidence	(Score from 2 groups) - More work to do around this. Varies by age, GP locality - good evidence of importance of work			
The size of the health	(Score from 2 groups)			

benefit	- Estimated over 73% of Shropshire adults are overweight or obese Type 2 diabetes increasing – estimated prevalence 9.4 % of the population			
The prevention of future illness	(Score from 2 groups) - Obesity linked to diabetes, cancer, heart disease			
Addresses health inequality or inequity		(Score from 2 groups) - Tends to cross the all sectors of society, but prevalence higher in deprived wards		
Delivers national or local priorities or targets	(Score from 1 group) LTP priority (national and local), HWBB	(Score from 1 group)		
The financial costs and benefits	(Score from 2 groups) - Significant return on investment attributable across future illness			

Potential enablers for change	
Communication	• Consistent health messages for the public, shared by organisations to avoid confusion and misinterpretation • Different evidenced messages for different audiences
Education	• Level of importance given to Physical Activity and Home Economics in the curriculum – national issue. Support schools to help staff, pupils, and parents with e.g. roll out the Daily Mile, support schools to teach nutrition.
Increasing knowledge of nutrition and cooking skills	For everyone, particularly young people and families. • Connect with private, VCS or not for profit organisations such as the National Trust or Acton Scott Farm – for healthier eating • Support parents to understand nutrition and food prep
Behaviour change	Nudges/reminders/rewards to support behaviour change for a healthier lifestyle
Regulation	Fast food outlets – managing the environment proactively
Increasing access to green spaces for all	• Encourage physical activity and love of the outdoors • Look at barriers to access, through cost.
Food poverty	• Continue to work in partnership to tackle food poverty in Shropshire • Connect to Food Poverty Action Plan
Workforce (links to the 'Workforce' priority)	• Workforce a key ally and group to support • Support the workforce to have a healthy lifestyle • Offer behaviour change and motivational interviewing training opportunities for more staff across the system • Gather more evidence about what works, including what works for workforce health (does mobile/ agile work help? how can physical health support mental health, what can employers do to best support their staff?) • Connect with the right influencers – connect with employers,

		create examples of good practice and support for people through their working lives • Ensuring a good work/ life balance, peripatetic or agile working doesn't necessarily help on its own, more information needed
Data	3.0	Understand the data and insight to know the causes (e.g. Mental Health and Poverty)
	4.0	Access people / risk stratify using data and information
Research	5.0	What's not working for adults – why is the over-weight and obese population growing? Conduct some ethnographic research to understand attitudes, beliefs and knowledge about weight
Other priorities needing consideration based on the evidence (not scored)		
		• Domestic Abuse • Smoking in Pregnancy • Social Prescribing • Dementia • Alcohol • Mental health - wellbeing support, suicide prevention • County Lines • Air quality

4.0 Conclusions

4.1 The two workshops have enabled a sound decision making process based on evidence and consensus, to recommend the Health and Wellbeing Board priorities. Provision of data has provided the evidence and prioritisation tools have been used to rank the priorities and to start to consider the potential enablers for change.

4.2 These workshops have now facilitated a prime opportunity to; refresh the Health and Wellbeing Strategy and Action Plan, formalise the Joint Strategic Needs Assessment – including governance of this and revisit and formalise the Health and Wellbeing Board Terms of Reference (TOR). All will be carried out with appropriate ratification.

4.3 Working groups formed from Board members and/or their representatives, will be arranged to carry out this work, and progress will be reported at the next HWBB meeting.

5.0 Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

Equality and equity elements were included in the prioritisation process and the development of the HWBB strategy will include an opportunity for broader stakeholder engagement to build on the ideas generated through the HWBB workshops

6.0 Financial Implications

There are no direct financial implications that need to be considered with this update, however the development of a new HWBB strategy will aim to support strategic planning and commissioning for the system.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr. Dean Carroll Portfolio Holder for Adult Services, Climate Change, Health and Housing
Appendices **Appendix 1 – JSNA Prioritisation Matrix** **Appendix 2 - Draft Prioritisation Matrix** **Appendix 3 – What to consider when prioritising the provision of health improvement programmes**

Appendix 1

Figure 3: JSNA Prioritisation Matrix

	Criteria	High 10 points	Medium 6 points	Low 4 points	Zero 0 points	Weight-ing
Estimated Level of Need	**Level of need – Volume**	Topic covers an estimated large 'in need' population (>25,000 people).	Topic covers an estimated medium sized 'in need' population (10,000 – 24,999).	Topic covers an estimated small 'in need' population (<10,000).	-	1.5
	Level of need – Severity	The population concerned have 'severe' needs.	The population concerned have 'considerable' needs.	The population concerned have 'moderate' needs.	-	1.5
	Level of need – Trend	Available evidence suggests rapidly worsening situation over time.	Available evidence suggests worsening situation over time.	Available evidence suggests situation has remained stable over time.	Available evidence suggests improving situation over time.	1
	Level of need – Benchmarks	Available evidence suggests very high prevalence relative to comparator areas (the County is a clear statistical outlier).	Available evidence suggests above average prevalence relative to comparator areas.	Available evidence suggests prevalence in-line with comparator areas.	Available evidence suggests relatively low prevalence relative to comparator areas.	1
Early Intervention	**Does the topic have early intervention implications? Is it an emerging issue which is likely to cause further problems in the future?**	Clear, demonstrable evidence that there is a strong case for early intervention.	Some evidence which highlights areas suitable early intervention.	Weak evidence that the topic has areas suitable early intervention.	No evidence to suggest that the topic contains areas suitable early intervention.	1
Inequalities	**What is the scale of inequality?**	Persistent, wide scale geographic and population-based inequalities are clearly apparent.	Some notable geographic or population-based inequalities are apparent.	Some minor inequalities exist.	Little or no evidence of inequalities.	1
Cost Implications	**Estimated economic cost associated with tackling the topic in Warwickshire**	High levels (multi-millions of £s) of both direct and indirect estimated economic costs both now and in the future.	Medium levels (c. £5 million) of direct and/or indirect estimated economic costs both now and in the future.	Low levels (<£1 million) of estimated economic costs either now/and or in the future.	-	1.5

Appendix 2 – Draft Prioritisation Matrix

Priority / Criteria	Level of Need Volume 1.5	Level of Need Severity 1.5	Level of Need Trend	Level of Need Comparison	Need responsive to intervention	Inequalities	Cost/Economic 1.5	Local or national priority	Total
Education outcomes for vulnerable young people	NEET 488 LAC SEN Priority familes CPP	considerable			Not achieving Level 4+ at KS4 means considerable amount of ground, NEET	Gap in disadvantaged communities	Investing in Ed will save millions to economy		
School readiness	2,884	moderate	Improving but level off most recent	Mid West Midlands table, 69.9 same as WM., Eng 71.5	Curiosity corner, FNF, Early Education, Perry Preschool Programme	SEN, gender, FSM	Rol K1 = K13	Local CYP	
LD and Autism		considerable							
Oral Health		moderate							
Alcohol	Low absence rates, harmful levels	severe to moderate	Increasing hospital adm	Middle of DPFA	Risks early identifiable, links to stroke, cancer, RTAs etc	Homelessness links, MH, all groups	Links to	National and Local	80
Diabetes	Low diagnosis rates, 7% of the population	considerable	Significantly High	Outlier treatment					
Smoking Cessation	55,000 estimate	considerable	Leveling	Middle of DPFA	Quitting has impact on health,	Biggest preventative case of health inequalities and case CVD, Cancer respiratory	188 million	National	69
Weight Management	73.2 %	considerable	Inc in Adults and Reception	Highest of stat neighbours	School based interventions, national policies, PA	Strong link with obesity and deprivation but all, place plan	In direct costs 27 billion, direct 84 million	National and Local	88
Smoking in Pregnancy	247 per year	considerable mother & baby	Increasing	Remain high	Stop smoking services, in hospital, leadership, community support	MD, younger mothers	Impact on NHS and Social Care	Local and LTP	79
Cancer	1 in 3 1,200 under 75 mort	considerable	Falling	Comparison to DPFA	% thought to be preventable	Age, men generally greater risk, place plan	5% of NHS budgets, could increase by 1/3	National, LTP, Targets	69
CVD		considerable	Falling	Comparison to DPFA	NHS health check, smoking, weight	Place plan,	14 billion costs nationally	National, LTP, Stroke	69
Road Traffic Collisions	600	severe	Remains High	higher	20 is plenty, speed watch, alcohol			Local	64
Mental Health and Suicde	Adults mental health 11,858 1 in 4 pop	severe to moderate	Increasing	Life Expectancy Outcomes Poorest qtile	Symptoms identified possible to reduce severity	Life Expectancy 20 years less	21 billion costs to NHS and Social Care	Both	
Dementia	Diagnosis 3,616 diagnosed (71%)	Severe to moderate	Growing with aging pop	Good diagnosis rates	Undiagnosed, early diagnosis impact on quality of life	Prevalence among women	Cost pp: Mild £14,568, mod £28K, Severe 28,500 care home 31K	National input, local?	
Falls and MSK		severe to moderate						Local	
End of Life		servere							
Loneliness and Isolation	54% of carers and ASC less contact	moderate							
Carers	11% of people are carers	moderate				Varies across the County but all areas	Largest cost if unpaid carers need support	Local Strategy	
Frailty		considerable							
Youth Unemployment		considerable							
Low Workplace Earnings									
Food Poverty									
County Lines		severe						National, Local	
Domestic Violence		considerable							
ACES		severe							

Appendix 3 – What to consider when prioritising the provision of health improvement programmes

Factors to consider	Scale of the factor			Weighting
	High Score 10	Medium Score 6	Low Score 3	
Strength and quality of evidence. Is the evidence base robust and is it appropriate to the topic in question?	There is peer reviewed evidence available. For example, a meta-analysis of multiple well-designed trials. There is high confidence that the proposed programme will have the expected and measurable effect.	There is some evidence and there is a moderate level of confidence that the evidence reflects the true effect.	Evidence is either unavailable or does not permit a conclusion. There is only low confidence that the proposed programme will have any measurable effect.	1
The size of the health improvement benefit. To what extent does the programme improve the health status for the population over a suitable comparator?	We can expect measurable improvements in health status from the proposed programme, affecting 1,000s of people.	There is a moderate benefit expected from the proposed programme. The proposal may lead to a measurable effect for 100s of people	The benefit from the proposed programme is negligible or there is no discernible improvement in health status.	1
The prevention of future illness Does this intervention support 1º or 2º prevention of future health conditions	There is a high level of measurable prevention benefit expected from the programme.	There is a moderate degree of measurable prevention benefit	The prevention benefit is nil or negligible	1.5
Addresses health inequality or health inequity Does this service reduce or narrow identified inequalities or inequities in the local population	There are multiple direct associations between the health state in question and a specific demographic / socioeconomic group. The proposal deliberately and specifically addresses the identified inequality or inequity	There is a direct association between the health state in question and a specific demographic / socioeconomic group and evidence that the proposal can tackle this issue	The proposed programme does not address any inequality or inequity issues.	1
Delivers national and/or local priorities and targets Does this intervention support deliver identified national or local requirements or targets	The proposal addresses the target and/or requirements directly and the evidence suggests the impact will be clearly measurable.	The evidence suggests that the proposal can address certain key elements of a targets or requirement.	The proposal does not clearly address one target or requirement	1
The financial costs and benefits. To include the costs of preparedness and delivery, along with a suitable measure to describe current and future benefits and discounting	The proposal requires new delivery infrastructure; health gain is inconclusive, according to the evidence	Some infrastructure is available; health gain is moderate; impact on population health status is sizeable with economies of scale	The infrastructure for delivery is already available; the unit cost is low; health gain measure is high	1.5

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Key

High	Medium	Low
8-10 points	5-7 points	1-4 points

Priority	Criteria	Level of Need: Volume (weighting 1.5)	Level of Need: Severity (weighting 1.5)	Level of Need: Trend	Level of Need: Comparison	Need responsive to intervention	Inequalities are evident	Cost and return (weighting 1.5)	Local or national priority	Total
Education outcomes for vulnerable young people and School Readiness		10	10	6	6	8	8	12	8	68
LD and Autism		Being completed								
Oral Health		Being completed								
Alcohol dependency		13	13	9	9	8	8	12	9	81
Diabetes		12	12	7	7	9	8	12	8	75
Smoking Cessation		13	13	8	8	8	9	13	9	81
Obesity and Weight Management		13	13	9	8	7	8	12	9	79
Smoking and smoking in Pregnancy		13	13	8	7	8	9	13	9	80
Cancer		Being completed								
CVD		14	13	9	8	9	8	13	10	84
Road Traffic Collisions		9	12	5	6	6	6	12	6	62

Priority	Criteria	Level of Need: Volume (weighting 1.5)	Level of Need: Severity (weighting 1.5)	Level of Need: Trend	Level of Need: Comparison	Need responsive to intervention	Inequalities are evident	Cost and return (weighting 1.5)	Local or national priority	Total
Vaccination and immunisation.		12	12	7	7	11	8	14	8	**79**
Domestic Violence		13	13	9	7	8	9	13	9	**81**
Mental Health		13	12	6	6	8	8	12	13	**78**
Suicide prevention		13	12	8	7	8	10	11	10	**79**
Dementia		12	12	8	7	8	5	12	8	**71**
Falls and MSK		12	11	7	8	7	10.	12	12	**79**
Adverse Childhood Experience		12	12	8	8	8	8	12	8	**76**
Carer support		12	7	8	6	8	7	10	7	**65**
Food Poverty		10	13	10	3	10	10	13	6	**75**
'County Lines'		To be completed								
End of Life		To be completed								
Loneliness and Isolation		To be completed								
Frailty		To be completed								
Youth Unemployment		To be completed								

Priority	Criteria	Level of Need: Volume (weighting 1.5)	Level of Need: Severity (weighting 1.5)	Level of Need: Trend	Level of Need: Comparison	Need responsive to intervention	Inequalities are evident	Cost and return (weighting 1.5)	Local or national priority	Total
Low Workplace Earnings		To be completed								
Transport		To be completed								
Air Pollution		To be completed								
Homelessness		To be completed								
NEET		To be completed								

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Shropshire Council	**Health and Adult Social Care Overview and Scrutiny Committee** **25th January 2021**	**Item** **Public**

Domiciliary Care Overview

Responsible officer: Deborah.webster@shropshire.gov.uk

1.0 Purpose

The Health and Adult Social Care Overview and Scrutiny Committee has requested that officers provide an overview of domiciliary care provision in Shropshire.

2.0 Recommendations

The report is shared with Committee members for information; further enquiry and discussion is welcomed.

3.0 Background

This report is intended to answer the series of questions sent by the Committee and in doing so outline the scope and nature of domiciliary care (also known as home care) in Shropshire with analysis of the current challenges resulting from winter pressures and the Covid-19 pandemic, and longer terms changes anticipated in the market.

3.1 Scope and size of domiciliary care provision in Shropshire

In Shropshire there are currently 84 companies registered with CQC to provide domiciliary care They report employing 3250 carers (Care Quality Commission- CQC, Homecare survey 30/11/20). The Council commission services from most of these CQC registered Shropshire providers as well as a small number which are based just over the border in neighbouring local authorities. We currently accredit 93 domiciliary care providers in total which includes 16 specialist (mainly Learning Disability) providers who are all contracted for packages of care via the brokerage system.

- The majority of the domiciliary care services we commission are from small, locally based companies.
- Around 75% of providers are small/medium sized local Shropshire businesses although some of those are franchises.
- Around 20% are regional to the West Midlands
- the remaining 5% are national companies which have bases locally, however, most of those businesses have small numbers of care packages compared to the local providers.

Geographical cover

The providers who work in Shropshire cover certain geographical areas. Our system allows us to see which providers work in which areas so we can approach those we need to and also carefully analyse where we are short of provisions. In each area we have providers as follows:

- Central 37
- North east 20
- North West 18
- South East 16
- South West 16

*Please note that some providers work in more than one area.

3.2 Customer base and care type

Information from the Care Quality Commission (CQC) Homecare survey 30/11/20 evidences that Shropshire based providers report supporting around 3500 people; this is made up if a mixture of Council funded, private or health funded clients. In response to a Shropshire Council survey the providers we contract with reported that their client base was made up of around 45% for Shropshire Council, 35% for self-funders and 20% for Health and other commissioners.

.2 The Council currently commission domiciliary care for around 1500 people over 65 years of age primarily because of age related conditions or disability.

.3 The Council also commission domiciliary care for around 600 people under the age of 65 due to needs mainly arising from their disability or long-term conditions.

For clients funded by Shropshire Council, Domiciliary care is commissioned whenever it is identified as required to meet individual needs following a Care Act assessment. Support provided is mainly for personal care, washing, dressing, medication, nutrition and daily living tasks identified in the support plan with an emphasis on maintaining independence. Some non CQC registered providers also support people with things like shopping and social support which may be funded by the Council; if for example, mental health issues prevent clients doing this for themselves.

3.3 Accreditation and performance management

Accreditation: Providers are accredited to provide care commissioned by Shropshire Council following an initial accreditation inspection by SC Contract monitoring officers, they can only be accredited if they pass all the required standards and checks. Once accredited and commissioned, there is a continuous and ongoing process of monitoring and assessment of the quality of care which is provided. We only open accreditation for area that we need additional provision and providers have to evidence that they are able to work in those areas without disruption to established providers.

Performance management: The current domiciliary care market contract took effect in early in 2019. The contract clearly sets out areas of contractual breach and non-compliance and we have a clear and robust process for monitoring performance. The provider performance oversight system is operated by SC Contracts Team; a risk matrix is maintained which draws information from many sources including our social work teams, complaints department, safeguarding team, CQC, CCG, Healthwatch and Telford and Wrekin Council to risk rate and score each provider. This system is also linked into the Liquid logic care system so that general issues with providers are monitored continuously. Monitoring visits are generally completed on a risk basis,

although the pandemic has meant that these are currently conducted physically only in the most concerning cases. Desktop monitoring is however taking place with important information requested from providers digitally.

Complaints: All clients or their representatives may make a formal complaint to a provider or directly to the Council. The Provider is required to inform us of the complaint for oversight or the complainant may go direct to Shropshire Council if we have commissioned the care.

When a complaint comes into the Council, we have a duty to investigate and respond and decide whether a complaint is upheld, partially upheld or not upheld. If the complainant remains unhappy with our conclusion, they may ask the Local Government Ombudsman to look at their complaint. The LGO will then consider the case and can and will give a verdict and may require the Council to provide compensation if they disagree with our conclusions.

When formal complaints have been received, investigated and fully or partly upheld or there are other concerns, providers are brought in meetings (currently remote meetings) to meet with Commissioning, Contracts and Operational team managers and required to devise and complete an action plan to address the elements in the complaint and issues raised by social workers. They are then monitored to ensure compliance. If a provider is not considered to be performing as they should and there are breaches of contract or poor performance that is not addressed the Council can suspend, partially suspend or dismiss a provider if necessary.

CQC inspections: CQC inspect and rate providers continuously. Shropshire providers CQC performance evidences a higher than average performance across England and : 87% are GOOD or OUTSTANDING, with only 1.5% rated as inadequate.

Where CQC have inspected and had concerns, their reports have generally reflected the concerns that are being addressed by ourselves and there is ongoing liaison between contracts monitoring officers, commissioning and CQC whenever issues arise.

Risks during the pandemic: Clearly during the pandemic there have been more risks to providers performance and more support needs for them than at other times, consequently the above processes have been reinforced with further checks and balances and information drawn from the wider system though tools like the National Capacity Tracker and CQC data sets so we can be sure that we are providing all the support needed for the market. Whilst this report is focussed on a general description of domiciliary Care we have included the detailed risk management processes and the Care Market Action Plan for the pandemic in **Appendix A** for further information.

3.4 Company structures and staff training

The structure of domiciliary care companies varies depending on the size of the company, however typically there will be a Registered manager, a Care coordinator and a number of senior carers plus administrators and finance staff, but the vast majority of staff roles will be front line carers. Many companies (typically the larger ones) also have their own training departments.

A great deal of the training provided in Shropshire to social care providers is by Shropshire Council Joint training team and Shropshire Partners in Care (SPiC) although other training providers do deliver in Shropshire. Joint training and SPiC offer training at subsidised rates (funded through Care Workforce development partnership) to social care providers which is significantly cheaper for providers than using the open market. Together SPiC and Joint Training form the Workforce Development Partnership through which they align the courses that they offer to avoid duplication and ensure they don't 'compete' against each other. Each January a training needs assessment goes out to the market and they work together to collate market requirements and agree how they can meet them. For example, SPiC concentrate on moving and handling, first aid, safeguarding and some technical/clinical training for the care homes and domiciliary care. In a typical quarter 1200 learners from 150 different providers attend courses. The pandemic has of course affected the delivery of training which has had to, in the main move online through webinars and self-learning modules, however courses such as first aid and moving and handling are being held in small Covid safe groups.

All carers are contractually required to undertake a thorough, documented induction programme followed by the Care certificate standards within 12 weeks of starting which covers all aspects of care provision. These include Duty of care, Equality and diversity, Communication, Privacy and dignity, Fluids and nutrition, Safeguarding adults, Basic life support, Health and safety, Infection prevention and control. New carers will need to work towards achieving the organisation's identified training/skills competency matrix or move onto health and social care diplomas following completion of the Care Certificate Standards.

Carers are required to be trained to a sufficient level to enable them to deliver support as required by care plans which may at times be of a specialist nature e.g. PEG feeding. Training must be updated at Industry recognised intervals.

During a CQC inspection the inspector will check files for identified care workers and want to see systems in place that demonstrate that all staff are suitably trained. SC contract monitoring officers will also view training records and interview staff to ascertain the percentage of staff trained in each subject and ensure compliance with requirements.

The Workforce Development fund (WDF) is funding from the Department of Health that is distributed by Skills for Care through a network of employer led partnerships across England. The Care Workforce Development Partnership (CWDP) which is part of SPiC is the employer led partnership for Shropshire and Telford & Wrekin. Adult Social Care employers in Shropshire can access the WDF via SPiC towards the cost of staff completing adult health and social care qualifications e.g. Apprenticeships, Diplomas, Certificates, Awards and Learning Programmes and circa £150,000 is disbursed to Care providers locally each year.

3.5 The process of procuring domiciliary care

The two main areas where domiciliary care is procured for people are within the community and for hospital discharge, however the Council is increasingly using our reablement service START to manage hospital discharge with the domiciliary care

market focussing more now on longer term care. A brief summary of the process is as follows:

- If the individual requiring care is coming out of hospital, there is a Fact-Finding Assessment completed (FFA). If the individual is already in the community then the Care Act assessment is completed (CAA)
- Fact Finding Assessments are completed in the hospital by a trusted assessor based on the condition and presentation of the patient at the time. Care Act Assessments are completed by the allocated Social Worker
- The assessment covers every aspect of an individual's current requirements and anticipated ongoing care needs
- Following completion of a CAA or FFA for each individual the package of care requirements are put on to a secure brokerage SharePoint site which can be accessed only by accredited providers. Initially the only details given are postcode, number of hours, and how many carers are required.
- New requests into brokerage are published the same day they are requested to all providers. Alerts are sent directly to providers each day as and when new packages are published or changed.
- If a Provider has the capacity to bid for the package of care they may ask to see the CAA or FFA before offering to contract for the work. The detailed assessment is only accessed for viewing through their individual secure SharePoint folder.
- If a provider considers they can meet the needs of the individual they may then bid for the work; each is awarded based on how quickly the care can start, how close to the times requested and cost. Providers can currently bid between £16.50 and £19.20 per hour.

This brokerage process is managed by a highly trained team of brokers who offer an extremely effective and robust service and have effective relationships with the market and with assessors requesting care. All domiciliary care packages are brokered in the same way regardless of whether they are Individual Service Funds', reablement packages or Direct payments for both community team (CAA) and ICS (FFA) requests.

Through our brokerage process we are also procuring care on behalf of the CCG as part of our development of partnership working. During the pandemic brokerage have also been procuring health funded packages which comprised mainly of hospital discharges for 'Fast-Track' assessed patients. (generally, end of life)

4.0 Market Challenges and support

The domiciliary care market has been challenged by issues such as recruitment and retention and funding for several years which we have been working together to address. For domiciliary care providers in Shropshire the main challenge has often been recruitment. The very successful Every Day is Different campaign (A National carers recruitment campaign) resulting in an uptake of care roles finished at the end of 2019 but SPiC have been continuing with this work locally in order to support members with their recruitment. SPiC advertise vacancies on behalf of providers on their Facebook page and other local jobs pages and also promote the Shropshire Chamber of Commerce as the local DWP approved organisation supporting small local businesses

with the recently launched Kickstart scheme for apprenticeships in regards to the care sector; this was only launched mid-September.

During the early months of the Pandemic recruitment was easier for many providers with significant numbers of people previously employed in the hospitality sectors looking for work. This was however still not always the case in all areas particularly the very rural.

Currently SPiC are working locally with the NHS and Health Education England to support a second rotational apprenticeship programme across health and social care after the success of the first.

The pandemic has added significant additional challenges to the domiciliary care market such as the cost and supply of PPE, managing financial risks, the size of the market in the County and understanding all the requirements to meet staff and service users' needs during a major pandemic. The Council have worked with SPiC and the market to assist with these challenges in many ways**:**

4.1 Financial Support

At the start of the pandemic, in recognition of the challenges that care providers would be likely to face, Shropshire Council wrote to all providers to offer assurance, support and flexibility in how care could be delivered. At the beginning of April, following guidance from ADASS and the LGA, further correspondence set out the way in which additional finance would be provided to specifically support the additional cost incurred by care providers due to Covid 19. Our engagement with providers confirmed that they were incurring significant additional costs in relation to the purchasing of PPE, agency staff, funding for staff who were unable to work and other financial challenges.

The decision was made to provide the funding as a one-off payment as there was clear evidence of an immediate need to support cash flow. In the week commencing 13th April, all County providers the Council contract with, received a one-off payment, representative of an additional 10% of their contract value (at 31.3.20) for 12 weeks – this included joint contracts with the CCG and amounted to just under **£2.4 million.**

We have also since this sent out Infection Control Funding grant (ICF) of over **£8.6 million** which has been distributed across the care market in Shropshire

In addition, we established a business grant fund for providers who have experienced financial loss due to Covid 19 of up to £10,000 and 41 provider companies accessed the grant money.

In total this means **£11.4 million** will have been injected into the Shropshire care market since the pandemic began and in addition, the Council made a further committed to pay invoices within 5 working days during the pandemic, rather than on the usual 30-day terms, the Council is also paying for 2 weeks in advance and 2 weeks in arrears.

In regards standard annual funding arrangements on top of pandemic money and following consultation with the market and SPiC, Shropshire Council made uplift arrangements for 2020-21. These arrangements are in addition to, and entirely separate of, the Covid-19 support described above. In order to utilise our limited resources to the greatest effect and support a sustainable market, the decision was made to uplift the lowest paid end of the market, resulting in a 2% uplift to any placements that fall below

the determined average weekly rate, with no uplift awarded to providers already receiving at, or above, the average rate. This uplifted rate is lower in terms of percentage than some neighbouring authorities however Shropshire Council base rates are in general higher and lowest rates were automatically uplifted. For example, domiciliary care lowest rates have been automictically uplifted from £14.95 to £16.50 this year whilst highest rates have remained the same. This is in order to support sustainability at the lowest paid end of the market. It is worth noting that our highest rate of £19.20 per hour is higher than our neighbouring authorities.

4.2 PPE support

We have also been providing emergency PPE which has been regularly accessed by providers. We set up an emergency response service very early in the pandemic and providers were able to access PPE through the Council as a result of the Local Resilience Forum drops throughout the week by applying for stock on line and being allocated a slot to collect from Shirehall We also worked closely with our colleagues in the NHS and CCG to develop a stock monitoring system through power BI which enabled us to successfully coordinate mutual aid where this was required. We also offered a fit testing service to providers who could not access FFP3 masks through their usual supply chains. We provided them with the masks and the fit testing as required.

- Since August a DoH portal has given providers access to larger amounts of free PPE to bolster what they can obtain through normal suppliers.
- We monitor providers PPE levels through the CQC home care survey; Most providers are currently stating they have reasonable stocks of PPE and no major concerns
- Advice on how to use PPE, donning and doffing etc available on SPiC website and links to videos and pictograms were added to market comms and many free training opportunities have been and continue to be available

4.3 Financial reconciliation support

The financial reconciliation process monitors the delivery of care at source and evidences where providers are over or underdelivering on care packages to ensure that care is delivered as commissioned and that we are paying providers correctly. In addition to Monitoring delivery the process will report to social workers so that care packages can be reviewed in order to be reduced or increased as required to ensure that the needs of the individuals are met but are not exceeded.

The reconciliation process also allows us to evidence if a provider is in a high-risk category financially. Indications would be where providers are reluctant to engage with the process, where repayments are not made or where they suggest supporting high risk providers

When concerns arise, the Reconciliation Team support and negotiate individually with each provider, on monies we can reclaim during each scheduled payment, during to financial difficulties they are currently facing.

4.4 Market size and stewardship

We are working with colleagues in our contracting team to ensure that we only accredit the right providers in the right areas in order to protect our existing provider market. Considering this we have not re opened our domiciliary provider accreditation process for over 2 years as we currently have a variety and high volume of care providers

accredited in Shropshire and bidding for packages on brokerage, with over 1800 hours of capacity in the dom care market. On balance the number of providers does provide some resilience to the market as there have been well documented issues nationally when large care companies go into financial difficulty.

4.5 Communications and forums

Since the beginning of the pandemic we have been robust in our communication with the market: Between the 1st February - 8th April 2020, formal communication took the form of regular Frequently Asked Questions (FAQ) bulletins, after this, we continued to provided FAQ updates but in a different way. Responding to requests from some providers who were overwhelmed by the number of emails they were receiving, from week commencing 13th April, FAQ updates were provided via the Shropshire Partners in Care website, with providers signing up for update notifications instead of receiving hard copy by email. From mid-May to present day, we have shared weekly briefings with the whole provider market. In addition, and in response to information requests form the market we have held provider forums; managed virtually and drawing in expertise form various system partners where providers have concerns about any issue.

We have also created service area specific dedicated welfare teams and this includes a team of 4 people supporting the domiciliary care market though ongoing welfare calls. Every provider has a each has a Key Contact or welfare officer for support. The focus of support is led by the company's needs and supplemented by insights from National Capacity Tracker and information sharing across the system. We work with Shropshire Partners in Care to respond to offer a shared response to national guidelines, maximise resources, identify gaps and ensure each business has its own contingency plan in place.

4.6 Testing and vaccinations

Up until October testing for domiciliary care workers was only available through the STP or pillar one testing for symptomatic workers and their families or through gov.uk.
In Early November, domiciliary care workers were allowed to take a test without symptoms through gov.uk however limits on numbers and frequency of tests soon became apparent.

Since November 23rd there is a new national regular testing regime in place – providers registered with CQC will be sent 4 tests per worker each month; workers will test themselves and then send off weekly. There is no largescale access to rapid testing as yet for domiciliary care providers.

Vaccinations for domiciliary care staff will be undertaken in Group two as designated by the JCVI. This means that Domiciliary care workers should be vaccinated by Mid-February 2021.

4.7 Feedback

Healthwatch Shropshire have recently carried out an Enter and View project on Homecare in Shropshire under responsibility given to Healthwatch under the Health and Social Care Act 2012. Healthwatch met with a number of local providers and ran a questionnaire for people using homecare services in Shropshire. Whilst recognising the limitations that the nature of domiciliary care and the Coronavirus Pandemic placed on the project, we felt that the report was a valuable insight into the home care market.

We were pleased that in general, the experience of the great majority of people receiving home care services from the providers detailed was a positive one, however we recognise that achieving feedback from people using the full range of home care services will be an important next step.

We recognised the themes of recruitment, rurality and hospital discharge picked up by the project as an ongoing challenge and we are working with Shropshire Partners in Care (SPiC) and the wider health and social care system in actively trying to address those issues with the aim of achieving better outcomes for the people of Shropshire.

We are currently looking at ways of sourcing care packages more quickly and more effectively in the South-West of the County where rurality, sparsity of population, recruitment issues, winter weather and the road network combine to make sourcing care very difficult in many parts of this area.

Continuity and consistency of carers is one of the most important things for people receiving support but a challenging issue to address in home care. During the pandemic providers have been able to use the Infection Control grant to limit the numbers of different carers going in to each client, however, without this additional financial support this is a challenge in 'normal' times due to the part time nature of the workforce and covering annual leave and sickness.

5.0 Current market position

Shropshire Council currently spend around £77,000 (not inc. START) per week on reablement and around £800,000 per week on long term domiciliary care.

Market availability, which normally at this time of year would be very limited is now in the region of 1800 available hours a week which is unprecedented. In the main this is due to the fact that there is a lower level of demand for care than we would expect at this time of year and some clients have said they do not want carers coming into their home during the pandemic and family have provided care, especially with numbers of people furloughed. The combination of less work and income and increased costs does present significant risks for providers.

Overall the risk to Shropshire Council is currently moderate as we are managing and supporting the market well. No Domiciliary care providers in the market have closed since the start of the pandemic and no providers have handed back placements on financial grounds. In addition, this winter we have more market capacity and contingency planning in place than ever before, and market providers indicate a very clear willingness to work with us productively and in different ways to ensure that we can meet the needs in Shropshire throughout the winter.

Although we are in a strong position in the County as set out in this report there is a remaining risk to the Council, to providers and to continuity of care due to the unpredictable nature of outbreaks, and financial impact if there were provider failure. Whilst we have been and will continue to give significant amounts of support to prevent failure, if a situation arose where a substantial provider was to withdraw from the

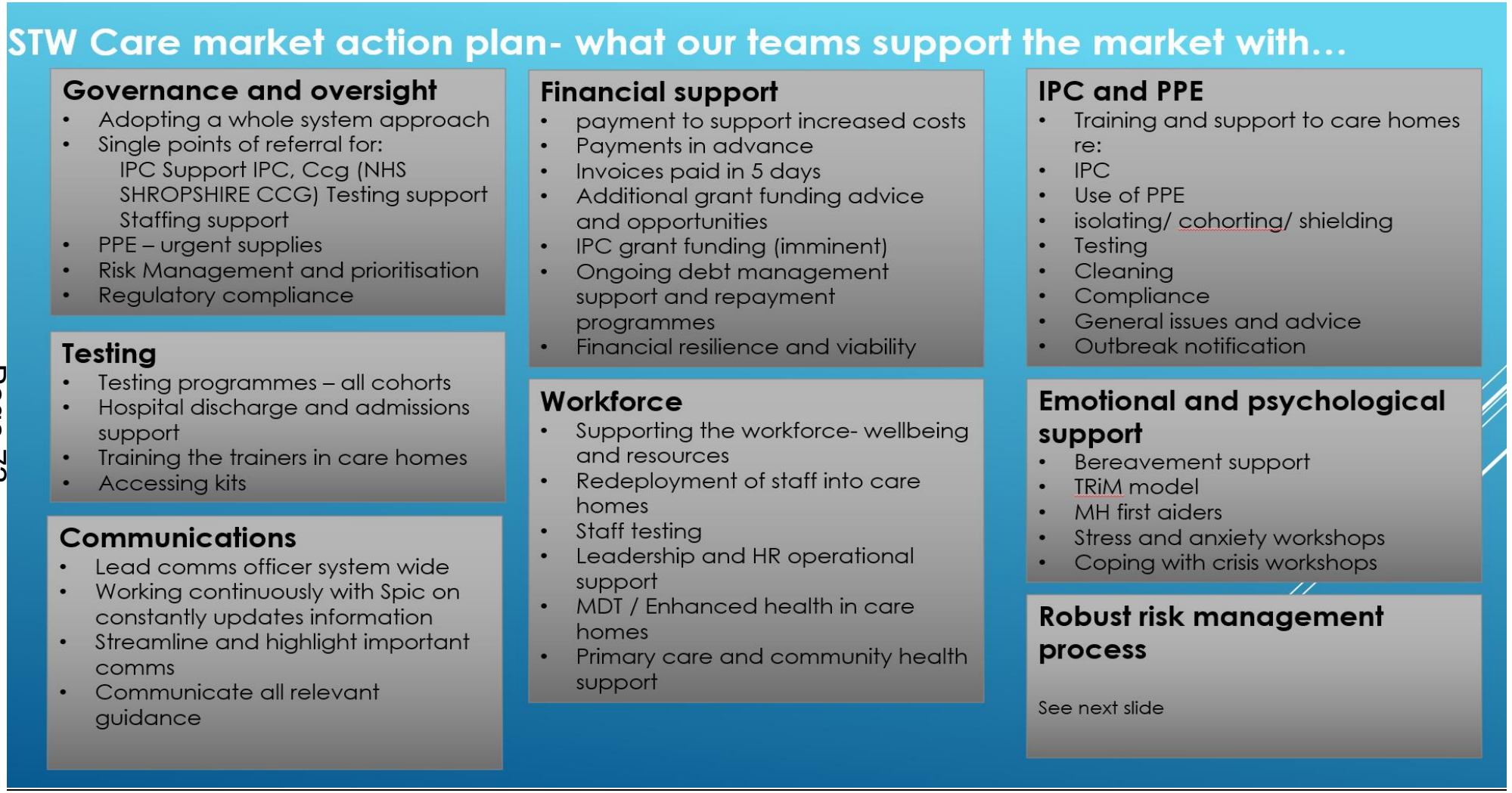
market, and we saw increased demands at the same time there are both financial and reputational risks to the council.

Going forward we want to support our Shropshire providers to diversify services into different ways of working to support their sustainability and make sure that Shropshire Council are prepared for the future through opportunities such as outreach care and alternative day offers, to name a few examples.

We have already started this work with significant engagement with providers and we are currently commissioning different kinds of community support such as the 2 Carers in a car service, and a new pilot service for community support in the South West of the County which will deliver outcome focussed community care for this rural area to support winter pressures which starts on 11th January.

List of background papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Councillor Dean Carroll
Local Member All
Appendices Appendix A Market support and risk management processes

Appendix 1


STW Care market action plan- what our teams support the market with…
Governance and oversight
• Adopting a whole system approach
• Single points of referral for:
IPC Support IPC, Ccg (NHS SHROPSHIRE CCG) Testing support Staffing support
• PPE – urgent supplies
• Risk Management and prioritisation
• Regulatory compliance
Testing
• Testing programmes – all cohorts
• Hospital discharge and admissions support
• Training the trainers in care homes
• Accessing kits
Communications
• Lead comms officer system wide
• Working continuously with Spic on constantly updates information
• Streamline and highlight important comms
• Communicate all relevant guidance
Financial support
• payment to support increased costs
• Payments in advance
• Invoices paid in 5 days
• Additional grant funding advice and opportunities
• IPC grant funding (imminent)
• Ongoing debt management support and repayment programmes
• Financial resilience and viability
Workforce
• Supporting the workforce- wellbeing and resources
• Redeployment of staff into care homes
• Staff testing
• Leadership and HR operational support
• MDT / Enhanced health in care homes
• Primary care and community health support
IPC and PPE
• Training and support to care homes re:
• IPC
• Use of PPE
• isolating/ cohorting/ shielding
• Testing
• Cleaning
• Compliance
• General issues and advice
• Outbreak notification
Emotional and psychological support
• Bereavement support
• TRiM model
• MH first aiders
• Stress and anxiety workshops
• Coping with crisis workshops
Robust risk management process
See next slide

STW Risk Management Process….

Risk assessment information sources

Baseline Risk Assessment
- CQC status and report
- Suspension, Change of Ownership, Concerns, Food Hygiene rating.
- Safeguarding issues
- MDT issues
- Concerns raised with contract and monitoring teams

C19 Outbreak risk assessment
- PHE England outbreaks information
- PHS/ Welfare calls outbreaks information
- Information from tracker
- IPC information and status

C19 Workforce Status risk assessment
- National tracker information
- Exclusivity of staff from tracker
- Welfare calls information

C19 PPE Risks
- National tracker information
- Welfare calls information
- IPC information and status

Outliers (general issues/wider concerns)
- Financial viability concerns (occupancy data/ contact from care homes)
- Welfare calls concerns
- Professionals report concerns
- Testing booking calls concerns

Risk Assessment and mitigation process

- Daily Care home review meeting
- Weekly care home risk analysis meeting incorporating social care and health protection risk (separate for each authority)
- Additional Mitigations and actions agreed
- referrals made as required
- Daily information into dashboards/ sitreps/PHE report/ admissions data

Referral destinations

Staff resource Risk
Referred For Wraparound support/
Redeployment from system
- weekly redeployment huddle meeting
- Referral to appropriate process

Health protection risk
- Outbreak control measures
- SPH/training/testing

PPE Risk
Identification of pathway dependent on nature of risk
- referral to LRF PPE team if issue is due to supply shortage
- refer to IPC team if issue is due to incorrect use / lack of knowledge

IPC Risk
Referral though to IPC team for support on training/ Testing/ IPC advice

Operational Risk
Referrals for multiple operational risks/ safeguarding/ medicine management/ clinical and discharge risks as required

Financial Viability Risk
Referred to commissioners for individual action according to viability issue

Actions and processes

Action - Redeployment from system
Process - redeployment request form, or

Action - Front line carers from Internal Local Authority staff resources
Process - referral to LA HR team, or

Action - Front line carers from Dom care market
Process - referral to brokerage team

Action – Referral to appropriate testing procedure for Staff testing and resident testing
Process – as required according to testing grid to ascertain cohort and symptom status

Supply shortage
Action - refer to LRRP PPE team
Process - contact www.shropshire.gov.uk/ppeform

Incorrect use of PPE/ Lack of infection control
Action - Enhanced IPC training referral (for IPC usage donning doffing etc) referrals and advice
Process referral email to ccg.ipc@nhs.net

Clinical issue
Action - clinical issues to be referred through to the named clinical lead for the relevant care home
Weekly GP calls to care providers
Process-email to katylewis@nhs.net

Regulatory issue
Action - to be reported through to CQC
Process - report to enquiries@cqc.org.uk

Individual Care/Safeguarding and discharge issues
Action - to be reported through LA routes
Process - report to Local Authority SW teams/ FPOC

Medicine management Issue
Action – Referral to medicines management team
Process – email address TBC

Action – Commissioner signpost to grant funding opportunities within council / individual discussion with provider/ SPiC as required and appropriate on an individual basis

All enquiries on this process to deborah.webster@shropshire.gov.uk v 0.3

Health and Adult Social Care Overview and Scrutiny Committee **25 January 2021**	**Item** **Public**

Health and Adult Social Care Overview and Scrutiny Committee
Work Programme 2020-2021

Responsible officer
Danial Webb, overview and scrutiny officer
danial.webb@shropshire.gov.uk
01743 258509

1.0 Summary

1.1 This paper presents the Health and Adult Social Care Overview and Scrutiny Committee's proposed work programme until May 2021.

2.0 Recommendations

2.1 Committee members to:

- agree the proposed committee work programme attached as **appendix 1**
- note the current task and finish groups attached as **appendix 2**
- suggest changes to the committee work programme and
- recommend other topics to consider.

3.0 Background

3.1 As there will a be an election of all elected members to Shropshire Council in May 2021, this draft work programme only includes items planned to be considered by the committee before the elections take place.

3.2 A refreshed draft overview and scrutiny work programme for this committee is attached as **appendix 1**. A refreshed list of current task and finish groups is attached as **appendix 2**.

4.0 Next steps

4.1 Overview and scrutiny updates this work programme on an ongoing basis and presents it at each committee meeting. This will allow committee members the opportunity to contribute to its development at each committee meeting.

List of background papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) None
Cabinet Member (Portfolio Holder) All
Local Member All
Appendices Overview and scrutiny work programme Overview and scrutiny task and finish groups

Appendix 1

Overview and Scrutiny work programme 2020-2021

Health and Adult Social Care Overview and Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Improved Better Care Fund	• Receive an update on the Government's arrangements for funding the fund. • Provide examples of work arising from Start funding.	Committee overview report	Interim Director Adult Social Care	Work undertaken with IBCF funding remains sustainable.	25 Jan 2021
Joint Strategic Needs Assessments	• To receive a resourced plan to create joint strategic needs assessments for commissioning health services and services for children and young people with a special educational need or disability.	Draft action plan	Chairs, Health and Wellbeing Board Director of Public Health	Ensure Shropshire has the robust intelligence it requires to make effective commissioning decisions.	25 Jan 2021
Domiciliary Care	• Understand the impact of Covid-19 on the provision of domiciliary services. • Understand through the brokerage systems patterns of demand, and how changing patterns influence strategy. • .	Committee overview report	Interim Director Adult Social Care SPIC	Domiciliary services meet the needs of people in Shropshire.	25 Jan 2021

Health and Adult Social Care Overview and Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
111 Review	• Scrutinise progress in delivering the new arrangements for 111 services in Shropshire. • Understand how cross-border arrangements are working.	Committee overview report Presentation to committee	Shropshire Clinical Commissioning Group Shropshire Community Health Trust Julie Davies	Arrangements for 111 services are working well.	22 Mar 2021
Delivering Public Health Outcomes - update	• To review the memorandums of understanding for substituted services.	Committee overview report	Director of Public Health	Substituted services deliver good public health outcomes.	22 Mar 2021

Health and Adult Social Care Overview and Scrutiny Committee

Topic	Intended outcomes or objectives	What output is required?	Who needs to be heard from?	Expected impact or added value	Work date
Future Fit and patient transport services	• To scrutinise current contract arrangements for patient transport services. • To receive an update on any proposed changes to commissioned patient transport services to meet Future Fit proposals. • To understand how commissioned services co-ordinate with other public and community transport services in Shropshire.	Committee overview report	Shropshire Clinical Commissioning Group		22 March 2021
Adult Mental Health	• Understand commissioning arrangements for adult mental health services. • Scrutinise how Shropshire Council works with health service partner to provide support to patients.	Committee Overview Report	Midlands Partnership Foundation Trust Adult Services Operations Service Manager	Shropshire Council has effective partnerships that provide good metal health services.	12 April 2021 (date TBC)

Appendix 2
Current and proposed task and finish groups

Road casualty reduction	• Understand the nature of road traffic collisions in Shropshire. • Understand feelings of road safety, and the effect of feeling unsafe when travelling. • Understand the factors that contribute to safer travel • Scrutinise how Shropshire Council and its partners work together to make travel safer. • Explore how Shropshire Council responds to new models of Government transport funding.	Place Overview Committee
Brexit	• To consider the information brought together to develop a view for Shropshire of the possible implications of Brexit for the Shropshire economy and the achievement of the Economic Growth Strategy. • To identify, with the relevant officers, the key evidence and related requirements of what Shropshire would require from a future UK funding approach. • To make evidence based recommendations to Cabinet.	Performance Management Scrutiny Committee

Section 106 and Community Infrastructure Levy	• To understand how Shropshire Council currently uses Section 106, CIL and NHB and the impact that this has had • To understand how Section 106, CIL and NHB could be used in Shropshire to enable or encourage projects or initiatives for economic growth and prosperity • To learn from other places how they have used Section 106, CIL and NHB to enable or encourage projects or initiatives for economic growth and prosperity • To make evidence based recommendations on how Section 106, CIL and NHB could be used in Shropshire to enable or encourage projects or initiatives for economic growth and prosperity	Performance Management Scrutiny
Climate Change	• To review Shropshire Council's existing work to reduce its CO2e output. • To scrutinise existing council policy and practice and recommend policy changes that would support further carbon reduction. • To identify and evaluate opportunities to reduce spending and generate income by adopting low-carbon technology and practices.	Place Overview Committee

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