SHROPSHIRE HEALTH AND WELLBEING BOARD

Meeting Date: Thursday 3rd, March 2022

Paper title: Better Care Fund (BCF) Update

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1. Summary

This report provides an update from the Joint Commissioning Board and highlights a number of developments and system challenges that have developed over the last number of months. These include:

- Government approval of Shropshire's 21/22 BCF Plan and Metrics submitted in November 2021, update on metrics and plans to update the section 75 agreement in accordance with the new metrics in the financial year
- System pressure and the collaborative response to support hospital discharge and system flow
- An update from the Joint Commissioning Delivery Group including joint commissioning projects and the Market Position Statement (to be delivered by September)
- Progress on prevention and early help work to support Children and Young People (CYP) in Shropshire, including CYP Social Prescribing
- Our Good New Story - Adult Social Prescribing

2. Recommendations

2.1 The HWBB to note updates on joint commissioning approach;
2.2 Note Section 75 update approach;
2.3 The HWBB note progress of Children and Young People (CYP) Early Help and Prevention work
2.4 The HWBB note the good progress of Social Prescribing

3. Report

BCF Plan and Metrics

3.1 In January, the BCF plan and metrics received final approval from the Department of Health and Social Care. The Shropshire BCF plan focusses on supporting people to live healthy, fulfilled, independent and longer lives; and requires services to work ever more closely together towards common aims. There is renewed emphasis in 2021/22 on system flow and hospital discharge; Shropshire's priorities are Prevention and Inequalities, Admission Avoidance and System Flow. The national conditions for the BCF in 2021 to 2022 are:

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

3.2 The framework retains two existing metrics from previous years:

- effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)

- older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.

New measures include:

- reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days
- improving the proportion of people discharged home using data on discharge to their usual place of residence
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator)

The following metric are proposed based on the data sets received for the Shropshire:

Shropshire metrics (Q = Quarter)	**Average 18 months data pack**	**Ave. by Q3**	**Ave. by Q4**	**Agreed target Q3**	**Agreed target Q4**	**Update on targets**
Length of Stay 14 days	9.6	9.75	10.9	9.3	9.6	9.7 to 11.21
Length of Stay 21 days	4.4	4.5	5.2	4.4	4.9	4.5 to 11.21
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Average annual target 90.3			90.3 maintain as annual target		Awaiting annual figure
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below)	20/21 actual 544		21/22 proposed target 543.2		Awaiting annual figure
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/reablement services.		20/21 Actual 85.3%		82% ASCOF set target		83.6%
Residential Admissions rate per 100,000 population		19/20 553	20/21 403	2021/22 590		Q3 399 vs target of 450

3.3 At a regional BCF update it is envisaged that planning for 2022/23 will start much earlier this year and it will align to the new 'Integration white paper' released on the 9th February 2022 which will aim to bring NHS and local government closer together to improve care for all and value for money.

3.4 In recognition that the CCG is on track to gain approval to become an Integrated Care System (ICS) from the 1 July this year, a new section 75 template will be issued nationally and it is our aim to update the Section 75 Agreement in line with the new metrics and the new organisation in Quarter 2 of the new financial year.

System Pressure and Response

3.5 Winter 21/22 has seen significant challenges in the health and care system, and there has been significant focus on supporting system flow for discharges from hospital. This has included system escalation calls 7 days a week via Bronze, Silver and Gold meetings daily to ensure flow and alleviate any pressures where possible.

3.6 Due to workforce pressures across health and care, exacerbated by Covid, responding to these challenges has been difficult for the system; this has been noted particularly across the Domiciliary Care sector. Additionally, due to the increasing number of Covid outbreaks across the Care Homes, in combination with the mandatory vaccination requirement (which resulted in a number of people leaving the sector), providing care has never been more difficult.

3.7 In order to manage this, additional funding for capacity has been invested into beds in and out of county; additional Domiciliary Care capacity has been facilitated by, increasing hours of existing

workforce, welcome payment incentives to encourage new recruits and sustain current staff, recruitment and retention campaign, carers payments; staff have also been moved to liaise with the care sector to update front line workers on live capacity that day.

3.8 Work has progressed with the voluntary and community sector to support admission avoidance and discharge:

Red Cross – Home from Hospital, Commissioned by the CCG	**Home from Hospital Service** – providing support for residents following discharge for up to 6 weeks. This service covers the entire county (excluding the SW which Age UK have a contract for). More recently the capacity of this team has extended into support surrounding **admission avoidance** – the type of support is comparable to what they do usually upon discharge.
Red Cross – Independent Living Coordinators (ILP), Shropshire Council Commissioned	**Independent Living Coordinators** – we have 3 ILP's (with a remit for Central / North / South). They work closely with ASC (ICS specifically) and Patient Flow Coordinators (employed by SaTH) in order to assist with a swift and supported discharges home (usually for people being discharged on pathway 0 or 1). For the longest time there has just been 1 ILC on-hand in the Central area, so it's great that we've been able to extend this provision countywide. The support offered by the ILP's is very short-term including: transport home; getting a resident settled back in at home i.e. heating on / food in the fridge; fitting low level equipment; perhaps liaising with family members where needed and may include a referral to the Home from Hospital service if it's felt that there is value for more on-going support.
Age UK Winter Support Service, Shropshire Council commissioned, referrals that come into the service. The WSS will end in April.	This service takes referrals from Independent Living Coordinators, Primary Care and other referrers. The service can offer - assessment and ongoing support to people identified as needing help, including: • Transport returning home from hospital • Settling people in at home following discharge from hospital • Fitting of low-level equipment e.g. key safes and pendant alarms • Collecting and delivering medications • Shopping and delivery • Wellbeing home visits • Companionship for isolated or lonely people • Hot food

3.9 Additional work includes, Social Work capacity has been placed at the front door of A&E, and additional training and support being developed to ensure people are referred into social prescribing as appropriate; Step up and step down provision continues with the inhouse START teams; and further work to scope 7 day working is currently underway across the system.

3.10 The challenges in the system and lessons learned through Covid have highlighted that working as a system can make real improvement in delivery and system flow. Work is progressing on how this can be streamlined specifically how the system works across 7 days and potential impact and change required to do this successfully.

Joint Delivery Group Update

3.11 There are a number of pieces of work currently being developed by the Joint Delivery Group, these include: Independent Living Service, re-commissioning of Healthwatch, re-commissioning of a learning disability residential home and the development of a Market Position Statement/Market Sustainability Strategy by September (which will need to include housing/accommodation).

3.12 The Independent Living Service will be recommissioned on a short-term basis in order to review this service along with the integrated equipment service to align pathways for residents. The availability of an Independent Living Centre service will support our priorities in helping to increase the availability and use of aids and adaptations through promotion and signposting, as well as its core activity of undertaking occupational therapy assessments, or 'consultations', for adaptations and equipment. This is an area of development for the council.

3.13 The Joint Delivery Group has approved and recommended the business case for the re-commissioning of a local learning disability care home contract; the business case highlights that Shropshire Council will retain ownership as a residential home for individuals with complex needs in Shropshire, and enter into a lease arrangement with the successful provider to deliver the care and support into the home.

3.14 Work is underway to scope out potential delivery models in order to recommission Healthwatch which is a statutory service. The work is in early stages and stakeholder discussions will be taking place in the coming months. Nationally a specification provides a blueprint for this work, but locally stakeholders provide great insight into how the role of Healthwatch supports service development and the people of Shropshire.

3.15 Finally, the Joint Delivery Group is leading the development of our Market Position Statement (MPS). A MPS is good practice for local authorities to evidence how its fulfilling its duties within the Care Act to manage the care market. As part of requirements to do a fair cost of care for care homes and domiciliary care by Sept 2022. There is also a requirement to produce a MPS/Market sustainability plan also to be complete by Sept 2022 and signed off by the DHSC. As part of the joint approach Shropshire is working with Shropshire, Telford and Wrekin CCG and LA to pull out an overarching ICS MPS.

Children and Young People (CYP) prevention and Early Help (including Social Prescribing)

3.16 Senior leaders across the NHS Community Trust, Shropshire Council Early Help, Children's Social Care and Public Health services met to agree and reinforce the need for dedicated work on prevention and early help to support children and young people.

3.17 Following this, a dedicated team is developing an overarching strategic draft framework which takes an all-age approach for Early Help and Prevention.

3.18 To support this development, two workshops delivered in December 2021 and January 2022 with a further 3 planned, have identified opportunities for joint working and a commitment to working differently. Initial projects are being implemented around the following:

- Best Start and Early Years
- Supporting schools
- Triage Model and Social Prescribing
- Supporting the Stepping Stones project

3.19 Staff attending the workshops clearly articulated their desire to work differently and to work collaboratively. Critical to the approach was working more closely with local schools and preschool, providing a stronger community offer and creating stronger connections across service areas.

3.20 The draft vision is as follows:

- Eyes and ears on all children, leaving no child or family behind
- Ensuring children, and families are at the centre of everything that we do
- Ensure our Early Help offer covering the locality based hubs includes early years, early intervention, wellbeing and resilience with schools at the centre
- Develop a more comprehensive community based prevention offer for CYP and families which incorporates effective early intervention, and prevention (primary, secondary, tertiary)

3.21 The work will take account of evidence base on what works, the data highlighting greatest areas of need and learning from local programmes such as Children and Young People Social Prescribing, triage models, the Holiday Activity and Food programme and others.

3.22 As an example, the CYP Social Prescribing programme is delivering a bespoke programme for CYP operating in the south west of the county, through a Social Prescribing Link Worker (SPLW) who takes referrals from schools, GP's, Early Help and other partners, where there are concerns about young people. The SPLW offers one to one support, over a few sessions. Shropshire Council also funded additional activity for young people in this rural area, which has resulted in a Provider Collaborative. In 7 months of the project 51 referrals have been made to the link worker; over 60 children (additional children) have taken part in activities (a range of boxing, multi-activity and art/ music sessions), to improve confidence, resilience and

happiness. Learning from the referrals into this programme and feedback from young people themselves gives us valuable insight into how to develop services going forward. The Board may wish to receive a full report of CYP Social Prescribing, which details progress and outcomes, in the future.

Good new story: adult Social Prescribing programme

3.23 Social Prescribing in Shropshire is demonstrating fantastic outcomes for people. Shropshire's Social Prescribing Service is offered across all 4 Shropshire PCNs. People referred to the service benefit from one to one support from a Healthy Lives Advisor and onward referrals are made when appropriate to community activity and support. Work is underway to make improvements to the service to bring more people through the service. The advisors are developing how they work in a multi-disciplinary way within the PCN to support people, working with care coordinators, mental health support offers, pharmacy and others. The service has also recently expanded to offer Health Coaching in the South East and South West PCNs. The service will work in tandem with a recently commissioned weight management service, and an in-house group weight management offer. **Appendix A** demonstrates good and improving referral rates across all PCNs, and fantastic outcomes for those who have been through the service.

3.24 As mentioned above, the service has also expanded in the South West of Shropshire to open a Children and Young People's service. The largest referral reason is emotional and mental wellbeing, followed by lack of confidence and isolated and/or lonely. This service has benefitted from developing positive relationships with schools and community provider organisations. To coincide with the link worker position, community providers have been grant funded to provide additional activity and are working hard to offer more than just new experiences for people; their approach provides mentoring and wellbeing to ensure both better outcomes for CYP, and also contributes to community involvement and development. Schools, activity providers and the Social Prescribing Advisor are articulating really positive outcomes for CYP. Schools are reporting that children involved are more engaged in school and seem happier; one activity provider reports that CYP have improved emotional regulation and happiness. More outcome data will be available as we use the co-produced Personal Care and Support plan to demonstrate outcomes.

4. Risk assessment and opportunities appraisal

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

4.1 The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.

4.2 The schemes of the BCF and other system planning have been done by engaging with stakeholders, service users, and patients

4.3 This grant funding to support system flow, admissions avoidance and transfers of care schemes, holds significant financial risk should the grant funding stop.

4.4 All schemes are being reviewed in 2022 with consideration on future strategy and developments to support the new metrics.

5. Financial implications

5.1 Financial allocations and requirements are set out below.

Better Care Fund Allocations

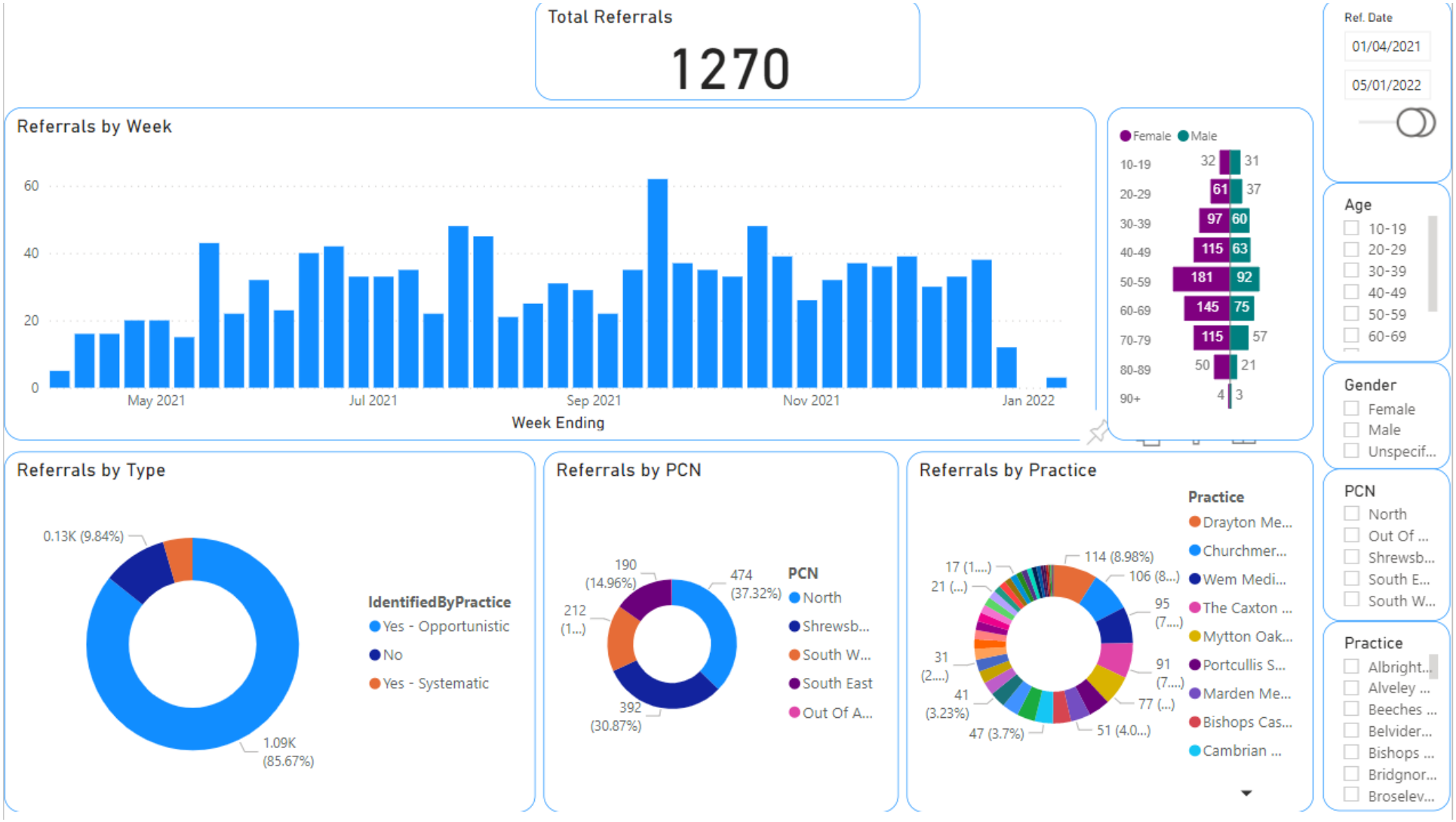
	2021/22 Planned Allocations	2020/21 Planned Allocations
Pooled Fund		
Shropshire CCG Minimum Contribution	7,872,538	7,475,229
Shropshire CCG Additional Contribution		304,073
Total	**7,872,538**	**7,779,302**
Non-Pooled Fund		
Shropshire CCG Minimum Contribution	15,443,430	14,303,923
Improved Better Care Fund Grant	11,514,602	11,514,602
Disabled Facilities Grant	3,641,433	3,641,433
Additional Shropshire Council Contribution	1,955,475	1,831,023
Total	**32,554,940**	**31,290,981**
Additional CCG Contribution – Covid-19	2,600,000	6,000,000
Total Better Care Fund	**43,027,478**	**45,070,283**

6. Climate Change Appraisal

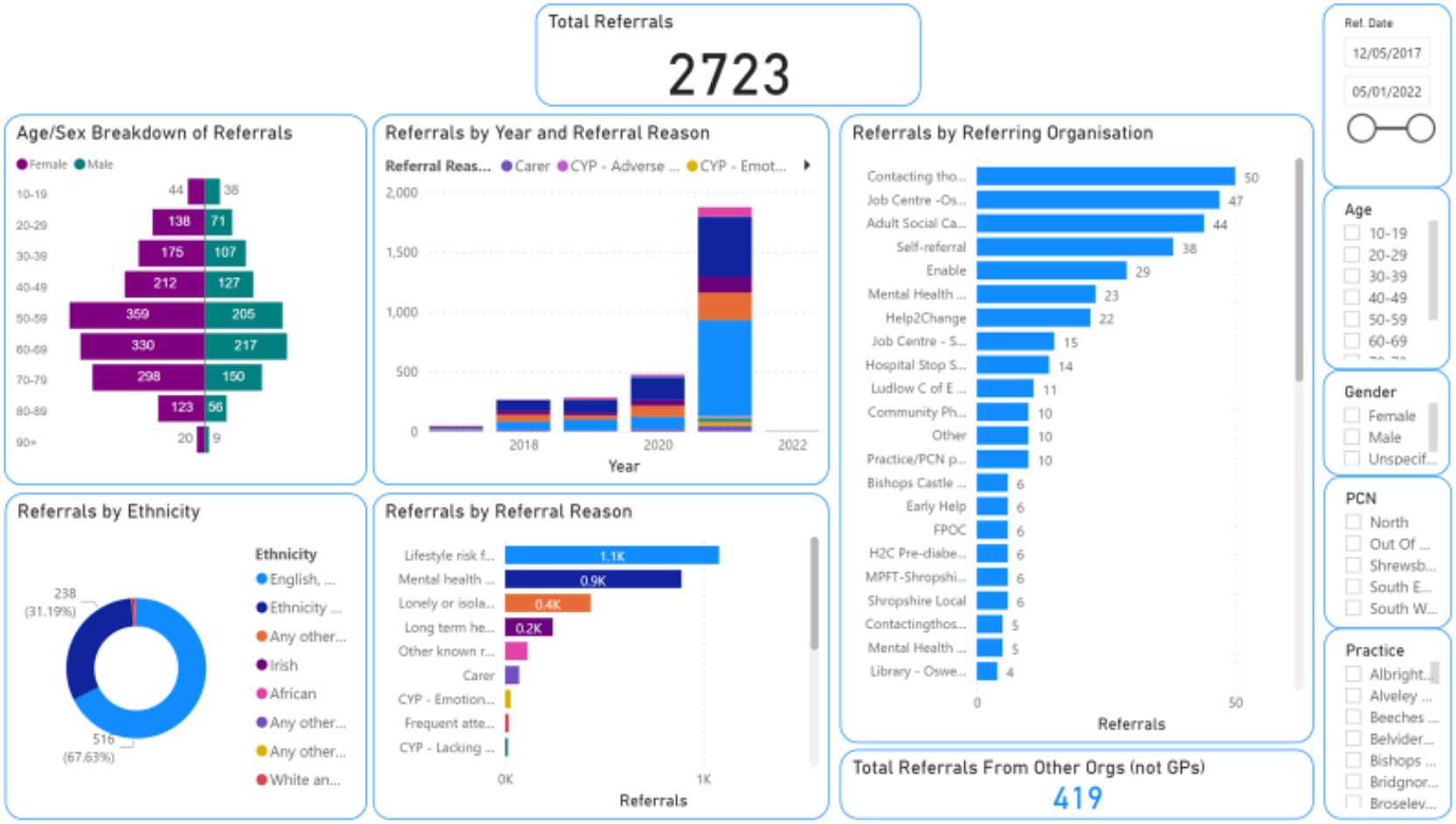
All projects and commissioned services need to evaluate climate impact on all service delivery if applicable.

List of Background Papers N/A
Cabinet Member (Portfolio Holder): Cllr. Simon Jones, Portfolio Holder for Adult Social Care and Public Health Tanya Miles: Executive Director Adult Social Care / Housing and Public Health
Appendices: **Appendix A: Social Prescribing referral and outcome data**

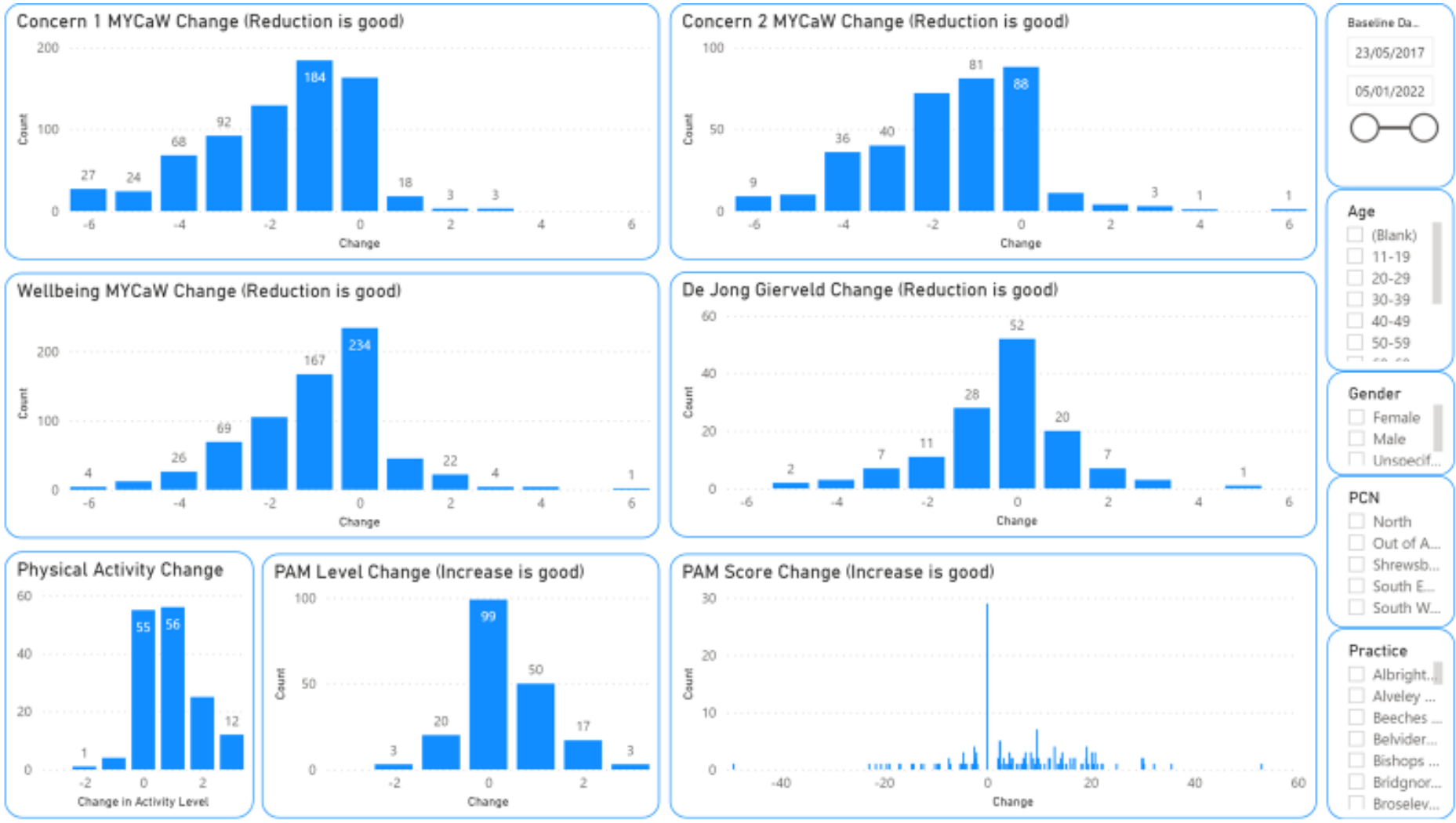
Appendix A – Social Prescribing Referral and Outcome Monitoring Data
Total Referrals – April 2021 – 5th January 2022



All referrals from 2017, with referral reason



Outcomes, demonstrating significant improvement in wellbeing



More recent inclusion of ONS measure demonstrates significant improvement in wellbeing