BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 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 in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

Through the Health and Wellbeing Board, Shropshire Infrastructure Partnership (Voluntary and Community Sector), 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 CCG
- Voluntary and Community Sector organisations (various)
- Voluntary and Community Sector Assembly
- Healthwatch
- Shropshire Community Health Trust
- Shrewsbury and Telford Hospitals
- Midlands Foundation Partnership Trust
- individuals

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.

As the ICS develops, we are working collaboratively to develop our approaches to coproduction and involvement. All schemes of the Better Care Fund will be part of our developing approach to working with our population to improve services.

Executive Summary

Since the previous Better Care Fund Plan (BCF), there has been significant local development and learning in the face of the pandemic. The Integrated Care System has been formalised and its pledges and priorities, along with the Health and Wellbeing Board, set the strategic direction for Shropshire. While the pandemic has had devasting effects on some families and communities, it has also left a legacy of significant growth of mindset and improvement in integrated approaches across services. Opportunities are plenty for more joined up working and the BCF continues to support the delivery of Shropshire's HWBB and Integrated Place Strategy and Priorities.

The HWBB Strategy has been refreshed in 2021/22 and after consultation with the community and partners will be launched in March 2022. The new strategy proposes to work through key areas of focus (Mental Health, Children and Young People, Healthy Weight and Workforce) to deliver the following 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

The BCF priorities have remained completely relevant and unchanged. The priorities and key programmes areas are:

Prevention and inequalities – keeping people well and self-sufficient in the first place; key programmes include: Healthy Lives, including community referral (Let's Talk Local, Community Development, Social Prescribing and Health coaches), Healthy Weight, new dementia vision, Voluntary and Community Sector grants and contracts (Wellbeing and Independence and Advice and Advocacy contracts), Population Health Management, Carers, Mental health and Early Help services for children and young people.

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

Delayed Transfers and system flow – when people have had to come into hospital, we are working collaboratively through the Hospital Discharge Alliance, using the 9 High Impact Model, learning from Covid, Discharge to Assess and an Integrated Discharge Hub, to ensure system flow; Key areas of work include: Integrated Discharge Hub (hospital social work interface and short term support purchasing), Start Reablement Team, Integrated community services, 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
- taking an evidence-based approach

Governance

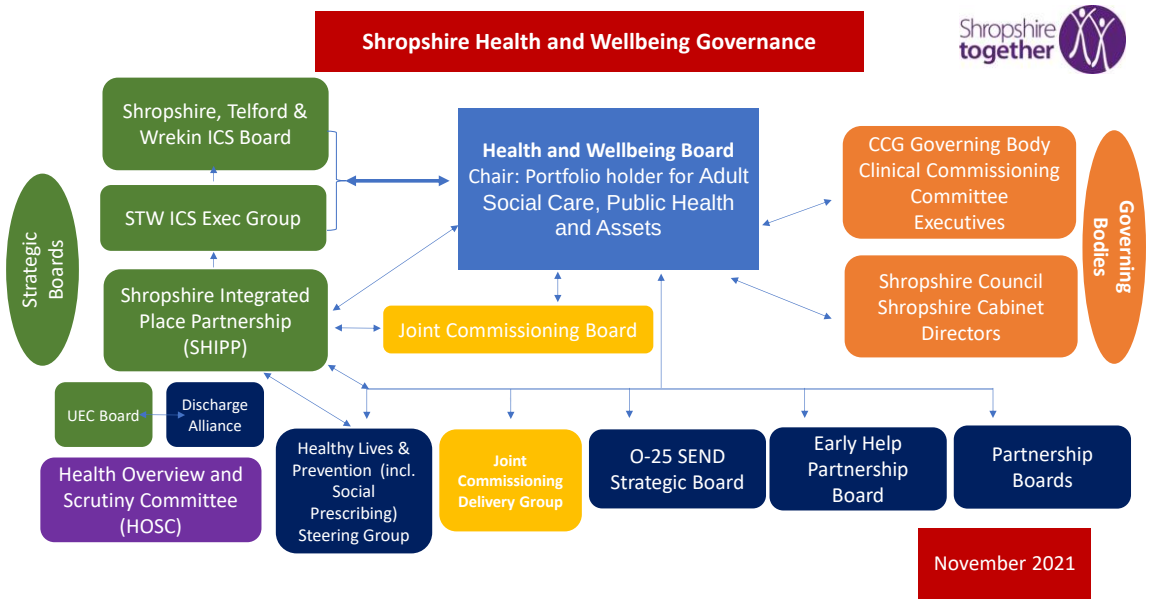
Please briefly outline the governance for the BCF plan and its implementation in your area.

The Better Care Fund programmes are developed through the newly formed Joint Commissioning Delivery Group, with governance through the Joint Commissioning Board and the newly formed Shropshire Integrated Place Partnership. 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.



Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

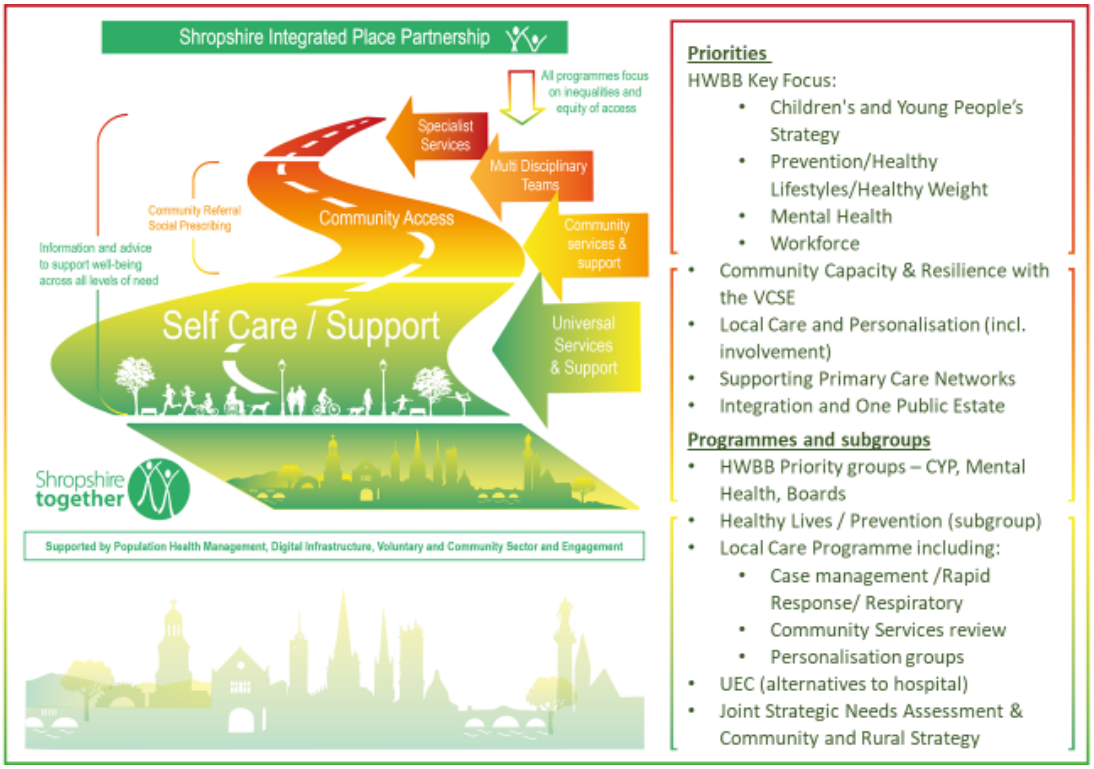
- **Joint priorities for 2021-22**
- **Approaches to joint/collaborative commissioning**
- **Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.**
- **How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.**

The BCF planning and delivery, the Better Care Fund work is delivered through the governance of the Joint Commissioning Board, HWBB and additionally with a focus on integration, the Shropshire Integrated Place Partnership (SHIPP). The Shropshire Integrated Place Partnership 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, b) provide community services where they are needed, and c) provide high quality specialist services when they are needed.



The BCF supports the delivery of the aims and priorities of the HWBB and SHIPP and are captured through 3 main headings:

Prevention and inequalities – keeping people well and self-sufficient in the first place; key programmes include: Healthy Lives, including community referral (Let's Talk Local, Community Development, Social Prescribing and Health coaches), Healthy Weight, new dementia vision, Voluntary and Community Sector grants and contracts (Wellbeing and Independence and Advice and Advocacy contracts), Population Health Management, Carers, Mental health and Early Help services for children and young people.

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

Delayed Transfers and system flow – when people have had to come into hospital, we are working collaboratively through the Hospital Discharge Alliance, using the 9 High Impact Model, learning from Covid, Discharge to Assess and an Integrated Discharge Hub, to ensure system flow; Key areas of work include: Integrated Discharge Hub (hospital social work interface and short term support purchasing), Start Reablement Team, Integrated community services, Equipment contract, Assistive technology, and Pathway 0.

Table 1 below highlights the interconnectedness between priorities and the BCF priorities and delivery programmes.

Table 1: Shropshire System Pledges and Priorities

STW ICS Pledge & * Big Ticket Items	HWBB and SHIPP Priorities	BCF Programmes (prevention, admission avoidance, system flow)
Improving safety and quality	Personalisation	Cross Cutting
Integrating services at place and neighbourhood level *** Place Based Joint commissioning** *** Local Care**	Supporting Primary Care Networks Local Care Strong and Vibrant Communities Joined up working	Healthy Lives (including social prescribing and let's talk local) Voluntary & Community Sector contracts Discharge Alliance
Tackling the problems of ill health, health inequalities and access to health care *** MSK Transformation** *** Outpatients Transformation** *** Hospital Transformation**	Inequalities Population Health Children and Young People, Supporting Primary Care Networks Healthy Weight/ Lifestyles Local Care	Healthy Lives (including Social Prescribing and let's talk local) Discharge Alliance 9 High Impact Model
Mental Health and Learning Disability/Autism provision	Mental Health Integrated working Children and Young People	Mental Health Mental Health housing options Autism support
Economic regeneration	Integrated working Strong and Vibrant Communities	Cross cutting
Climate change	Strong and Vibrant Communities	Cross cutting
Governance	Joined up working	HWBB Governance
Enhanced engagement and accountability	Strong and Vibrant Communities	SHIPP Principles
Creating system sustainability	Joined up working	Cross cutting
Workforce *** Workforce Transformation**	Workforce	Cross cutting

Prevention:

Keeping people well in the first place remains a top priority for our system. Our prevention programme Healthy Lives drives forward vital preventative activity in Shropshire including, Social Prescribing (including Health Coaching and broader community referral), Shaping Places Food Insecurity project, Lifestyles and cardiovascular disease prevention, and Population Health Fellow projects (Mental Health including Complex need and CVD). The programme provides a place for preventative programmes to join and make best use of resources. It has been built on the approach we term, a team of teams. By joining forces across organisations (including Health, Care, VCSE and Primary Care Networks), we pull together funding and resource from numerous sources to deliver whole system approaches to prevention.

The pandemic has demonstrated how vital our voluntary and community sector is in supporting people to remain independent and well in their own homes for as long as possible. Therefore, 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 contacts covering Advice, Advocacy, housing 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 can't offer - a crisis response or personal care, but it will work as part of the health and care system to ensure that people get the support that they need through appropriate referrals and signposting.

Below, please find Table 2, which highlights our prevention (and admission avoidance) metrics and rationale. The metric below will be impacted by all the Better Care Fund themes, but we have specifically embedded schemes to support people to remain independent at home, through our Prevention theme. We have taken a cautious approach to the metrics this year, given the uncertainty with Covid.

Table 2: Metrics associated with prevention (and also associated with admission avoidance)

Shropshire metrics	Average 18 months data pack	Average by qtr3	Average by qtr4	Proposed target qtr3	Proposed target qtr4	Comments/ Rationale
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/reablement services.			20/21 Actual 85.3%		82% ASC OF set target	Although the result for 20/21 was improved on 82%, this target ia often problematic for us, due to our ageing population, and that the target does not exclude those who have died. With the expected issues related to Flu and Covid during winter 21/22 we propose to maintain 82%.
Residential Admissions rate per 100,000 population		19/20 553	20/21 403		2021/22 590	The target for ASCOF this year is 590 and based on the population estimates used in the template; this equates to 492 people. This is higher than performance last year, which was significantly impacted by the pandemic. It is not clear yet how much change there will be this year. Early figures so far indicate admission numbers are higher.

Admissions Avoidance:

Our Local Care Programme is a new programme of significance for the delivery of the BCF. The programme is one of the ICS Big Ticket programmes, and its 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.

The COVID Pandemic has shone a bright light on the issues surrounding health inequalities across the UK. Our Local Care Programme will strive to empower our residents and communities, by building community confidence this will be an essential requirement to reducing health inequalities.

Vision

The STW system through collaboration, will work together to support individual residents in our local communities. New models of care will be designed with residents and local communities, with a focus on prevention and promoting good health and wellbeing. Residents with long term conditions will be supported to manage their care and we will respond swiftly to those in crises to avoid unplanned admissions.

Our vision will be driven by a Local Care Transformation Programme of change, underpinned by the principles of:

- Collaboration - Care delivered by our local health and care teams coming together providing integrated support and care. The teams will work in partnership with residents, voluntary and community sector, using the full range of collective skill knowledge, and expertise
- Understanding and managing the needs of our residents and communities through risk stratification and case management. This will enable a more targeted approach to supporting and responding to the needs of our residents.
- Contributing to addressing Health Inequalities - through earlier interventions, embedding a systematic approach to proactive prevention, and building a strength based approach to how we empower individuals, families, and communities in achieving their aspirations for better health and wellbeing.

Two -year Vison

By the end of year 2 the STW system will have the following priorities and new models of care co-designed, tested, (where applicable) and implemented

- Proactive Prevention model adopted for all interactions and interventions with residents/patients, with our workforce provided with the necessary tools and information to support residents build on their strengths and fulfilling their short medium and longer term aspirations
- Case management approach embedded and aligned to a comprehensive risk stratification needs based model.
- Rapid Response service embedded across the county of STW
- A New Community Respiratory model (including virtual ward and IV Therapy)
- A full review of the current estate (ShropComm) with clearly defined options and recommendations for how the estate will enhance our local care offer during years 3-5
- An Asset Mapping exercise completed across health and care with defined plans for how we maximise the use of our assets in the delivery of care closer to our resident's homes.
- End of Life Care Review Community model agreed with plans for implementation
- Point of Care Audit completed and used to inform both Hospital and Local Care Programmes
- Celebrating our successes through story telling where we are making a real difference to people's lives, alongside examples from our workforce describing the benefits of integrated working.

Five-year Vison

By the end of year 5 the STW system will see

- Services in STW empowering people to have a greater say in their care
- A transformed, integrated health and social care system
- Evidence that will show improvements in population health, measured in relation to defined outcomes
- High quality, safe and clinically sustainable services meeting NHS Constitutional Standards
- Comprehensive workforce strategy detailing new health and care roles will be supporting our transformed integrated health and care system
- Embedded integrated pathways between hospital and community services

Our Local Care Programme will have significant impact on avoiding admissions from this year, however the impact will be greater in the years to come as the programme is rolled out across the Shropshire Council area (and the system). We have proposed a small stretch target as described below.

Table 3: Metrics associated with Admission Avoidance (in addition to those above)

Shropshire metrics	Average 18 months data pack	Average by qtr3	Average by qtr 4	Proposed target qtr3	Proposed target qtr4	Comments/ Rationale
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital, at local authority level.		20/21 actual 544		21/22 proposed target 543.2	This is the current predicted number based on data trends. Trends have been affected by covid and reduced flu during 20/21 and 21/22. We have proposed to reduce slightly, which we believe to be a stretched target.

System Flow:

Our key programmes of the BCF which support the System flow are the work of the Discharge Alliance (described in the section below), the DFG (described below) and our reablement programme START.

START reablement Team START (Short Term Assessment and Reablement Team) is our highly respected, homecare re-enablement service. START currently works alongside the Integrated Care Service (ICS) and is currently jointly commissioned by Shropshire Council and Shropshire Community Health NHS Trust, and is a locality-based health and social care team, which incorporates community and voluntary sector teams.

The service provides personal care and support to all Shropshire Council residents aged 18 and over who have been assessed as requiring short term support to help them regain the level of independence they had before they became unwell, or to achieve their personal new level of independence.

Its key objective is to support wellbeing by working alongside an individual to maximise their independence, and work with a range of people who have care and support needs as a result of age, disability or illness.

Utilising the range of support available in the county and funding opportunities, the START team provides personalised goal planning with the people it supports, whilst ensuring that all records are accurate and up to date.

Our approach to collaborative and integrated working has been bolstered over the last year with the development of three new jointly funded (Shropshire Council and STW CCG) and appointed posts. These are:

- Assistant Director Joint Commissioning
- Head of Joint Partnerships
- Population Health Management Analyst

The Discharge Alliance (as described in detail below) are working hard to embed new integrated practices to significantly improve the length of stay targets and normal place of resident targets. The Alliance will be aided by the winter pressures scheme which are support hospital discharge (as described above), however we anticipate a challenging winter ahead.

Table 4: Metrics: System Flow

Shropshire metrics	**Average 18 months data pack**	**Average by qtr3**	**Average by qtr 4**	**Proposed target qtr3**	**Proposed target qtr4**	**Comments/ Rationale**
LOS 14 days	9.6	9.75	10.9	9.3	9.6	Considering the average by qtr 3 and 4, the proposed targets are stretched, this is especially true with the pressures in the dom care market in the wake of Covid.
LOS 21 days	4.4	4.5	5.2	4.4	4.9	As above.
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Average annual target 90.3			90.3 maintain as annual target		Due to pressures in the system especially across domiciliary workforce it is considered that maintaining this average is a stretched target.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

Background

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.
The White Paper, mandates that systems must come together and 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

Covid 19 challenged the way in which we work and of our delivery of services. Government guidance stated that systems must implement a Discharge to Assess (D2A) model to speed up hospital discharge times, helping patients get home quicker.

Discharge to assess will be the default for all patients who require assessment of their care needs.

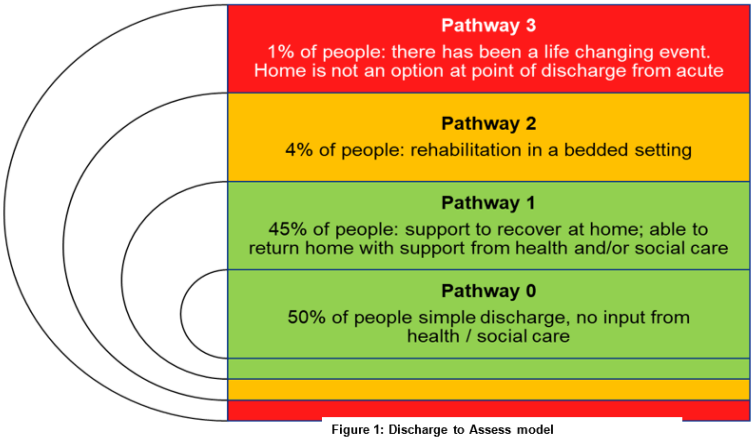


Figure 1: Discharge to Assess model

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 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.

Outcomes to date of Integrated Discharge Hub

- A total of 6,714 Fact Finding Assessments (FFA) were completed in the 2020/2021 reporting period with 655 being accomplished in April 21.
- The average System Length of Stay (LoS) for patients from being Medically Fit for Discharge to discharge pre the Integrated Discharge Team was 4 days. This has reduced to an average of 2.4 days for the 2020/2021 fiscal year.
- 55% of total discharges from point of referral occurred within 72hrs plus. This is in contrast to 92% of FFA referrals being completed within 24hrs.
- 56% of all Fact Finding Assessments were discharged through Pathway 1. This demonstrates an 8% achievement above baseline.
- A total of 61 Fast Track's were completed in April 79% of which were discharged within the target of 48hrs.

Data evaluation of the IDH metrics.

In March 2021, the System Discharge Alliance group was set up to scrutinise and identify areas of improvement in relation to patient discharges, patient safety and learning from patient experience. The group meets at three weekly intervals with membership from system partners. Part of the role of the group, is to monitor discharge performance metrics using data to drive improvements.

A number of working groups and task and finish groups are in place to address the key issues, and they report into the discharge alliance group, which in turn reports to the Urgent Care (UEC) Operational Group through to UEC Board.

The group monitors the progress of these groups and manages escalations and risks that may be identified.

Purpose of System Discharge Alliance

The purpose of the Alliance is to improve discharge performance for the Shrewsbury, Telford and Wrekin system ensuring safe and timely discharge and a positive patient experience. This will ensure no one is in hospital longer than need by and will be done by:

- Monitoring discharge performance metrics using data to drive improvements

- Utilising national priorities for discharge, previous reviews, health watch surveys and MADE events to plan a programme of work required.
- To identify issues that impact on safe and timely discharges and those that affect patient experience.
- To enable the system to meet standards required on discharge
- The Alliance will develop a work programme to ensure improvement. This will be done by ensuring working groups/task and finish groups are in place to address the key issues.
- The group will then monitor progress of these groups and manage escalations and risks identified from the work/task and finish groups which will report into this group

A number of Task and Finish groups, with attendees from system partners relevant to that work area report into the System Discharge Alliance. Each Core Programme of work is linked to one of the ICS 6 Big Ticket items, found in Table 1 above.

Improvements will be made to discharge through the implementation of the following work streams:

System Discharge Alliance Group Workstream

Workstream	Title of Project	Linked Big Ticket
1	Systems Discharge Alliance	1,3
2	Reporting patient concerns pathway	1,3
3	Reporting patient concerns sub group	1,3
4	Pathway Zero refresh	1,3
5	UEC Performance Dashboard & Data Pack	1,4
6	NHS Benchmarking submission	1,3
7	Monitoring High Impact Change Metrics and linking to workstream progress	1,3
8	Quarterly meeting in place to review action plan from Audit by Ian Sturgess	1,3
9	Community MADE action plan	1,3
10	IDT Staffing and location	1
11	Complex Discharge process T&FG	1,3

Workstream 1 - Early implementation of the Hospital Transformation Programme
Workstream 2 - MSK transformation
Workstream 3 - Alternatives to hospital admission –
Workstream 4 - Outpatient transformation – LEAD
Workstream 5 – Workforce – LEAD (Jonathan Rowe)
Workstream 6 – Integrated Procurement

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Our approach to bringing together housing, health and care is to work collaboratively across partner organisations including the Voluntary and Community Sector to support people. We take a person-centred approach to understanding and assessing needs and strengths of individuals and families, and we put in place through the DFG, the support people to live a fulfilling life, preventing needs escalating and reducing pressure on services. Our approach includes making best use of available funding from a variety of sources to find the best solutions for individuals and families.

Before a referral for major adaptations can be sent to Private Sector Housing (PSH), Occupational Therapists (OT) complete an assessment of needs to identify what is necessary and appropriate for a person. During this assessment an OT will liaise with other health professionals and, if applicable, the voluntary sector to gain a person-centred focus so that the assessment is holistic in nature and addresses the umbrella of needs going forward. Major adaptations support vulnerable people in their homes enabling them to remain independent in their own communities. They have the potential to reduce hospital admissions and readmissions brought about by slips, trips and falls. Adaptation work may also reduce the cost of care for an individual; not only can they reduce the number of care calls per day but also the number of carers supporting a person.

In addition to the mandatory Disabled Facilities Grant, Private Sector Housing can offer several discretionary grants which can provide alternative financial assistance to people with disabilities. These types of grants can enable people to have adaptations in a more flexible and or timely manner than that of the DFG. For example, the Major Equipment Grant has a much quicker application process, including a simpler financial eligibility test. This allows the installation of equipment, such as stair lifts and hoists, to be carried out in a much more appropriate timeframe, especially for those applicants who require the replacement of faulty equipment and for people who are due to be discharged from hospital or a care setting. This also prevents admission to residential homes and hospital. Other available grants provide help to those that would not normally be financially eligible for a DFG or make relocation a possibility for clients whose homes are not practicable to adapt. By providing these discretionary grants the Council is reaching out and supporting a larger number of people within Shropshire than ever before.

Case study:

House2Home is an example of how we are working. It is different for multiple reasons…

It is a multi-agency, multi-funding and multi-option approach to resolving complex cases where disabled children and their families live in unsuitable housing. We think outside of the box, using various funding streams in non-traditional ways, focusing on finding the right home in the right place.

In Shropshire, the percentage of bungalows being built, compared to other property types, is 1%. This is primarily due to 2 things:

- Development economics - bungalows take up more land and offer reduced economic return;
- The fact that when most people think of bungalows, they think of the older population and their needs

Because of this, it is difficult to find suitable housing for a family with a disabled child or children, where a 3 or 4 bedroom bungalow may be required.

The Senior Children's Occupational Therapist (OT) approached the Housing Team for help. She was aware of families who were living in unsuitable accommodation where their current property could not be adapted. There was always a child (or children) in the property with complex needs and their current accommodation was putting their safety and wellbeing, along with that of the rest of the household, at risk.

It was apparent that there was limited suitable housing stock and households were being 'skipped as unsuitable' on the Housing Register as the properties did not already have the adaptations the families needed.

It was identified that this was a problem that was only worsening with more and more households being identified as having complex housing requirements.

The process is based on a multi-agency approach using innovative thinking to resolve complex cases.

Officers from different areas of the Council and different external agencies come together. The team includes:

- Housing Options
- Disabled Facilities Grants Officers
- Housing Register officers
- Housing Enablers
- Social Landlords
- Occupational Therapists
- Social Workers

The thoughts and wishes of the family are always paramount.

Ongoing discussion and liaison with local housing providers means we can explore both current and future stock options, as well as open market possibilities. Factors taken into consideration are , cost, affordability,and available funding. The aim is to ensure the property is a lifetime option, so it must be financially suitable too.

There are also regular conversations with local housing providers to influence developments at the pre-planning application stage.

- Disabled Facilities Grants (DFGs) - mandatory and discretionary are available to make adaptations to a home.
- S.106 monies is capital funding to support additional affordable housing beyond the policy required provision.
- Homes England Funding is used by social housing providers to assist people who need a property in a specific area but where there are no new developments planned.
- Social Housing Providers contribute capital funding towards the purchase, renovation and future maintenance of these properties.
- Homeless Prevention Grant is used to cover any shortfall in purchasing a property and to fund deposits and / or rent in advance.
- Discretionary Housing Payments (DHPs) and Local Support and Prevention Fund (LSPF) is utilised to assist with rent shortfalls, deposits, removal costs and furniture.

The following is written by the Father of a child living with a disability… prior to our involvement

“Some days are better than others and he can manage getting out of the house into his wheelchair using a cushion to negotiate the steps. Other days are worse and he has been locked in a position for hours on end crying out in pain.

<THE OT> explained that the house we were currently living in was not suitable for my son; he needed to climb the stairs on his knees to use our only bathroom and we could not fit or build a ramp into the property for him to get in and out of.”

Following our involvement, things improved drastically for the family…

“Since the adaptions have been fitted the difference is amazing. We have a clear idea of how our son will manage his daily routine and the installation of a downstairs wet room will hopefully relieve the stress on his body, enabling him to function better for longer without injury.

This property is more than just a roof over our head, it is a gateway to a better life where my son is in less pain meaning tensions within the family have subsided.

I don't think that I can overstate just how much better my family's life is going to be due to this property. Our heartfelt thanks go out to all involved for all that they have done and for working above and beyond to make this happen for us.”

Equality and health inequalities.

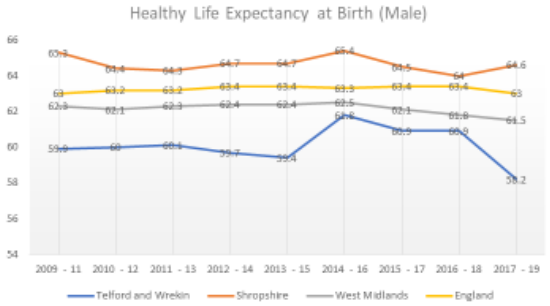
Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

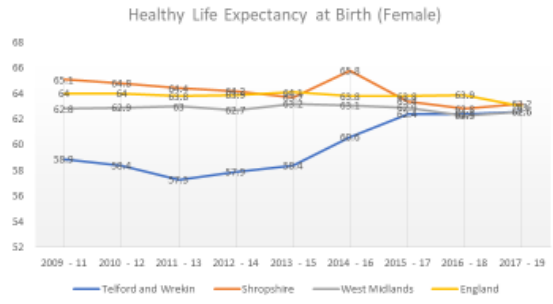
- **Changes from previous BCF plan.**
- **How these inequalities are being addressed through the BCF plan and services funded through this.**
- **Inequality of outcomes related to the BCF national metrics.**

The COVID-19 pandemic, and the wider governmental and societal response, has highlighted and exacerbated existing health inequalities and exposed multiple disadvantage and discrimination faced by some communities. This is evident in Shropshire and affirmative action is being taken across all sectors to address inequalities. Services are operating under the imperative to restore services inclusively, and where appropriate to target those who need it most. The narrative below highlights the strategic approach to inequalities, and through the Inequalities Framework, specific action that is being taken.

Key Shropshire data is displayed in the slide below.

- STW have overarching inequalities regarding **mental health** and healthy life expectancy, with a life expectancy gap of over 20 years for those with **serious mental illness**, and a declining healthy life expectancy in overall Shropshire, and mixed picture in T&W.
- Inequalities across STW in health life expectancy by ward
  - Male Healthy Life Expectancy inequalities 15 years Telford 11.5 Shropshire
  - Females Healthy Life Expectancy inequalities gap is 15.5 Telford 10.3 and Shropshire
- The emerging data regarding the impact of Covid suggests a fragility within the system regarding the wider determinants of health, which will make the health and care response so much more important.
- Health inequalities are widening (evidence base through numerous local and national 'impacts of COVID' documents)
- Demand on NHS services has been increasing and waiting times increase post COVID
- Much of this extra demand is for treatment of conditions which are preventable.
- At heart, the NHS remains a treatment service for people when they become ill. This needs to be reversed we need to focus on early intervention and prevention and taking a population health approach





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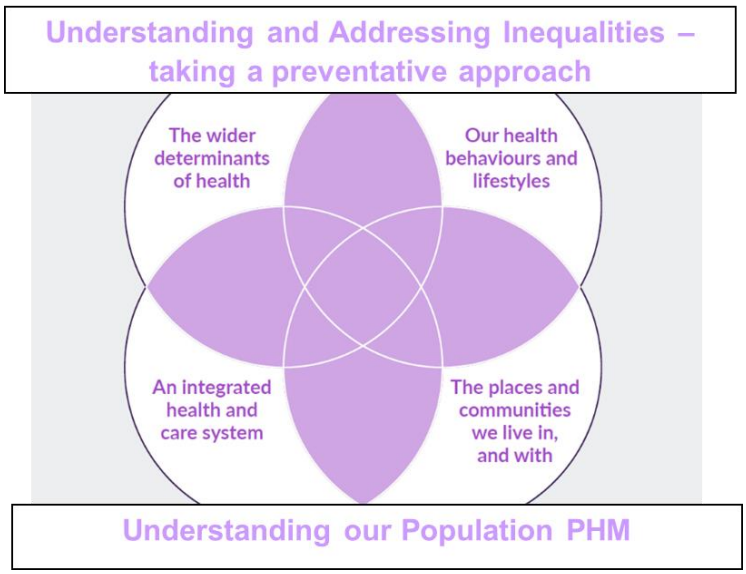
To improve our populations health, we need to take action across 4 areas, while ensuring our populations health is protected (e.g reducing COVID):

1. wider determinants, including the economy and housing,
2. working in our communities
3. creating healthy lifestyles and
4. health and care integration

The interaction between these four pillars is described in the diagram below.



Focus needs to take place from childhood to end of life and improving population health requires collaboration across all partners. Leadership across all these areas is crucial and necessary to drive forward healthier communities and healthier economies, reducing demand and to allow Shropshire to flourish

An inequalities plan is being developed for Shropshire and Telford and Wrekin ICS (and will be produced in March 2022); it will highlight our we are taking a 'whole system approach' to tackling inequalities; addressing key inequalities in Shropshire around:

- mental health and taking a trauma informed approach
- Complex need
- Lifestyles
- Wider determinants of health, including food insecurity

Table 5 below highlights the framework as part of Shropshire's Inequalities Plan. In bold are the key areas of connection with the BCF planning and delivery. This incudes work on locality Joint Strategic Needs Assessments – which have a focus on considering inequalities and the 9 protected characteristics.

Table 5: Shropshire Inequalities Framework

Wider Determinants	**Healthy Behaviours and Lifestyles**	**Healthy places and communities**	**Integrated Health and Care**
Marmot: (i) Create fair employment (ii) Ensure healthy living standard	Marmot: (iii) CYP and adults – maximise capability and control (iv.a) strengthen Ill-health prevention (lifestyles)	Marmot: (i)v Create healthy and sustainable places and communities	Marmot: (vi) Give every child the best start in life (iv.b) strengthen Ill-health prevention (transformation/disease programmes)
Health Inequalities Work Programmes			

Health in all polices	Smoking/tobacco dependency treatment (Incl NHS must do)	**Rural inequalities (Proactive prevention by all programmes)**	Whole System Approach – **HI Action embedded throughout all programmes**
Integrated health assessment	Healthy weight (Incl NHS must do)	**Local Care, Rapid Response, Case Management**	Population Health Management
Economic strategy	Physical Activity	**Winter Pressures**	**Leadership and accountability for HIs**
Thrive at work	Alcohol	**Discharge Alliance**	Data sets complete and timely
Reduce NEETs	Drug/substance misuse	**JSNA place based process – ensuring focus on the 9 protected characteristics**	**Personalisation (include SP)**
Employment MH/LD	Reduce school exclusions	Air Quality	**Mental Health (bereavement & Suicide)**
Reduce Food Insecurity	Reduce inequalities in academic achievement	Health contribution to Core Plan	SMI
	Trauma informed approaches	**Dementia vision and strategy**	**LD and Autism**
		Care Home MDT	Complex need
		Personalisation	Maternity Transformation
		Social Prescribing	Cancer
		Community Development	Diabetes
		Community Outreach and health promotion	CVD (Incl PCN HI plans for hypertension/AF)
		Strengths based care assessments	COVID//Flu vaccination
			Restore NHS services inclusively
			Inclusive digital pathways