HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Shropshire Health and Wellbeing Board

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

- Shropshire Council (including Adult Services, Housing, Children's Services, Public Health and Place)
- Shropshire, Telford and Wrekin ICB
- Voluntary and Community Sector organisations (various)
- Voluntary and Community Sector Assembly (the Voice of the Sector)
- Healthwatch Shropshire
- Shropshire Community Health Trust (ShropCom)
- Shrewsbury and Telford Hospitals (SaTH)
- Midlands Foundation Partnership Trust (MPFT)
- Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust (RJAH)
- Individuals, patients, experts by experience

How have you gone about involving these stakeholders?

Our system works with individuals and patients, delivering personalised care to ensure shared decision making and choice; we work with statutory and non statutory partners (listed above) through integration programmes; and we work through partnership boards to involve the right stakeholders at the right time.

Additionally the Better Care Fund plan is produced through a collaborative working group with members from across the system, including the Local Authority, ICB, Primary Care, VCSE, and Provider Partners.

Through the Health and Wellbeing Board, Shropshire Integrated Place Partnership, Shropshire Infrastructure Partnership (voluntary and community sector forum of interest), Joint Commissioning Board, the BCF working group, the Discharge Alliance, and the Urgency and Emergency Care Board, the following groups have been involved in developing the Better Care Fund Plan:

- Shropshire Council
- Shropshire, Telford and Wrekin ICB
- Voluntary and Community Sector organisations (various)
- Voluntary and Community Sector Assembly
- Healthwatch
- Shropshire Community Health Trust
- Shrewsbury and Telford Hospitals

- Midlands Foundation Partnership Trust
- Shropshire Partners in Care (SPIC)
- Individuals/ patient reps/ experts by experience

Additionally, through partnership groups, (such as the Mental Health and Carers Partnership Boards) and involvement processes (such as , individual schemes within the BCF have included patient and service user involvement in their development and review.

Through our partnership boards transformation programmes are routinely challenged to ensure the appropriate service user/ stakeholder involvement in the development of our work.

We have a strong track record of working closely with our partners in the Voluntary and Community Sector. We have two key umbrella organisations Voluntary and Community Sector Assembly (VCSA) and Shropshire Partners in Care (SPIC) who represent the Voluntary Sector and Care sector and the independent sector respectively. To aid joint working Shropshire Council has signed up to the Compact with the VCSA which sets out principles of working – to ensure respect and mutual support. Recently the ICB has also led on developing a Memorandum of Understanding with the VCSE.

Through SPIC (who have a place on our Health and Wellbeing Board and who are members of multiple system groups) we are able to connect easily with our Care partners and develop joint working in a very positive and respectful way.]

Governance

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

The Better Care Fund programmes are developed through a range of system programmes. Oversight for the development of the plan (which joins up the work of our system) is through the Shropshire Integrated Place Partnership (SHIPP) Board and approval sits with the HWBB. A BCF working group works with the Joint Commissioning Delivery Group and system groups to determine the plan. The Governance diagram below demonstrates the interconnectedness of the programme boards, the Health and Wellbeing Board and the ICS. Endorsement and approval of the Better Care Fund plan sits with the HWBB.

Our prevention programmes are governed through Healthy Lives, Joint Commissioning Board and Shropshire Integrated Place Partnership; with final approval and endorsement through the Health and Wellbeing Board.

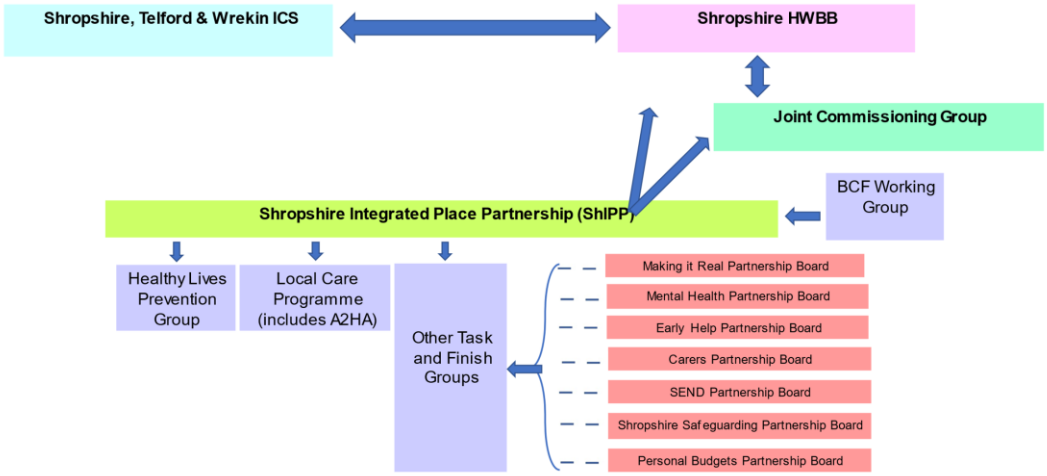
In addition to admission avoidance through our prevention programmes, our key admission avoidance programmes are governed through our Local Care programme, with approvals through Shropshire Integrated Place Partnership and the HWBB.

Central to delivering against the discharge targets is the Urgent & Emergency Care Board (UEC) and the Discharge Alliance, who support strategic planning and operational delivery of discharge processes, respectively, in Shropshire. The Governance for this Board is highlighted below, connectivity between the UEC and the HWBB is through the ICB Board. However, system partners flow information and joint working through system working groups and boards regularly.

While the BCF is a regular item at Joint Commissioning, SHIPP and HWBB, improving our governance arrangements will involve BCF having regular reporting at our Urgent and Emergency Care Board, as well as the System Executive group. Governance diagrams below.

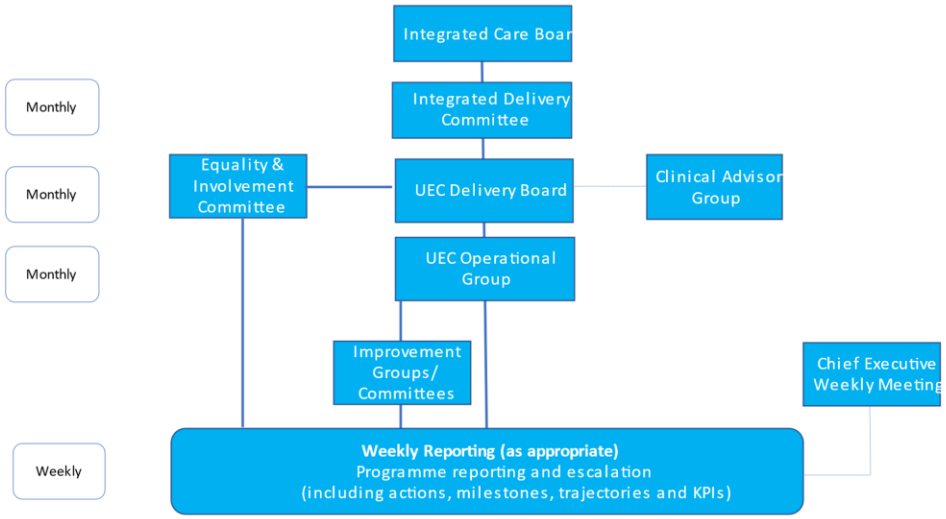
Through 2023/24 our governance will continue to be reviews and synthesized to realise opportunities for greater integration and greater collaboration across Shropshire and Telford and Wrekin.

Shropshire HWBB Governance Structure



Governance Framework

Urgent and Emergency Care Improvement is embedded into the systems structures to ensure actions and decisions leading to implementation are visible and agreed.



Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Since the previous Better Care Fund Plan (BCF), there has been good local development and learning, as well as the development of the Integrated Care Board as part of Shropshire Telford and Wrekin Integrated Care System. The system continues to work collaboratively to integrate services, reaffirm its vision and priorities through the Joint Forward Plan, strategically led by the Shropshire Health and Wellbeing Board and the ICB Board, informed by the Joint Strategic Needs Assessment. STW ICS continues to work collaboratively to reduce inequalities and reduce the impact of the covid pandemic and subsequent economic and health equity issues facing our families and communities. Opportunities are plenty for more joined up working and the BCF continues to support the delivery of Shropshire's HWBB and Shropshire Integrated Place Strategy and Priorities.

The HWBB Strategy has been refreshed and launch in March 2022. The strategy works through key areas of focus (Mental Health, Children and Young People, Healthy Weight and Workforce) to deliver the following strategic priorities:

- **Reducing Inequalities** – Everyone has a fair chance to live their life well, no matter where they live, or their background.
- **Improving Population and Environmental Health** - Improving the health of the entire Shropshire population, including preventing avoidable health conditions and helping people manage existing health conditions so they don't become worse.
- **Joined up Working** - The local System (i.e. the organisations who provide or support health and care such as NHS/Council/Voluntary and Community Sector), will work together and have joint understanding of health being social and economic, not just absence of disease.
- **Working with and building strong and vibrant communities** - Working with our communities to increase access to social support and influence positive healthy lifestyles

Key elements of ours strategic plans include developing our Person Centred Care approach, as well as an integrated approach, working towards more equitable good quality services, preventing ill health and wellbeing as a first port of call.

Informed by the strategic plans mentioned above, the The BCF priorities have remained completely relevant and unchanged from the previous year. The priorities and key programmes areas are:

Prevention and inequalities – keeping people well and self-sufficient and in their usual place of residence; key programmes include: Healthy Lives, including community referral (Let's Talk Local, Community Development, Social Prescribing and Health coaches), Healthy Weight, Dementia strategy, Voluntary and Community Sector grants and contracts (Wellbeing and Independence and Advice and Advocacy contracts, Falls and hospital discharge), Assistive tech (through the DFG), Population Health Management, Carers, Mental health and Early Help services for children and young people. Our inequalities work crosses all work programmes but can be articulated in this section. We have developed a Shropshire Inequalities Strategy and are implementing a number of

programmes under the banner of the Core 20 Plus 5 model (articulated in the Inequalities section). Despite a strong focus on prevention in the Shropshire system, investment in prevention has stagnated, and as such investment in our Voluntary and Community Sector is not where it needs to be to really provide the prevention approach that is needed to reduce pressure on our secondary services. As such we are in the midst of developing a Prevention Strategy/ Framework, that puts primary through tertiary prevention at the heart of all that we do.

Admission Avoidance – when people are not so well, we support people to find the right service at the right time, in the community; key programmes include: Local Care (Rapid Response, Proactive Care (Case Management), Respiratory, Virtual ward, Care at Home), Integrated Community Services, Carers, Winter Pressures schemes, Occupational Therapy and Mental Health.

Delayed Transfers and system flow – when people have had to go into hospital, we are working collaboratively through the Urgent Care Board and the Hospital Discharge Alliance, using the 9 High Impact Model, learning from Covid, Discharge to Assess and an Enhanced Integrated Discharge Hub, to ensure system flow; Key areas of work include: Enhanced Integrated Discharge Hub (hospital social work interface and short term support purchasing), Reablement Transformation, Start Reablement Team, Integrated community services, UEC improvement plan (including therapies and supporting people to be independent), Joint Equipment contract, Assistive technology, and Pathway 0.

Four key elements unite all of our programmes:

- a focus on inequalities
- a focus on integration and collaborative commissioning
- taking a strengths-based, person centred approach at every stage – personalised care
- taking an evidence based approach

Key development areas for 23/24 include:

- Continuing to improve discharge arrangements, working closely with UEC Improvement Plan and D2A, including launching a Reablement Transformation programme
- Care Homes and domiciliary care – commissioning of the Independent Sector
- Supported Living – MH/LDA – commissioning of the Independent Sector
- Complex CYP placements – commissioning of the independent Sector
- Falls admission avoidance and preventative services
- Prevention and the Voluntary and Community Sector
- Carers support and Offer
- Digital offer
- Local Care Transformation Programme – Place and neighbourhoods (which will link to Reablement Transformation and Proactive Care)

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

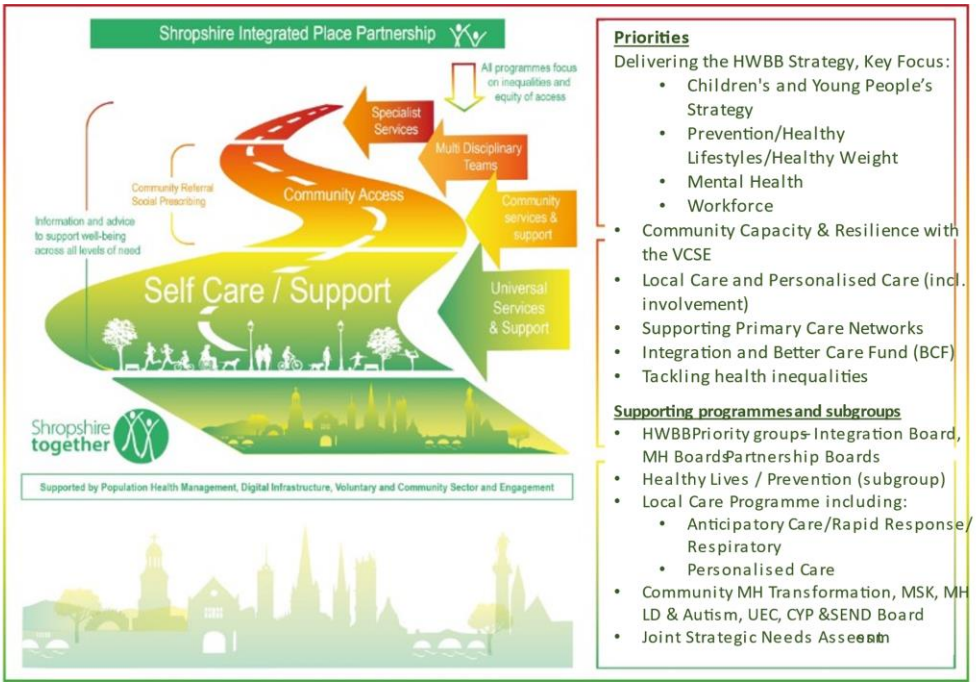
- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

The BCF planning and delivery, the Better Care Fund work is delivered through the governance of the Shropshire Integrated Place Partnership (SHIPP), which has a focus on integration. SHIPP is a sub-group of our ICS Board and our Health and Wellbeing Board. The visions of our HWBB and SHIPP Board work collectively; the HWBB vision is **for Shropshire people to be the healthiest and most fulfilled in England** and our SHIPP vision highlights that we will do this by **'Working together to ensure people in Shropshire are supported to lead healthy, fulfilling lives.'**
The purpose of Shropshire Integrated Place Partnership (SHIPP) is to act as an integrated partnership board of commissioners, providers of health and social care and involvement leads, in Shropshire, to ensure that the system level outcomes and priorities agreed at ICS and Programme boards are implemented at place level in Shropshire. The Board takes into account the different communities and people we work with, the individuals/ citizens (including carers) that we serve, the different delivery models needed, and our focus on reducing inequalities. To set our direction for integrated working, the SHIPP has adopted the following principles for place-based working:

- Take a person-centred approach to all that we do; celebrating and responding to the diversity within our population.
- Follow the Public Health England guidance described in the document Place Based Approaches to reduce inequalities, which involves 3 keys segments:
    - o civic-level interventions, all aspects of public service from policy to infrastructure (including health in all policies)
    - o community-centred interventions, asset (human and physical) and strength based community development
    - o service-based interventions, including unwarranted variability in service quality and delivery (effectiveness; efficiency and accessibility), as well as embedded
- Brief Interventions and Making Every Contact Count pathways (including social prescribing).
- Seek to understand, take a Population Health Management approach to all transformation.
- Recognise the importance of system thinking for all ages and families, ensuring that inequalities are addressed from pre-birth.
- Systematically undertake integrated impact assessments to determine how its delivery could better reduce inequalities and support protected groups (9 protected characteristics); this work should look at how it can support preventing the 'causes', and the 'causes of the causes', of ill health. In particular, each service should consider how it can help people improve health behaviours around weight, smoking, and alcohol
- Utilise a system approach to co-production for service development and delivery.

- Value the community and voluntary sector and consider how the voluntary sector can work alongside statutory services to reduce inequalities.
- Promote understanding of how to prevent or reduce inequalities for staff working in all partner organisations
- Use digital resources to remove geographical barriers to place based working.

The SHIPP diagram below demonstrates how our system works together to a) firstly support people to self-care, in the communities where they live, with community support as needed, b) provide community services where they are needed, and c) provide high quality specialist services when they are needed. **The system is focussed on keeping people healthy and well in their usual place of residents, but also providing the right care at the right time through the programmes and priorities of the HWBB, SHIPP and the ICS.**



Our Draft Joint Forward Plan describes good synergies across our system priority planning as described in the table below.

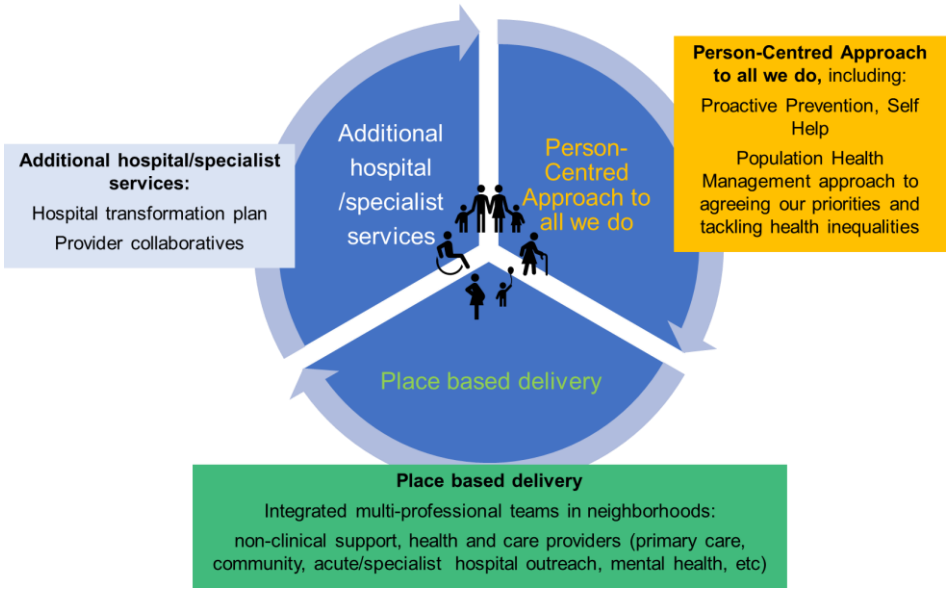
Telford & Wrekin Health & Wellbeing Board proposed Priorities	Telford & Wrekin Integrated Place Partnership (TWIPP) Priorities	Shropshire, Telford & Wrekin ICS Priorities	Shropshire Health & Wellbeing Board Priorities	Shropshire Integrated Place Partnership (ShIPP) Priorities
Population Health Priorities				
Best Start in life • Start for Life Family Hubs	Best start in life	Best Start in life	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' strategy
Healthy weight	Healthy weight	Healthy weight	Healthy Weight and physical activity	Prevention/healthy lifestyles/healthy weight
Mental health and wellbeing	Mental Health	Mental wellbeing and mental health	Mental Health	Mental Health

	Learning Disability & Autism			
Prevent, protect and detect early	Reducing preventable diseases through early diagnosis, immunisations, screening and improving the reach of services	Preventable conditions – heart disease and cancer	-	-
Alcohol, drugs and domestic abuse	-	Reducing impact of drugs, alcohol and domestic abuse	-	-
Inequalities priorities				
Inclusive resilient communities Housing and Homelessness Economic opportunity	-	Wider determinants: • Homelessness • Housing • Cost of living	Working with and building strong and vibrant communities	Community capacity & building resilience within the VCSE
Prevent, protect and detect early • Closing the gap Starting well - Living well – Ageing well	Core 20plus5 and reducing barriers to access	Inequity of access to preventative health care: • Cancer and cancer screening • Heart disease & screening • Diabetes • Annual health checks for severe mental illness and learning disabilities and Autism • Vaccinations and immunisation • Preventative maternity care	Reduce Inequalities Improving population Health	Tackling health inequalities
Closing the gap – deprivation – equity – equality - inclusion	-	Deprivation and rural exclusion	• Reduce Inequalities • Improving population Health	Tackling health inequalities
-	Reducing barriers to access	Digital exclusion	-	-
Health and Care priorities				
-	Proactive prevention Local Prevention and early intervention services	Proactive approach to support & independence	-	-
Integrated neighbourhood health and care • Primary care • Closing the gap	Local Care transformation (includes neighbourhood working)	Person-centred integrated within communities	Joined up working	Local Care and Personalisation (incl. involvement) Integration & Better Care Fund (BCF)
-	Older adults and dementia	Best start to end of life (life course)	-	-
Best Start in life	Best Start in Life	Children and young people's physical &	Children & Young People incl.	Children's & young peoples' strategy

• Start for Life Family Hubs • Social emotional & mental health SEND	SEND & transition to adulthood	mental health and focus on SEND	Trauma Informed Approach	
-	-	Mental, physical and social needs supported holistically	-	-
-	Accessible information, advice and guidance	People empowered to live well in their communities	-	-
-	Primary Care access and integration, place-based development in line with the Fuller report	Primary care access (General Practice, Pharmacy, Dentists and Opticians)	-	Supporting Primary Care Networks
-	-	Urgent and emergency care access	-	-
-	-	Clinical priorities e.g. MSK, respiratory, diabetes	-	-

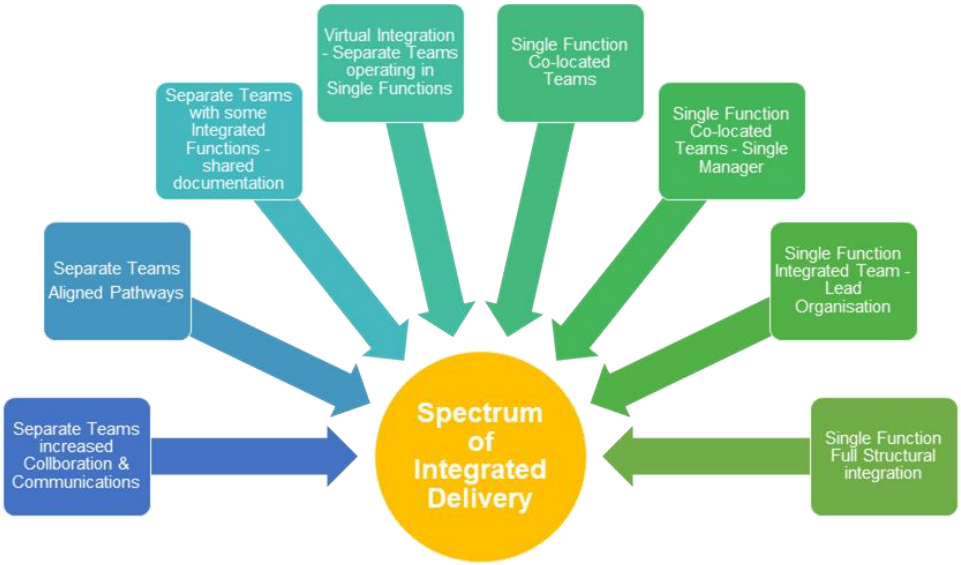
The DRAFT Joint Forward Plan describes how we will work together to achieve our priorities.

To achieve our priorities, there are three key components of our Plan, as shown in the diagram below:



Integration is at the core of our transformation planning. Successful integration is defined by Department for Health & Social Care as "the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Everyone should receive the right care, in the right place, at the right time" (Health and social care integration: joining up care for people, places and populations, Feb 2022).

Integration can be seen as a spectrum, ranging from increasing collaboration and communications between separate teams/organisations, through to a single organisation with a single function and full structural integration. The following maturity integration spectrum below highlights this range. The HWBB and SHIPP have committed to follow the spectrum as a guideline, working towards the highest level of integration that is practicable for each programme.



Integration focuses on the strengths of people and communities as a cornerstone of how we will work. The core of the model is people and communities, with public services working together to support people to build the foundations for a healthy and fulfilling life. The model on the right demonstrates this people and community centred approach that is echoed throughout all the Integrated Care System's work.

Additionally, the system is developing a Prevention Strategy/ Position statement that calls on all partners to act on inequalities and embed key prevention activity in all that we do. Specific activity of this prevention work will link to all BCF development areas including Reablement and Neighbourhood transformation.

Collaborative/ Joint Commissioning supports the activity of the system, in particular the integrated approach described above, and is key to our 2 year Better Care Fund Plan.

The system invests in Joint Commissioning through our Assistant Director of Joint Commissioning, Joint Commissioning Group, and through the Better Care Fund numerous joint commissioned contracts.

Developments are captured in our SHIPP strategic plan and for 23-25 include:

- **Delivering an all age Local Care Programme across communities in Shropshire; improving access to health, care and wellbeing services and community support. This includes:**
- Expanding the current Local Care programme and aligning services across health, care and the voluntary and community sector
- Using the Shropshire Integration Model to integrate services where possible, and working in partnership where integration is not possible, to deliver multi-disciplinary approaches in local communities
- Unleashing the power of communities and the voluntary and community sector and maximizing their power to support people to maintain their independence and wellbeing at home
- Using public sector estate in our communities to best effect, collocating in local communities where possible (see case studies below)
- Delivering specific elements of the Local Care programme in a collaborative and integrated way, including:
- **All age integration test and learn sites (Led by Public Health)**
- **Social prescribing, children and young people, families, and adults (Led by Public Health)**
- **Rapid response, including falls response and prevention (Led by ShropCom)**
- **Virtual ward (Led by ShropCom)**
- **Respiratory (Led by ShropCom)**
- **Proactive Prevention (Led by ICB)**
- **Neighbourhoods (Jointly led)**
- **Care at Home (Led by Adult Social Care)**
- Expanding CYP integration test and learn sites to become all age delivery in North Shrewsbury, Ludlow, Market Drayton, and develop roll out plan for rest of county, inclusive of:
- Trauma informed approaches, Social Prescribing and Carers (underpinned by Personalised Care)
- Multi-disciplinary teams to include Social Care, Public Health Nursing, MPFT (Mental Health in Schools), voluntary sector and other partners
- Grant funding for additional community activity for children, young people and their families (working with Town and Parish Councils)
- Develop more Health and Wellbeing Centres; Oswestry, Highley, Ludlow, Shrewsbury, that include MDT approaches (as per below)
- Primary Care Networks are supported by joint working and integrated approaches on Proactive Care, Neighbourhood, Integrated Discharge and Social Care Hubs (including reablement), and Rapid Response, to be developed together, through a jointly developed Neighbourhood Model – to connect with Health and Wellbeing Centres (timeline from NHS led Local Care below)
- Social Prescribing expansion into A&E, midwifery, children, young people and families and local health and wellbeing centres

- The development of a Joint Equipment contract across both Shropshire, Telford and Wrekin LA's Shropcom and the ICS.

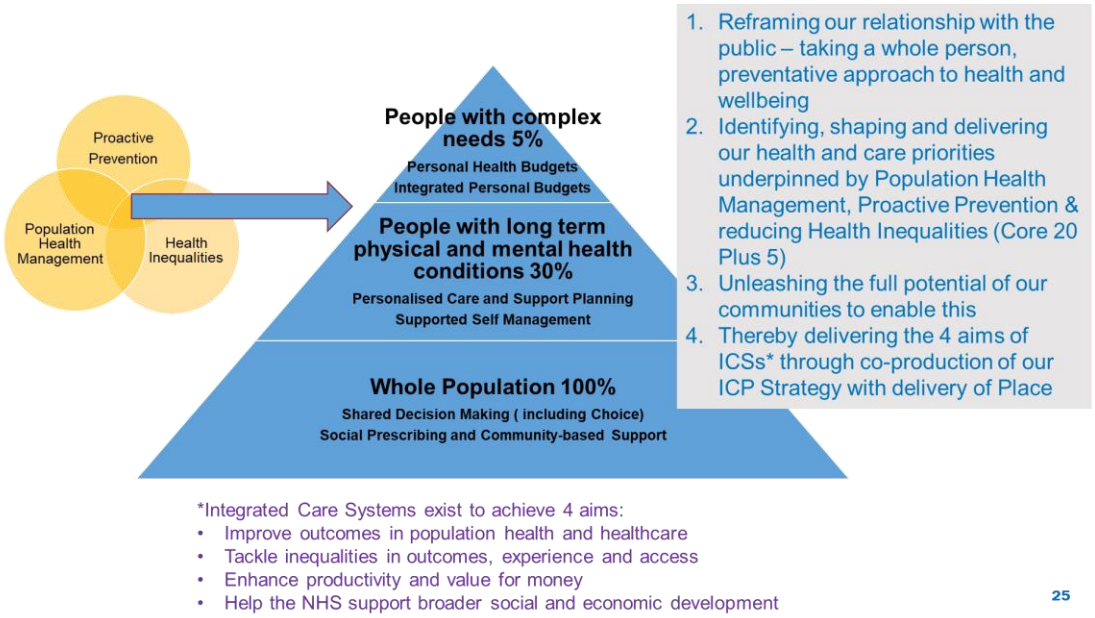
National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Our Person-centred (Personalised) care approach is described in the diagram below (as part of the Joint Forward Plan). In order to deliver this approach we are: 1. enhancing our leadership (and clinical leadership), accountability and resource; 2. embedding the approach in all priority workstreams; and 3. bolstering our communities and the infrastructure of our voluntary and community sector.



Enabling people to stay well and independent at home for longer and providing the right care at the right place and the right time is embedded throughout our system planning (see SHIPP diagram above) and throughout our Better Care Fund themes, as our mechanism for delivery; it is also a clear ambition as part of the Shropshire Plan. Below describes our themes and programmes and highlights delivery of the national objectives as well as approach to integrating care to deliver better outcomes.

Prevention:

Keeping people well in the first place, and in their usual place of residents, remains a top priority for our system.

We believe our voluntary and community sector is in supporting people to remain independent and well in their own homes for as long as possible. Therefore, as a cornerstone of our Prevention Strategy, the Better Care Fund has ensured the continued delivery of our voluntary and community sector contracts and grants that support people in their own home, by providing a number of services covering Advice, Advocacy, Housing, Falls Prevention, as well as wellbeing and independence. The Wellbeing and Independence Service (WIPS), as an example, is delivered in communities across Shropshire, supporting people to stay well and independent at home – delaying their need for formal care and support. The WIPS contract is delivered in consortium (members are Age UK Shropshire Telford & Wrekin (Age UK STW), The Mayfair Centre, Oswestry Qube, Royal Voluntary Service (RVS) and Shropshire Rural Communities Charity (SRCC) and all members have longstanding experience of working in our communities, understand them well and have some great ideas about making a difference to the lives of our residents.

We have been able to build on this work to introduce additional activity in the system through the winter period. The WIPS contact has been expanded to receive referrals from partners organisations and to deliver additional activity through the winter months, connecting with the red cross and also facilitating hospital discharge. 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
- Hot meal delivery
- Companionship for isolated or lonely people

The service works as part of the health and care system to ensure that people get the support that they need through appropriate referrals and signposting.

Despite having a strong offer, investment has stagnated and not kept in line with inflation or uplifts to other services, resulting in a disinvestment in offer. Because of this and the pressure on our acute sector, our ambition for 2023/24 is to adopt a system approach to prevention. This will allow the system to look systematically at prevention and demand management. Our vision is to have a thriving community and voluntary sector, supported by commissioning and integrated working, this integral to a strong preventative approach from primary to tertiary prevention. Our commissioning arrangements and resource allocated to prevention must

match the scale of need and ambition on preventing ill health and wellbeing in the VSCA as well as prevention programmes/priorities. This will be done by embedding prevention at all levels, bolstering infrastructure within the VCSE and commissioning services that support people to remain healthy and well in the communities where they live. This builds on the current infrastructure investment in place through the pandemic and in 2022/23. The first year of this 2 year plan does not sufficiently address prevention and necessary resource to embed and upscale prevention, however, the work will happen in year 1 to ensure that in year 2 (2024/25), we have the investment needed to significantly reduce demand, improve outcomes and gain the return on investment for our residents and system partners.

In line with the developing Prevention Strategy, the contracts will be reviewed in 2023 to inform 2024 services onwards but build upon the learning and best practice.

The BCF also funds the Local Authority's contribution to the Shropshire Social Prescribing programme. This asset based service provides a consistent offer across the Shropshire Council area. Additionally, our Social Care Let's Talk Local programme, works with people to unlock their potential in the communities where they live.

Additionally, the BCF funds our Falls Prevention Programme (Elevate); this programme does not have funding attached to 24/25 and work is underway in 23/24 (as a follow on to the Winter 2022/23 Falls pilot), to develop a business case for a whole system Falls approach. The system sees preventing falls and responding quickly to falls as a key improvement area for improved outcomes and reduced demand in the system.

Admissions Avoidance:

Admission Avoidance is supported by a number of work programmes and teams that are funded or part funded by the BCF. Working collaboratively to jointly commission and deliver these programmes is a cornerstone of the work. The programmes work together to support people at the right place and the right time. The programmes include:

- Integrated Community Service
- Local Care Programme (including Care at Home)
- Two Carers in a Car

Our Integrated Community Service (ICS) is a joint Shropshire Community Health NHS Trust & Shropshire Council team, called Integrated Community Services (ICS). The team works closely with local hospitals to identify patients who are well enough to be discharged back to their own homes with appropriate support. Once our patients have returned home, they can expect a visit from a member of the team within 24 hours to establish whether the level of care is appropriate and work with the patient to set their goals to maximise independence.

The team also works with patients needing support to avoid unnecessary hospital stay: The team works closely with all our partner organisations to ensure their patients who are unwell, but not requiring an acute hospital to treat their condition, are supported in own home.

Our Local Care Programme is our key community transformation programme, working closely with ICS) that ensures the delivery of system priorities and the BCF. The

programme's ambition is to build on our existing good practice and develop more systematic, preventative, integrated interventions that will support independence and well-being of residents in our local communities.

The delivery of sustainable improvement requires a whole system approach to the design, testing and implementation of new models of care. The models of care will be centred around proactive prevention and care closer to home.

SHIPP has agreed its strategy and deliverables, which are as follows:

Delivering an all age Local Care Programme across communities in Shropshire; improving access to health, care and wellbeing services and community support. This includes:

Expanding the current Local Care programme and aligning services across health, care and the voluntary and community sector

Using the Shropshire Integration Model (highlighted above) to integrate services where possible, and working in partnership where integration is not possible, to deliver multi-disciplinary approaches in local communities

Unleashing the power of communities and the voluntary and community sector and maximizing their power to support people to maintain their independence and wellbeing at home

Using public sector estate in our communities to best effect, collocating in local communities where possible (see case studies below)

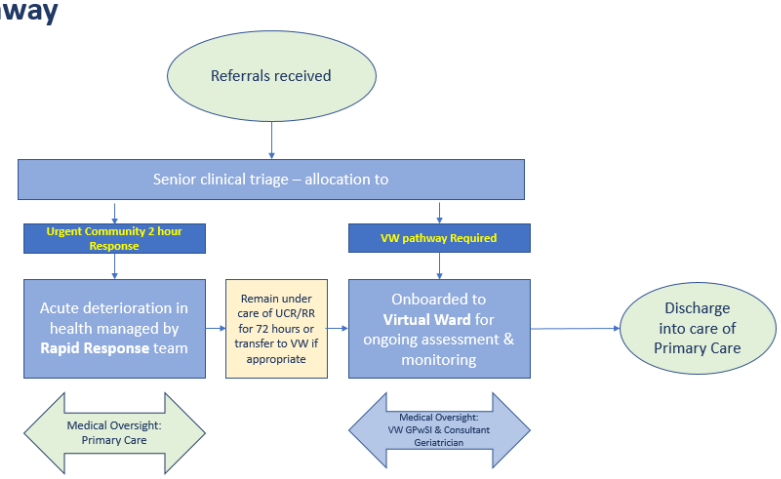
Delivering specific elements of the Local Care programme in a collaborative and integrated way, including:

- All age Integration Programme (Public Health led)
- Social prescribing, children and young people, families, and adults (Public Health led)
- Rapid response, including falls response and prevention (Community Trust led)
- Virtual ward (Community Trust led)
- Respiratory (Community Trust led)
- Proactive Care (ICB led)
- Neighbourhoods (Jointly led)
- Care at Home Transformation (Social Care led)

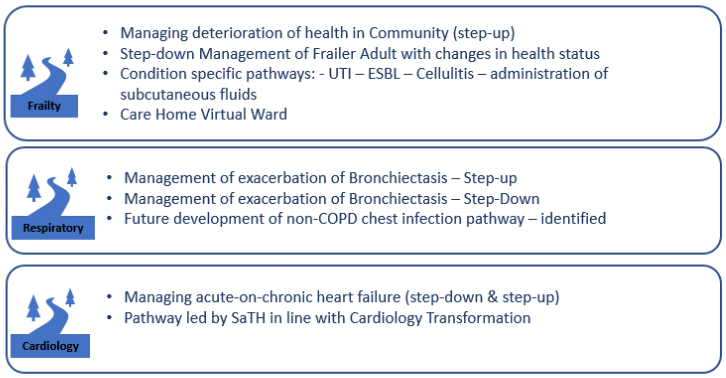
Virtual Wards:

A key element of Local Care, keeping people at home is our Virtual Ward programme. The two diagrams below describe the pathway.

UCR pathway



Pathways



Red/Amber/Green status refers to potential escalation routes dependent on a combination of patient's level of acuity, clinical presentation, history & social support available.

Key points and digital monitoring:

- Docobo solution provides digital monitoring
- Supports self reporting of physical observations taken by patients
- Includes 'soft' questions about how patient is feeling
- Monitored centrally by senior clinicians 08:00-20:00
- Supported by guidance for out of hours
- Patient remains responsibility of locality Virtual Ward team

Rapid Response:

The Rapid Response team integrates Community Nurses, Social Workers, Physiotherapists, Occupational Therapists, Paramedics, Non-medical prescribers and Call Handlers into one team.

Residents can be referred to the team from a range of agencies such as the emergency department, West Midlands Ambulance Service, 111, GPs, Family Connect, community health and social care teams, care homes and the voluntary sector.

Residents are then assessed within two hours from being referred to the Rapid Response Team.

On receiving a referral, the team provides an immediate response to crisis using new, state of the art equipment as well as puts a plan in place to help resolve the health issue and prevent it from happening again – enabling residents to remain as independent as possible in their own home.

95% of residents referred to the team were able to stay in their own home rather than be admitted to a hospital or care bed.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations

    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Discharge Alliance - We have been working as a system to look at our demand and capacity numbers. This is changing constantly as we make other system changes. It is anticipated that we will see an increase in pathway 0 to get more people home with minimal or none support required from social care as we step up early intervention and support in the community (with referral into Social Prescribing and Voluntary Sector Support as appropriate).

The challenge has been predicting the demand and capacity when we saw one of the challenging years across health and social care last year. Demand was based on previous and current activity, we saw this increase and with very challenging and complex individuals coming out of hospital.

It is also expected that we will see an increased demand for pathway 1. 2022-23 was one of the hardest years we have ever seen for capacity within the domiciliary care market. With workforce pressures across the system we saw an increased reliance in having to use more community bed via pathway 3. This resulted in an increased number of care beds being used and in particular residential beds which would not be the norm. Shropshire council took action and used the market sustainability funds to increase the hourly rates for domiciliary care by 12% and so far this seems to have a big impact and pw1 delays in the hospital has reduced as a result. This has in turn has improved START our inhouse service provision metrics with the usual los now about 14 days because individiuals who need a long term care package are now able to access one much quicker.

In addition to the demand and capacity we are signalling an increase in complex nursing placements being required. The need for nursing placements has remained high with people currently needing nursing support and coming out very poorly. Shropshire's ageing demographics we are prediciting that this pattern will continue.

Through system groups described previously (and in the next section), system partners are working collaboratively together to look at the discharge and reablement models. This will help inform the demand and capacity needed as a system across the year.

We do know that the funding for discharge is unlikely to meet the demand with escalating costs across the market we have seen huge increases in care home placement cost in

particular which has been due to agency staffing costs, utility cost hikes and NMW increases.

The system flags this risk at every SHIPP meeting (and report to the HWBB). Additionally, reduced (in real terms, due to inflation), investment into prevention contracts will impact negatively on demand and capacity.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

A number of programmes support people who have fallen or need additional support through residential and nursing care. These include:

Rapid Response:

The Rapid Response team integrates Community Nurses, Social Workers, Physiotherapists, Occupational Therapists, Paramedics, Non-medical prescribers and Call Handlers into one team.

Residents can be referred to the team from a range of agencies such as the emergency department, West Midlands Ambulance Service, 111, GPs, Family Connect, community health and social care teams, care homes and the voluntary sector.

Residents are then assessed within two hours from being referred to the Rapid Response Team. The team supports people who have fallen, to reduce the number accessing A&E and follow on admissions.

On receiving a referral, the team provides an immediate response to crisis using new, state of the art equipment as well as puts a plan in place to help resolve the health issue and prevent it from happening again – enabling residents to remain as independent as possible in their own home.

If START need to support for a shorter time they will also support the client for a set time as they do for discharge.

The wider prevention contracts support people to remain well within their own community to reduce the pressure on hospital admissions.

Admission Avoidance is supported by a number of work programmes and teams that are funded or part funded by the BCF.

Other work programmes that are collaboratively developed or jointly commissioned to deliver include:

- Integrated Community Service
- Local Care Programme
- Two Carers in a Car

System partners are also looking at how they can expand the development of virtual wards model to support in admission avoidance, working with GPS and technology solutions to avoid admissions.

A pilot was done for a falls response, partners are reviewing the learning from this and a business case will inform a future model especially to support winter pressures and admission avoidance. Additionally, the BCF funds our Falls Prevention Programme (Elevate); this programme does not have funding attached to 24/25 and work is underway in 23/24 as part of the Winter 2022 Falls pilot, to develop a business case for a whole system Falls approach. The system sees preventing falls and responding quickly to falls as a key improvement area for improved outcomes and reduced demand in the system.

Long term admissions in residential and nursing are one of the lowest numbers we have seen in 4 years. However we need to caveat that we have seen an increase in short term placements to support discharge however we have been successful in supporting more people in their own homes. This is particularly for residential, we are however seeing a

increase in demand for complex nursing placements. We are working with commissioners to consider one contract framework for more complex care placements.

UEC Improvement Plan has a number of key workstreams to support independence and system flow. These include:

- Ward processes to improve early discharge planning
- Direct Access pathways
- Improving discharge flow
- Length of stay harm reduction
- Virtual Ward step down
- Choice policy and delivery (connected to Person Centred Care)
- Therapies – getting people moving and working towards independence

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

. **System Flow:** Our system flow is supported by a number of work programmes and teams that are funded or part funded by the BCF. The national objectives are echoed throughout each of the programmes and teams. Working with people to continue a strengths based and personsalised care conversation, ensuring choice an supporting people to their usual place of residence is of primary importance. There are a number of programmes, teams and BCF funded schemes across all of the priority areas that support this work, including: Brokerage and Bed Hub services (described below) START – reablement service (described below) Local Care (described in objective 1 above) Virtual wards (described in object 1 above) The System Discharge Alliance and Integrated Discharge Hubs (described below) Joint Commissioning of Reablement beds (described below) Community Mental Health Transformation (connected but not funded by BCF) The Urgent and Emergency Care Delivery Board is responsible for improvements in our system flow, recognising input from other workstreams, such as Local Care Programme, is vital to success and full delivery of the system plan. STW ICS has developed its short to medium-term intentions for urgent and emergency care (UEC). With alignment to national priorities and addressing local population needs, the strategy sets out the improvements for 2022-2025. The Urgent and Emergency Care Delivery Board is responsible for the oversight of this strategy, reporting to the Integrated Care Board (ICB); collaborating with Place-based delivery partnerships and system partners to ensure delivery of improved care pathways and services. Implementation of the improvements will be linked to place-based partnerships serving the communities of Shropshire Telford and Wrekin. The ICS UEC Delivery Board will oversee the implementation of the UEC Strategy through its programme focused on: Wider integration and system-wide reform Transformation and improvement Assurance – oversight of national and local performance standards STW ICS will demonstrate compliance with implementation of the National UEC Recovery Plan(2023). NHS England published a Delivery Plan for Recovering Urgent and

Emergency Care Services acknowledging that demand has returned to pre-pandemic levels. The key areas have been incorporated into the UEC strategy. **Meeting the recovery challenge will require sustained focus on the five areas in the NHSE document: Increasing capacity Growing the workforce Improving discharge Expanding care outside hospital Making it easier to access the right care** A key priority for improvement is improving discharge, sustained improvement for ambulance handover delays and reducing the time spent within Emergency Departments. **This year's plan will focus on stabilization, standardization and sustained improvements across the Urgent and Emergency Care Pathway.** The vision for urgent and emergency care in STW remains that it is focused on continuing to transform our services into an improved, simplified and financially sustainable 24 hour/7-day model; delivering the right care, in the right place, at the right time for all our population. The STW UEC Improvement Plan will follow a 3S methodology Stabilise Standardise Sustain The STW UEC Improvement Plan will focus on three specific work stream areas: Appropriate Access to Care Early Flow (within 72 hours) Prompt and Effective Discharge The plan has been developed following a review of the 22/23 UEC Improvement Plan and incorporating learning from winter 22/23. It was developed following triangulation with the System operational Plan and the Clinical Strategy and was developed with all partners at a UEC Clinical Summit. The review work has been led by the UEC Operational group which will remain the governing body.

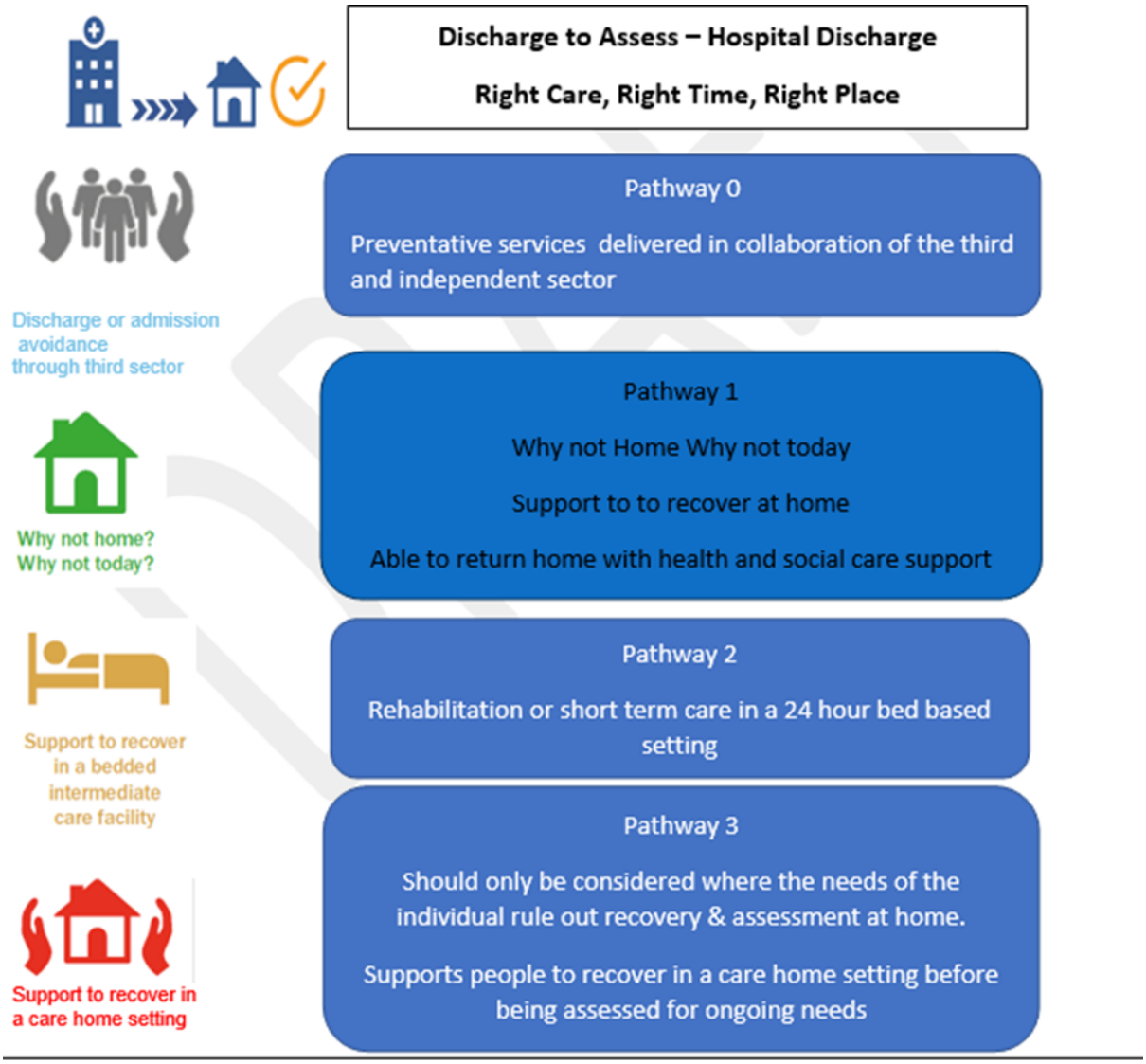
Urgent and Emergency Care 23/24

	Appropriate Access to Care	Early Flow (within 72 Hours)	Prompt and Effective Discharge
Stabilise	• Provision for high intensity users • Redesign of Pre-hospital Integrated Urgent Care including: UEC, Pharmacy, Mental Health, Out of Hours, SPA, Acute Respiratory CCC. • Initial Assessment in ED (redirection)	• Enhanced Integrated Discharge Team (D2A) • Frailty Pathway • Criteria led discharge • Virtual Board Rounds • Right care for paediatrics	• Care Home Demand & Capacity • Learning from MADE • Improved discharge model (7/7) • Antibiotic therapy in the community
Standardise	• Direct access pathways (IPS) • Ambulance delays /Ambulance Receiving Areas • GP Capacity and Access Improvement. • Health Inequalities & Prevention	• Next Patient Model • Ward Processes • Escalation & System Risk • SCC (Escalation and Site Management)	• Virtual Ward expansion (part of LCP)
Sustain	• Single Point of Access (SPA) development (alternatives to ambulance conveyance to ED) • Acute Floor • Mental Health Services • NHS 111 Improvements/Expansion	• Improving Discharge Facilities	

Key Enablers: Including Patient Involvement, Demand and Capacity, **Digital** & Workforce

Improvement delivered through effective communication and engagement, robust governance and effective programme management putting with our service users at the centre and maximising value for money

The System Discharge Alliance (SDA) is a whole system approach, with representation from all system partners. As part of the UEC Improvement Plan, an ENHANCED INTEGRATED DISCHARGE TEAM will continue to grow Integrated Discharge services to reach more people, extending operating hours where demand necessitates. It will be consistent and comprehensive coverage in line with the national framework through a whole system, collaborative, proactive approach that is centred on the needs of individuals, families and staff. The workstream governance will be via the discharge alliance and Local Care Programme (LCP). The Discharge Alliance works to deliver these priorities as well as the BCF priorities to work together to prevent ill health, avoid admissions and to ensure timely discharge from hospital (System Flow). **Discharge model** Covid 19 challenged the way in which we work and of our delivery of services. Government guidance stated that systems should implement a Discharge to Assess (D2A) model to speed up hospital discharge times, helping patients get home quicker. This way of working has provided impetus for long term improvement to discharge planning and delivery.



This model reduces the need for hospital-based assessment activity and places an even greater influence on the need to increase short term intervention, and reablement to maintain people's independence in the community for longer. An integrated team must work as part of a systems approach to provide the following service outcomes; Efficient, streamlined and consistent approach Reduction in Length of hospital stay Better patient's outcomes/experience **Local Response: Development of the Integrated Discharge Hub (IDH)** The Integrated Discharge Hub (IDH) was set up in March 2020 in response to local and national requirements, in line with Covid. The IDH brought together personnel from different parts of the system to implement the requirements and implement fast tracked changes that otherwise may have taken the system longer to achieve. The IDH uses the 9 High Impact model and 100 days as a guide to inform all processes. The IDH ensures that once a patient is ready for discharge, all discharge arrangements are organised by the multi-professional team, with the patient, family and carers all being informed. The aim is to discharge on the same day, with the focus being to support patients to return home first, whenever possible. As a system piece of work, this is a collaborative service partnered with Shropshire and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust (SCHT), Shropshire and Telford and Wrekin Local Authority and Powys Teaching Health Board (PTHB). The purpose of this standard operating procedure is to set out the process requirements and staff responsibilities to support well-organised, safe and timely discharge for complex patients. The Team include Nurses, Social Workers,

Therapists, Support workers and administration / coordinator roles. It aims to fully involve patients and their carers/relatives in the discharge process and ensure that patients receive appropriate assessment, planning and information about their discharge and after care. This standard operating procedure (SOP) provides guidance for clinical, administration staff and managers for the professional practice and operational procedures that must (i.e. mandatory) or should (i.e. advisory) be performed by Integrated Discharge Team. The overarching aim of the Integrated Discharge project team is to: Provide expert advice to the hospital ward teams to support in decision making for hospital discharge pathways Collate and complete a transfer of care/ Fact Finding Assessment for patients requiring pathway 1,2,3, services on discharge from hospital Proactively review and monitor patients identified with complex discharge needs to assess, plan and agree a discharge pathway and plan within the estimated discharge date. Focus on patients identified by the frailty team to prevent avoidable admissions from A&E through the provision of community-based care pathways allowing patients to be seamlessly step up to levels of care/support. Enable adults (aged 18+) to improve, maintain or manage changes in levels of independence, health and wellbeing, through a process of care, re-ablement or recuperation. A multi-disciplinary decision-making approach providing a person-centred service collaborated care between acute and primary care, adult social care, and voluntary sector. Deliver services in partnership with health and social care, forming multidisciplinary integrated teams, including support staff, therapists, social workers, mental health, medical practitioners and nurses and the falls service. Deliver timely, cost effective, efficient services that meet a patient's needs. Key Changes to Practice during test of change • IDT Ward Based Assessment agreeing discharge pathway • IDT Ward / Board Round attendance • Utilise revised Transfer of Care Document (FFA) • Case Management – allocated worker to patient • Patient Journey Facilitator dedicated to project ward 28 • Nurse Specialist (DLN) to work across all complex discharge pathways • Community and Adult Social Care in reach – ward focused • IDT preliminary clinical handover for community hospital bed transfers •Capacity Hub SCHT processing Sheldon Ward referrals • Transport planned booking The Service which has been developed in order to implement an expert complex discharge team, working in a seamless and integrated way across partner organisations both health and social care. The Integrated Discharge Team (IDT) will proactively 'pull' and case manage a range of patients with complex discharge needs and progress these patients safely to discharge via an appropriate path-way.

Brokerage and Bed Hub Our Brokerage service 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. The service is delivered for all local residents who have a Care Act Assessment or Fact Finding Assessment (hospital discharge), and as part of our integrated working, it is delivered on behalf of the Integrated Care Board as well. 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. A jointly commissioning Bed Hub service has been recently added to this service. Work is underway to

integrate the two services, and create a full brokerage service for residential care. Once a FFA has been completed for hospital discharge, the Bed Hub service finds suitable placements and provides options and choices for discussion with the person and/or family. This can be a short-term placement while a long term solution is found or a permanent solution. We have invested in permanent staff members in the care bed hub to support workers to source care home placements and from July 23 they will do the negotiations with Providers to ensure the process is aligned. **In addition, we are looking at jointly commissioned reablement beds** to ensure that people have the best possible outcome and we get people home where they belong as quickly as possible. All of this work has resulted in so far in a reduction in LOS for pathway 1 from 3.5 days to 1.5 days. The LA has the highest number of discharges within 48 hours compared to the last 3 years. Discharges are up by 17% compared to this time last year. Over 20% increase of people returning home compared to the same time last year and 135% increase in pathway 0 compared to last year. All the changes being implemented is making an impact; there is still concern on a potential funding gap this year which has aready been stated in the narrative.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations

    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Predicting demand and capacity is really difficult due to the last few years changes and market workforce challenges. In 2022/23 we experienced one of the worst winters for our system as many systems also experienced. Shropshire is a rural, ageing population and we saw a high number of poorly and complex individuals needing support.

Pw 1 referrals were high as were pw3, referrals to care homes increased due to the market capacity issues within the domiciliary care market. The use of 24 hour live in care was also used in order to support more people getting home to reduce hospital pressures.

Where we as a system use demand numbers via no criteria to reside and ready for discharge the reality is that those that actually fit and ready for discharge do not match this number and therefore it is very challenging to identify the 'real' demand number across the pathways. This along with having an assessment profile we can send to Providers in a timely way has also been problematic, hence why system partners are working together to address.

As we do not necessarily block hours or beds within the community (we tend to during winter periods) the capacity numbers reflect the number of discharges as we do not have an accurate picture of the capacity across the market despite the fact we request this information especially through the capacity tracker, this in fact rarely evidences actual usable capacity. This in addition to being an area with a high self funding market means that whilst we have capacity the market can choose its clients who tend to pay a higher rate.

This last year in particular we have seen a 28-35% increase on the care home placement costs which has put budget pressure on both the LA and health partners.

In order to address these challenges and due to the high levels of pw 1, the LA raised the hourly rates by 12% for 23-24 for the dom care market and increased the pay for our START reablement team to encourage recruitment and retention which to date has made a big difference and we are seeing sustained and continued pick up of packages which has reflected in more timely discharges and reduced LOS for pw1 clients. The capacity for the community numbers reflect a 75% sourced for dom care packages which has improved compared to the overall 60% sourced as last years average,

since commencing a higher rate from April 2023 we have seen this pick up to over 80% as the norm for the last few months so we are optimistic this will remain this year as the market recovers with the additional investment.

A wider piece of work is being implemented by both the LA and health to look at care homes rates and improved working on quality and contracts to ensure we have a high quality market keeping bed capacity across the county.

As part of Local Care, a Care at Home Transformation board has been set up with system partners to focus on remodelling the dom care model, making use of digital solutions, reviewing pricing, other short term support and remodelling the front door to improve the outcomes for our residents. This work will connect in with system integration, Proactive care, and all other Local Care programmes.

The current demand and capacity work is based upon an average of numbers over the previous years. We have done due to an uncertainty on how the numbers and needs may change this next year with being 3 years out of the pandemic. We have not used the no criteria to reside or ready for discharge numbers as stated before because this is not the best indication of demand due to complexities as many people may have not had an assessement, family disagrees, they become medically unfit or other reasons but its probably the best number we have to work towards as a system to support predict demand.

We also need to consider how we implement new changes and how this may impact on the numbers by pathways with increasing the discharge options for individuals, we will continually review this. It is anticipated that we will continue to see higher numbers of pw0 due to the joint working of the IDT, high numbers of pw1 and have therefore increased the hourly rates for the market and START to ensure capacity and swift discharge. Both health and LA have jointly commissioned 2 carers in a car to maximise resources to support swift discharge, we aim to build upon this so people can access night time support and get home.

We are also expecting a demand for complex nursing discharges via pw3 therefore we are currently doing some soft market testing and likely to consider block bed capacity with therapy input. We are also looking at social prescribing/community navigator roles to support discharge improving our offer of support to people. The capacity with beds reflect the number of beds we can buy with the current funds, that's not to say there isnt capacity within the market necessarily but the number of beds within the market available does not reflect capacity as they may not be able to meet needs and decide to support self funders.

The other demand coming in is based on virtual ward support which is developing at pace, we are working together to address but this has not been reflected within the capacity numbers whilst we continue to understand what the demand will be as not everyone will need support in addition such as home care, it is predicted at 10% of the total for now but likely to increase and will do so through the winter period. This numbers are probably at this stage an underestimation however this will be worked through with partners.

Community demand continues to be high as we work at pace on waiting lists through the LA.

Whilst a lot of work is being done to address the gaps the demand numbers will be a lot higher than the capacity reported especially for care home placements and for the reasons set out the system

are concerned about the financial implications to manage this. We are predicting their will be a deficit for discharge but it is difficult at this time to predict how big a gap this will be and we will monitor on a monthly basis. Partners need to work with us to reduce the demand, ensuring the right therapy input from the time they are admitted to reduce the reliance on formal care being needed.

We plan to access some wider BCF support to look at our planning locally and this will also help inform the next return and the wider reablement work as described within this document.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Flow:

Our system flow is supported by a number of work programmes and teams that are funded or part funded by the BCF. The national objectives are echoed throughout each of the programmes and teams. Working with people to continue a strengths based and personsalised care conversation, ensuring choice an supporting people to their usual place of residence is of primary importance.

There are a number of programmes, teams and BCF funded schemes that support this work, including:

- Brokerage and Bed Hub services (described below)
- START – reablement service (described below)
- Local Care (described above)
- Virtual wards (described above)
- The System Discharge Alliance and Integrated Discharge Hub (described above)
- Reablement (described below)
- Community Mental Health Transformation (connected but not funded by BCF)
- Care at Home (Led by Adult Social Care)

The System Discharge Alliance (SDA) is a whole system approach, with representation from all system partners. The aim is to move discharge towards the requirements of the White Paper (Integration and innovation: working together to improve health and social care for all 11 Feb 2021), and using the learning and building on the improvements made post the Covid 19 Discharge Requirements.

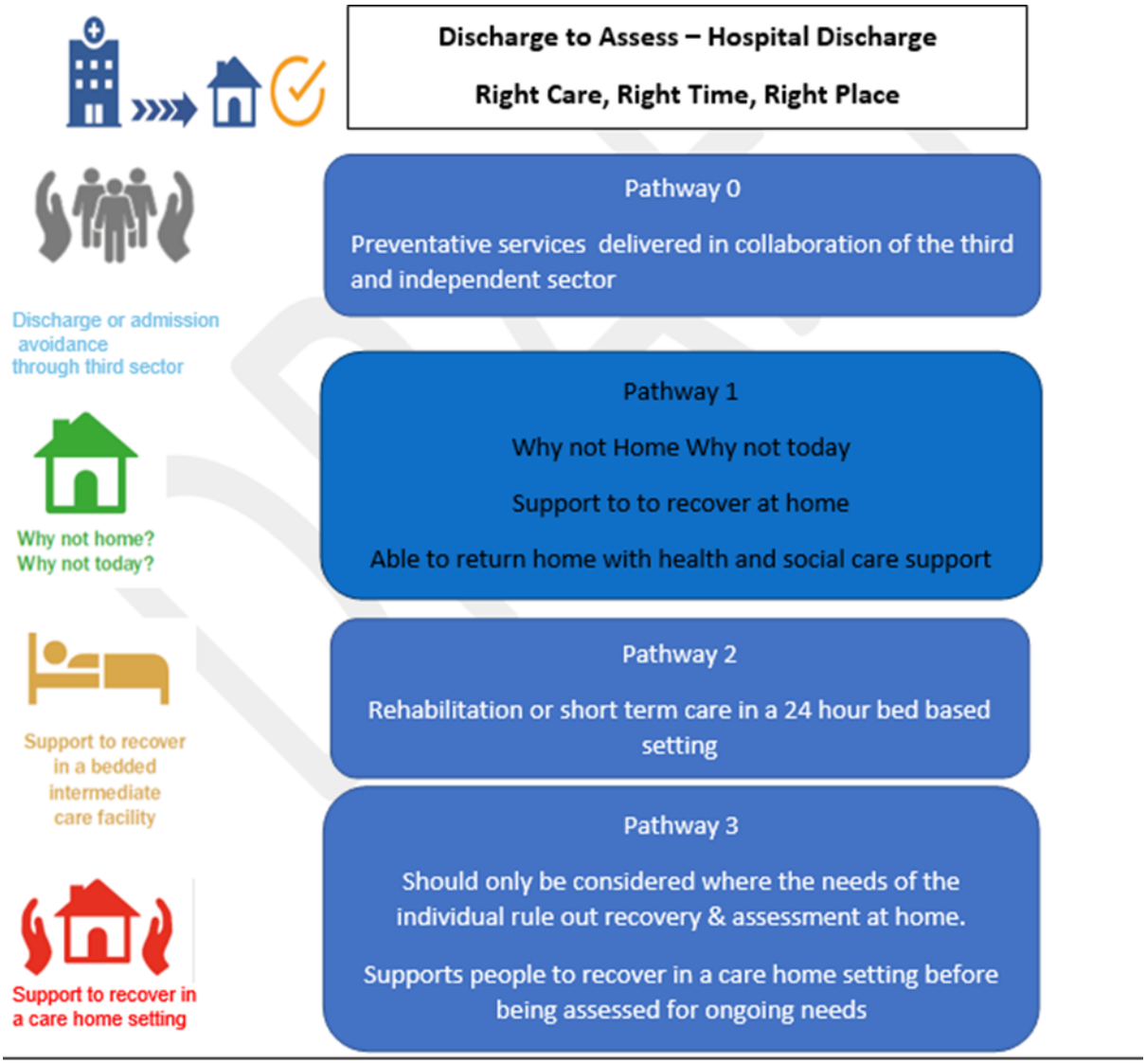
As a system we have come together to work differently to respond to the current and future challenges by;

- working together and supporting integration;
- stripping out needless bureaucracy;
- enhancing public confidence and accountability;
- additional proposals to support social care, public health, and quality and safety.

Locally our HWBB and ICS strategies call for integrated working, commissioning and action to reduce inequalities. The Discharge Alliance works to deliver these priorities as well as the BCF priorities to work together to prevent ill health, avoid admissions and to ensure timely discharge from hospital (System Flow).

Discharge to Assess model

National guidance stated that systems should implement a Discharge to Assess (D2A) model to speed up hospital discharge times, helping patients get home quicker. System partners are working closely together to look at what this looks like, it has been a costly model to date due to the demand and cost inflations across the market, therefore work is ongoing with a focus on reablement across the customers journey.



Brokerage has embedded a new system which will make it easier for domiciliary care providers to look up potential packages of care across the rural county. In addition they are now jointly supporting health on their fast track cases for domiciliary care providers.

The START team which is the inhouse reablement team have recently had a successful recruitment campaign which has increased the number of clients supported upon discharge (double since last year). Some of the winter discharge funds have helped with additional agency capacity for times of pressure and high sickness levels. Another campaign will commence now for the summer to ensure capacity is available ready for winter pressures

Reablement Transformation – system partners are currently working on the reablement model to ensure its bedded across the customers journey through the system. This identifies several system challenges but aims to have the individual at the centre to improve the outcomes for them.

Below describes the challenge and the proposed development for our Reablement Transformation:

Context and background

The demand on both health and social care services within the UK has increased year on year for the last decade and has significantly risen during the ongoing recovery from the Covid-19 pandemic. As a result, there is a need to further embed integrated/partnership working with a focus on discharge and reablement models/patient flows through Shropshire's health and social care system in order to optimise the flow and to improve patient experience and outcomes.

The current state of health and social care systems nationally:

25%+ of ICSs have at least 20% beds occupied by patients who are fit for discharge

46% of delayed hospital discharges awaiting short-term services which attract just 5% of adult care spend

30% Increase by December 2022 of patients remaining in hospital despite being fit to leave compared to December 2021

The current state of Shropshire's approach to health and social care:

Sustainable systemic change has not yet been achieved. Although the transformation of the reablement offer is underway, there is a **need to work across the health and care system to proactively support people across Shropshire** and to build a stronger and more resilient community. This will require:

- **Maximising ways of working across the system** to make the most of the resources available for the people of Shropshire;
- **Achieving a common understanding** on where the pain points exist;
- **Building an effective system wide approach** that is understood and endorsed by all partners; and
- **Maximising the potential of the established IDT approach**

With an effective integrated approach to discharge, discharge to assess, and reablement, Shropshire will be able to achieve:

- **a reduction in the average acute hospital length of stay, including a Medically Optimised for Discharge (MOFD) percentage reduction by pathway aligning to national targets;**
- **reduced avoidable admissions and/or readmissions;**
- **an opportunity to manage the existing backlog of care through improved system-wide working practices; and**
- **improved outcomes for patients.**

2

Changes in the reablement approach need to be driven by all system partners to sustainably improve patient outcomes, performance measures, and system costs

Our ambition is to **create a single, system wide approach to Reablement** with effective ways of working between the Council and Health, delivering seamlessly as one. **As partners, we must work together on discharge, reablement, and enablement; to address the elective backlog issue, manage costs, and prepare for new CQC assurance requirements later this year.**

Drivers for change

- There is a pressing **need to make progress over the summer** (2023) to implement changes ahead of winter pressures; and also to contribute to the financial sustainability of all partners.
- There are continuing national expectations of a 10% reduction across some metrics.
- The continuing rise in demand (compared to the same period in 2021) still needs to be addressed and make a contribution to issues elsewhere in the system such as the elective surgery backog.

What needs to happen?

- **All partners to buy -into** a system-wide approach, outcomes, improvement plan, and ways of working.
- **Agree strategic governance** that incentivises cross-system investment, delivery, risk-sharing, engagement with all staff and clear accountabilities that go beyond representing respective organisations.
- **Define joint funding routes** for investment in improvements.
- Cultivate an environment where **continuous learning** is the norm.

What does success look like?

Reduced MOFD patients in acute bed base	Reduced LOS	Improved staff experience
Reduced system costs	More appropriate support & better quality of care	Improved partnership working
Alternatives to short stay beds	More personalised patient experience	Measurable additional capacity in the system

What have other systems achieved?

- **45% reduction** in number of MOFD in acute setting, 14% of total patients to 7% total patients
- Over twofold (34% to 73%) increase number of people directed towards **Pathway 1**

3

What needs to be in place to optimise discharge into ASC?

Integration requires structures and methods, with ways of working that enable and empower collaborative system working.

NHS

- Close to real-time patient status that reduces time spent on non-starters/failed discharges e.g. relating to TTOs or transport
- Detailed patient information that enables a trusted assessment model into onward pathway
- Productive ways of working to enable timely discharges

An effective integrated discharge operating model

MDT decision making	Shared and agreed 'paperwork'	System data and governance
Trusted assessment	Huddles and collaborative working	Tech-enabled information sharing
Accountability and action/task management	Links to out of county Hubs	Professional-led D2A reviews
Shared system resources	Clear processes and pathways	Patient and staff communication
Strategic and Operational Dashboards	Escalation protocols for delay	Leadership and trusted assessment

Council

- Dedicated Reablement resource (internal or provider-led) that is responsive to same day discharges
- Brokerage and Commissioning teams that are proactively managing the market
- Hospital SW resources that are responsive to the pace and demand of hospital teams

4

Through the development of this work, working with system partners as an integrated system, we plan to improve our metric on discharge to a usual place of residence. This work will also have a large impact on improved outcomes for people, decreased length of stay and a reduction in readmission.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Shropshire and Telford and Wrekin works together on the High Impact Change Metrics which were reviewed alongside the 100 Day Challenge Best Practice initiatives in 2022. There was recognition of the significant overlap and that action planning would essentially be the same for aligned areas. The Gap Analysis identified good practice and specific gaps (below) and specific actions are included within the SDA action plan above. Work continues against this analysis described below.

Good Practice identified

100 day challenge requirement	HICM link	Current position summary
Identify patients needing complex discharge support early	Change 1	Process in place: Board rounds. Patient Journey facilitators and flow coordinators; Check Chase Challenge; Long Stay Wednesday; MADE events and Lessons Learned
Ensure multi-disciplinary engagement in early discharge plan	Change 1 Change 2 Change 4	MDT approach to Long Stay Wednesday, Senior Reviews, MADE events, IDT. IDT review to be carried out as part of Local Care programme
Set expected date of discharge (EDD), and discharge within 48 hours of admission	Change 2	Two pilot wards to develop EDD (realistic date and plan towards the date)
Ensuring consistency of process, personnel and documentation in ward rounds Transport capacity to plan discharges late in day.	Change 1 Change 2	Good consistency within SCHT through MS Teams. Funding for additional transport in place to manage surges in demand
Apply seven-day working to enable discharge of patients during weekends	Change 5	Currently system partners are spreading 5 day capacity over 7 days adapted to working in SATH and RJAH. 7 day IDTs Social Care staffing across 7 days and bank holidays
Treat delayed discharge as a potential harm event		Daily Bronze review all post 5 days on worklist and daily review of cancelled discharges.
Streamline operation of transfer of care hubs	Change 3 Change 4 Change 6	Integrated TOC/ IDT Hub in place. Virtual IDT in place for real time updating of discharge planning progress. Completed reviews of the IDT effectiveness and efficiency throughout last 12 months Completing a formal review of the IDT processes.
Develop demand/capacity modelling for local and community systems	Change 2	Mature and well established approach in place across acute, community services and admission avoidance
Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges. Social Care identification of available capacity across the week to support discharge planning	Change 2	Mutual Aid included within Escalation Actions. On-going capacity tracking across Health, Social Care and independent sector providers
Revise intermediate care strategies to optimise recovery and rehabilitation	Change 3 Change 4 Change 6	MDT approach to intermediate care pathways and protocols in place. Revision of Intermediate Care within Business cases. IDT review Test of Change project commencing 22/8/22 on 2 wards on RSH site

Gap analysis

100 day challenge requirement	Gaps
Identify patients needing complex discharge support early	Social Care and Independent Sector in ward/Board rounds to support early planning. Providers having early involvement/information as needs change rather than at point of discharge. Strength based, person centric approach. Therapy workforce main focus on MFFD rather than early identification of needs and interventions.
Ensure multi-disciplinary engagement in early discharge plan	Therapy capacity in SATH and SCHT. Inclusion of other key stakeholders in the MDT meetings Increased demand for complex discharge and admission avoidance without associated funding
Set expected date of discharge (EDD), and discharge within 48 hours of admission	EDD not currently evidence based. Criteria Led Discharge (CLD) is under-developed Therapy workforce main focus on MFFD rather than early identification of needs and interventions.
Ensuring consistency of process, personnel and documentation in ward rounds Transport capacity to plan discharges late in day.	Delays in completion of discharge medication, letter and booking transport Levels of Cancelled discharges on a daily basis. Robust consistent FFA's impacting confidence in accepting. Transport capacity to plan discharges late in day. Limited next day discharge planning / early readiness. Trusted Assessors completing assessments and building relationships with providers . A Portal to share daily capacity for accepting admissions. High vacancy rates across disciplines / professions
Apply seven-day working to enable discharge of patients during weekends	Lack of consistency and standardisation in relation to 7 day working arrangements, with all key stakeholders. 7 day working not modelled financially to meet the need of a fully mature and developed 7 day working arrangement. Medical and other capacity for 7 day working. Transport capacity across 7 days Limited move-on; decision-makers in providers and confidence of independent sector providers to accept over weekends.
Treat delayed discharge as a potential harm event	Need to develop a process - define this as a measure eg when is a delay a delay that is potential harm
Streamline operation of transfer of care hubs	Links between ward and IDT are not robust and streamlined. No early conversation with family clarified Need a case management (or similar approach) to ensure effective processes and communication with families. Ward staff ownership in discharge planning and connectivity to the IDT. Transport capacity to plan discharges late in day. Limited next day discharge planning / early readiness Capacity gap to deliver full case management
Develop demand/capacity modelling for local and community systems	Utilising beds to offset domiciliary care packages which risks de-skilling and more use of LT care Recruitment challenge across NHS, social care and independent sector
Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges	Medical , nursing, therapy and care sector challenges in recruitment and retention impacting flow - limited capacity to be immediately responsive to demand across EDD, flow and discharge planning and step down from hospital Impact of fuel costs on domiciliary care providers Increased costs to fund higher agency domiciliary care rates - not sustainable System wide approach to support totality or workforce growth, recruitment and retention
Revise intermediate care strategies to optimise recovery and rehabilitation	Limited therapy capacity in SATH and SCHT. Lack of mobilisation by non-therapists within SATH and some care providers. Need to develop providers skilled to deliver Enablement plans and Trusted Assessors

Key UEC improvement workstreams and outcomes include:

- Ward processes to improve early discharge planning
- Direct Access pathways
- Improving discharge flow
- Length of stay harm reduction
- Virtual Ward step down
- Choice policy and delivery (connected to Person Centred Care)
- Therapies – getting people moving and working towards independence

In practice, the work connects to the Reablement Transformation described above and includes managing transfers of care to minimise unnecessary hospitals stays is a priority for our system. We have an Integrated Discharge Team (IDT) which meets daily to manage cases and if delays occur this is escalated. Improving ways of working has involved:

- Visiting individuals on the ward, prior to a referral (FFA) being received, to ensure earliest intervention
- Allocated workers assigned to wards and attending daily huddles and morning planning meetings.
- 7 day working week trialled and now implemented to be able to promote discharges across the weekend – this includes having a physical presence in the hospital on weekends
- Closer working between Brokerage and START (Short Term Assessment and Reablement Team) to maximise discharges to patients own home
- START reviewing live IDT list ahead of receipt of TOC's for earlier intervention

- Growing the workforce to include a range of roles, including a Unpaid Carer liaison worker based in the acute
- Improving discharges by MDT working on the ward, prior to individuals have no criteria to reside or are referred for social care assessment. Therefore becoming involved at an earlier stage. This includes better triage of TOC's and de-escalation of levels of pathway, i.e; PW3 move to PW1 and PW1s move to PW0
- Working closely with colleagues to ensure the right information is being given to individuals the first time
- Use of Assistive technology – such as 'Genie' devices which support people more independently in their own homes and reduce dependence on paid services
- Strengths Based conversations encouraging greater levels of independence with individuals
- Use of third sector services including social prescribing, voluntary organisations and charities. Connecting people to their communities.
- Streamlining our own processes for working with individuals to ensure maximum efficiencies and best outcomes for individuals
- Working as part of an IDT (Integrated Discharge Team)
- Preventing admissions; piloting falls response service
- Local Care Programme. Neighbourhoods work
- Improving internal processes with transfer between hospital and community ICS teams for reduced interactions of individuals with multiple workers
- Finalising a Standard Operating Procedure as part of the Inter Disciplinary Team (IDT) to define the roles and responsibilities of all key partners

We agree the default position should always be home first and the LA has increased the funding to START to improve recruitment and retention for the reablement team and also a 12% on the domiciliary care hourly rate to encourage the same across the market. The capacity has improved with pathway 1 numbers increasing compared to the same period last year.

The hospital IDT are working closely together to do early discharge planning with Social workers now on site to support early conversations and as a result it has increased the number of pw 0 getting people home quickly. Pathway 1 LOS have reduced compared to the same period last year as a result of some of this work.

START LOS has also improved with people on a reablement for approx. 14 days.

We have supported discharge into care homes by having a dedicated small team who (Bed Hub) who support with sourcing placements and from July 2023, will also do the negotiation for these beds to improve the time taken to address this.

In addition system partners are currently working together on a discharge process with a focus on reablement which will commence from the time of admission through to discharge and enuring people are on the right discharge pathway therefore improving their outcomes. This remodelling will include talking to patients and learning from the experiences of individuals and aligned to the 'I' statements making sure people have a say on what they want.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

BCF supports the discharge in multiple ways, its supports how we meet eligible needs and how we offer a wide range of choice to support people to live well and independent as long as they can. When they need support these projects ensure that services are there in the right time and place for them. Funding is being used in a multitude of ways to ensure choice and control remains with the indidivual but also timely so not delay discharges. The discharge team work with clinicians to support these conversations

In addition our Care Act duties are also about managing the market and therefore how we commission services is an important part of this including a careful balance of both SPOT purchasing and where appropriate block purchasing support. This ensures that the market has the ability to access funds through supporting discharges.

The Prevention contracts and wider local care programmes support in reducing and/or delaying the need for more formal care through DFG's, information and advice, direct support to help people navigate their own solutions within their own communities.

See previous sections above for the detail on this question.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The BCF prioritises support for carers. The system recognises the additional strain caring for others causes our residents and the vital role carers play and are committed to supporting carers of all stages and ages (Carer Strategy). Through Partnership discussions at SHIPP, the carers strategy has been adopted across the Shropshire System and with the Primary Care Networks.

Young carers are supported through our Crossroads Together Young Carer Service, and the BCF funds a number of services that support Carers (directly and indirectly); these include:

- Carers Support service (described below)
- Let's Talk Local (one to one Personalised Care approach to supporting those stay well in their communities and their carers)
- Social Prescribing (Personalised Care)
- Wellbeing and Independence service
- Advice and Advocacy service
- Alzheimer society
- Care Navigation
- Autism West Midlands – support for families and carers of autistic children

The work of our programmes take a Personalised Care approach – understanding what matters to people/ individuals as a first discussion. This ethos is embedded within many of our programmes and developing in others (where we are offering Shared Decision Making training and other Personalised Care Institute accredited training).

In additional to understanding and embedding support throughout many programmes, we have a bespoke Carers support service. Our support for informal carers aims to:

- Reduce the risk of carer breakdown – carers have ongoing support and information for each stage of their journey, giving them the confidence to continue in their caring role .
- Reduce isolation and loneliness.
- Allow carers to make informed decisions on the choices available, now and for the future.
- By supporting the carer, the cared for person may also be healthier and happier reducing their feelings of anxiety and guilt.
- Ensure that people with caring duties for family and friends of all age (including parent carers and young carers) have access to the information advice and guidance they need to make informed choices.

The Carer Support team currently supports adult carers of adults. It is not a time limited service and may be working with individual carers for a short time or for longer periods of time, or carers may dip in and out of our service depending on their individual needs.
Carers can self-refer, or referrals are made via statutory, voluntary and community sector organisations.

A broad outline of support provided to adult carers of adults through the team is:

- **Information and advice** - general and personalised information for carers Provided through:
  - 1:1 discussions
  - Support Line – operated daily Mon- Fri 9-00am till 5-00pm. Carer Support Practitioners (CSP) man the line on a rota basis – each taking a day of the week.
  - Carer Register – which incorporates an emergency plan and card. Every carer is contacted on registering to introduce the relevant CSP and check on what support, if any, they may require currently. We also check to see if they are on the council database, LAS, if not, with their permission, we add them. We currently have 1092 carers on the Carer register - numbers are increasing by approx. 180 per quarter. (Increasing yhr number is a local target)
  - Peer groups
  - 6 monthly check in and chats - the biggest complaint received about both the Council and the previous external support provider was that after the initial assessment they received no further contact.
- **One to One Support -** providing **ongoing** support, working with carers to explore their options. The carer support team operate a 'coaching approach' to support carers to understand their choices and make their own decisions on how they would like to move forward.
  Provided through:
  - Face to face
  - Telephone
  - Virtual
  - 6 monthly check-in and chats – as a preventative service.
- **Carers Network** – provided through:
  - peer groups – physical and virtual.
  - WhatsApp
  - Networking with health, voluntary and community sectors in their areas.
- **Future planning** – provided by:
  - 1:1 support
  - Future planning events

Raising awareness of carers and events – attending other organisations events and organising our own

Hospital Carer Support – provided by:

A dedicated Hospital Carer Support worker supporting carers whilst their cared for person is in a hospital setting, by providing:

- support through discharge procedure and information
- emotional support
- personalised information
- registering with Carer Support team for ongoing support
- signposting to other organisations
- links to ward staff, therapists and social work teams
- contingency planning

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Through collaborative working with partner organisations, including the voluntary and community sector, we aim to bring together housing, health and social care to better support some of Shropshire's most vulnerable people. A person-centred approach is taken to better identify and address the needs of individuals and families. The financial support provided via the grant process enables people to live their best life in Shropshire. It may also prevent escalating care and support needs and thus reducing unnecessary costs to the client and the Council. Our approach aims to make the best use of available funding from a variety of sources to find the most suitable solutions for the people of Shropshire.

Prior to any grant application, the Occupational Therapy (OT) team will undertake an assessment of needs to identify what is necessary and appropriate for a person to remain living independently in their own home. During this assessment an OT may liaise with other health professionals and, if applicable, the voluntary sector to gain a holistic viewpoint to address a persons identified needs. The result of any OT assessment may range from advice to minor adaptations, such as grab rails or assistive technologies, up to major adaptations like shower facilities or stairlifts etc. As previously mentioned, adaptations can help alleviate the need for care and support but they also have the potential to reduce hospital admissions and readmissions, for example, by removing the risk of slips, trips and falls in a person's home.

By utilising some of the adaptation budget, Shropshire Council has made assistive technology more accessible and easier to understand by providing a new directory of services available. Assistive technologies have the ability to prevent accidents from occurring. Like adaptations, it can also provide a more independent lifestyle and give reassurances to family and friends who are concerned for their loved ones by alleviating the pressure of carers who are struggling to cope in their role. There are a wide range of assistive technology and telecare devices available, for example, specialised bath plugs, remote monitoring devices, and falls alarms. Residents will be required to have a needs assessment by the Council to determine whether they are eligible for assistive products. The directory will provide an 'assistive technology checklist' for people to view before purchasing any devices. It covers important questions about whether the device is fit for purpose, easy to use, portable, reliable, costly, and more.

Additionally, a new project was started in 2021 to identify how some of the more advanced technologies could be of benefit to residents in Shropshire across Supported Living, focussing on greater independence, management of daily living activities, risk management and learning and development. The project has been hugely successfully and has generated the following outcomes:

- Users across Supported Living have had the opportunity to develop their skills for more independent living
- Users have been able to build their confidence in the use of technologies to creatively meet their needs
- Family carers have felt the benefits and are thrilled to see how their loved ones develop their independence

- Care staff and providers are seeing the benefits of how each piece of new technology kit can reduce anxieties, repetition and frustrations / behaviours that result from continual prompting by staff which can be replaced by technology
- Risks are managed in more creative ways
- Face to face care and support can be reduced, or even removed, safely
- Social Workers are learning through the implementations, how tech can benefit users which promotes more creative approaches to commissioning care
- Significantly reducing the spend on care packages

A New Approach to Major Adaptations

As of February 2023, Shropshire Council has started to pilot a new method of providing funds for major adaptations. It is hoped this new approach will update or replace virtually all the current grants that deliver financial assistance for adaptations. This includes changing and improving the mandatory Disabled Facilities Grant (DFG). If successful, a new assistance policy will be established from the results of the pilot scheme. The aim of this new way of working is to provide a simpler, more streamline process which is easier to understand for grant applicants. It will have an improved and fairer financial 'means-test' for applicants and a higher funding limit giving us the potential to help more people than ever before.

Previously, the Council used a number of different types of grants for clients to apply for funding for adaptations, however, due to the steady rise in demand for the financial assistance, issues have developed over time:

- Administrative burdensome – potential multiple applications, numerous associated IT records etc.
- Two different financial budgets – mandatory & discretionary funds result in unnecessary additional administration work.
- Confusion for clients – the various grants have different qualifying criteria and upper limits and can require the completion of numerous forms

As a result of the above issues, waiting time for clients during the application process has increased.

In addition, due to successive governments not updating the legislation associated with the DFG since 2008, the funding limits and the financial checks for eligibility have not moved with the times and no way does the mandatory grant reflect the current financial struggles people currently experience or the rapid increase in costs for labour and materials.

The premise of the new funding is still based upon the main principles of the mandatory DFG, (owner or tenant applications, a form of means-testing for clients, occupational therapy (OT) assessed need for adaptations etc.) The new grant has been developed to bring the provision of adaptations in line with the incoming change to the financial assessment for social care, this being: full eligibility for applicants and their partners, if applicable, with savings levels below £20,000, expected contributions for savings between £20,000 and £100,000 and no eligibility for clients with above £100,000 in savings, capital etc. This should make financial eligibility for adaptations a more equitable test and a much less complicated calculation for applicants than the current DFG test.

Due to the 'means-test' being much simpler to determine, it is possible that the conversation around eligibility to the grant could be had at a much earlier stage, possibly at the first point of contact with a client in the process. This has potential to save time on wasted assessments for OT teams, and the clients, if it is known at an earlier stage that a client is or is not eligible for financial assistance.

The new grant will have an upper funding limit of £100,000, which is a much more realistic amount of money to provide all types of adaptations than the £30,000 maximum of the DFG. As previously outlined, this element of the DFG has not been reviewed since 2008 and with the excessive price increases in the last 18 months alone, £30,000 is not enough to address the needs of some of the more complex work we fund.

It is hoped that, along with it being a fairer funding assistance for clients, it will be a more manageable administrative process for the Council. This new assistance will replace or improve all the various mandatory and discretionary funding streams we already have in place. Instead of some clients needing to apply for several grants, this grant will provide the same funding but only requiring one application form. Along with a fairer means-test, the new assistance will require less paperwork, be less confusing and have one budget to draw from instead of the existing two mandatory and discretionary ones. It is hoped that this will reduce time needed for officers to administer the grant and consequently reduce waiting time for clients.

Below are the numbers of grants we approved for the 22/23 financial year:

- Disabled Facilities Grant (DFG) = 143
- Major Equipment Grant (MEG) = 147
- Discretionary Adaptation Funding (DAF) these are essentially DFG Top Up grants = 12
- Major Adaptation Grant (new grant to replace DFG & DAF) = 12
- Relocation Grant = 2

This gives a total of **327** approved grant applications for 2022/23.

The total grant provision will be less than this, due to the timing of the completed work (sometimes going into the next financial year), and some will have applied for more than one grant and not needed all/more than one.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Click or tap here to enter text.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Please see DFG narrative

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Inequalities and specifically health inequalities are interlinked. Action to reduce health inequalities requires action to improve outcomes across all the factors that potentially determine our health outcomes. Only around 10% of our health is impacted by the healthcare we receive, other determinants such as the places and communities in which people live, education, housing and access to green space, individual lifestyle behaviours and the quality and accessibility of health and care services (including inequalities in these determinants), can all impact on health and inequalities in health. Taking action to reduce health inequalities is both a national and a local priority, the importance of which has been dramatically highlighted through the recent Covid-19 pandemic.
Given the need for concerted action to reduce health inequalities the Shropshire Health and Wellbeing Board (H&WBB) requested development of a plan for Shropshire. They requested that the plan should recognise the importance of both health inequalities and the wider inequalities that underpin their development. As such, the prevention, admission avoidance and system flow themes of the Better Care Fund Plan all reflect how we are working to reduce inequalities.
The Shropshire Inequalities Plan highlights different needs for different population groups including:

- Those with protected characteristics (Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or believe, Sexual orientation)
- Health inclusion groups including homelessness, traveller community, sex workers, people in contact with the justice system)
- Lifestyles and Health inequalities
- Health and digital literacy
- Rural deprivation and hidden deprivation

Intersectionality and Health Inequality
It is recognised that the factors that underpin health inequalities do not operate in isolation of each other but that they interact reinforcing and amplifying their potency in damaging health. For example, when looking at links with protected characteristics in terms of sex women are more vulnerable to poverty than men primarily because they are paid less, work fewer paid hours over their lifetimes and lose income because of caring responsibilities. Female lone parent households have twice the poverty rate of male lone parents and single mothers in particular are more reliant on benefits and as such are vulnerable to welfare cuts.
In terms of race those from ethnic minority groups are more likely to work in low paid occupations or earn below the living wage. Those from black ethnic groups have higher rates of unemployment and are more likely to have insecure work. Whilst pensioner poverty has fallen over recent years

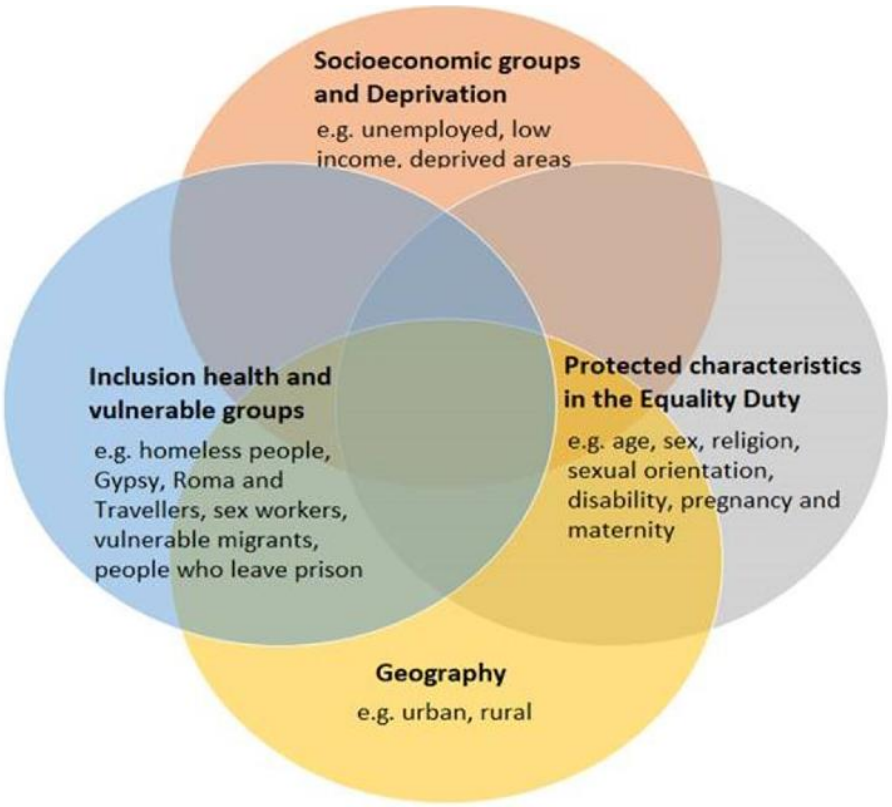
some pensioners are more likely to be in poverty than others in particular those with protected characteristics, as follows:

- Asian or Black pensioners
- Single female pensioners
- Pensioners with disabilities.

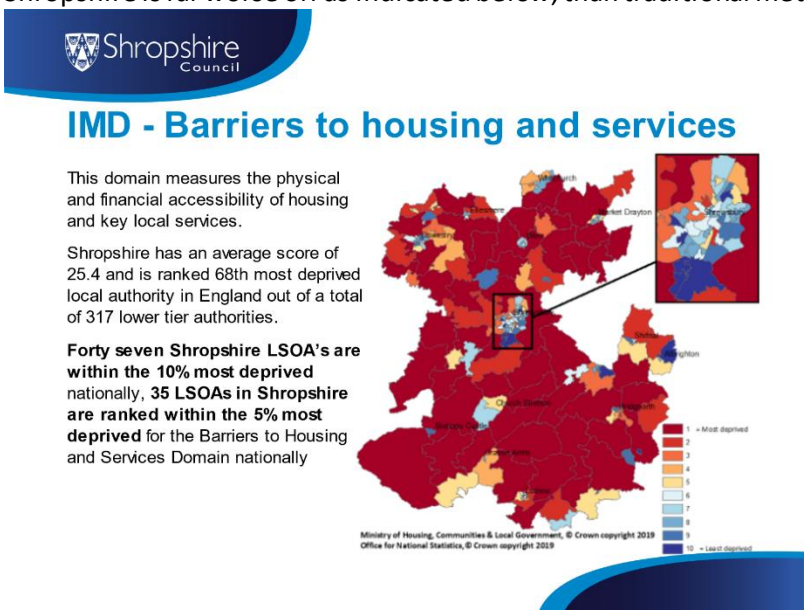
There is a very strong relationship between poverty and disability. Almost half of working age adults in poverty have someone who is disabled in their household. Poverty for those with disabilities is often related to the costs incurred for a disabled person to enjoy the same living standards as a non-disabled person. Disability-related benefits are included in measures of net income, but do not account for the additional costs incurred; thus, a disabled household may appear to have sufficient income whilst in reality their income is insufficient.

Whilst those with protected characteristics are independently more vulnerable to poverty there is an additional impact through intersectionality. For example, women with disabilities are lower paid than women without disabilities and youth unemployment rates for young people from Black, Pakistani or Bangladeshi backgrounds are more than twice the rate among white, young people. The overlapping dimensions of health and health inequalities are recognised and are illustrated in figure 3 below.

Figure 3. The Overlapping Dimensions of Inequalities[15]



Additionally, and crucially for delivering services in Shropshire, the plan recognises the impact of rural deprivation. The , diagram below highlights an additional way to understand deprivation and access to services; which provides better insight to the needs of a rural community, where Shropshire is far worse off as indicated below, than traditional methods of considering dep rivation.



The Shropshire Better Care Fund programmes and service delivery recognise the importance of the factors listed above and is making significant strides to reduce the impact of health inequality through the work we do. Key aspects of this work are embedded within the implementation of Personalised Care Approaches across programmes, working with housing colleagues through the DFG, transforming Local Care and improving system flow with a focus on the most vulnerable.
The prevention theme of our BCF has a significant focus on delivering Personalised Care, which places takes holistic approaches to understanding individuals' needs and working through community-based solutions (which are proven to reduce inequalities). Elements of this work inclu de the Prevention contracts, Social Prescribing, Community Development contracts (as part of Social Prescribing), Let's Talk Local (ASC provision in communities), Assistive Tech through the DFG. This work has been long embedded in the BCF but it continues to grow in strength and recognition.
Delivery of specific programmes addressing the Core 20 Plus 5 are underway. A project, funded by NHSE but long-term sustainability will sit within the social prescribing community development work, is developing community cancer and CVD champions, with a focus on those geographic areas in most need in Shropshire. Additional work includes a focus on CVD and Diabetes and connects with Primary Care inequalities delivery, ensuring integration. In STW rurality is a key concern with regards to inequalities and part of our 'Plus' grouping. As described above rurality causes both difficulties with our population ability to get to services, as well as issues with driving up the cost of delivering services. All service development and transformation programmes must take this into consideration.
With regard to both Admissions Avoidance and System Flow our programmes take a person centred (Personalised Care) approach, focussing on a 'what matters to me' ethos. This coupled with Proactive Prevention helps services to connect with and support people who need it the most (proportionate universalism). Our reablement service START works to support all those in need, but

takes particular care to ensure those who need additional help (such as debt, housing, advice), receive what they need to remain healthy and well.
Changes since the last BCF plan include:

- Shropshire Inequalities strategy launched September 2022
- Delivery of Core 20 Plus 5 programmes including the development of community cancer champions (linked to community development as part of Social Prescribing); additional work includes CVD and Diabetes prevention as well as Respciratory worth through Local Care
- Launch of system Core 20 Plus 5 CVD champion project – July 2023
- Embedding Personalised Care in NHS Provider Contracts (Shrewsbury and Telford Hospitals, Shropshire Community Trust, and Robert Jones and Agnes Hunt)
- Expansion of the Social Prescribing Adult Service – delivering over 6000 referrals from beginning August 2021 to end April 2023, across all 4 Shropshire PCNs
- Expansion of Social Prescribing to deliver a Children and Young People's service across all 4 Shropshire PCNs, working closely with schools and Early Help, targeting children and families in most need
- Establishment of a Social Prescribing as part of the front door to Children's Social Care, targeting children and families in most need
- Working with social care and partners to pilot social prescribing with ASC waiting lists, A&E and other health waiting lists
- Developing Assistive Tech offers through the DFG, targeting those most in need and the digitally excluded, generating savings and supporting people
- Joint Commissioning of 2 Carers in a Car – providing equitable access across the county
- Amplify the WIPS contract in winter to provide additional support at home following hospital discharge (to reduce readmission and support people to improve their health and wellbeing)
- Local care
    - Development of Rapid Response to target vulnerable
    - Development underway of improved Falls response (based on winter 22/23 pilot)
    - Development of neighbourhood MDTs
    - Developing Proactive Prevention
    - Developing joint approach to funding and working with our communities and working with our Voluntary and Community Sector
    - Care at Home