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 but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to 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 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.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this 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, housing organisations, district councils)

- Shropshire Council (including Adult Services, Children's Services, Public Health and Place)
- 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
- Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
- individuals

How have you gone about involving these stakeholders?

Executive summary

This should include:

- Priorities for 2022-23
- 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 pledges and priorities, strategically led by the Shropshire Health and Wellbeing Board and Joint Strategic Needs Assessment. STW continues to develop its post pandemic response working collaboratively to reduce inequalities and reduce the impact the 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 new strategy proposes to work 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

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 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, new dementia vision, Voluntary and Community Sector grants and contracts (Wellbeing and Independence and Advice and Advocacy contracts), 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).

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, Case Management, Respiratory, Virtual ward), 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 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 – personalised care
- taking an evidence based approach

Governance

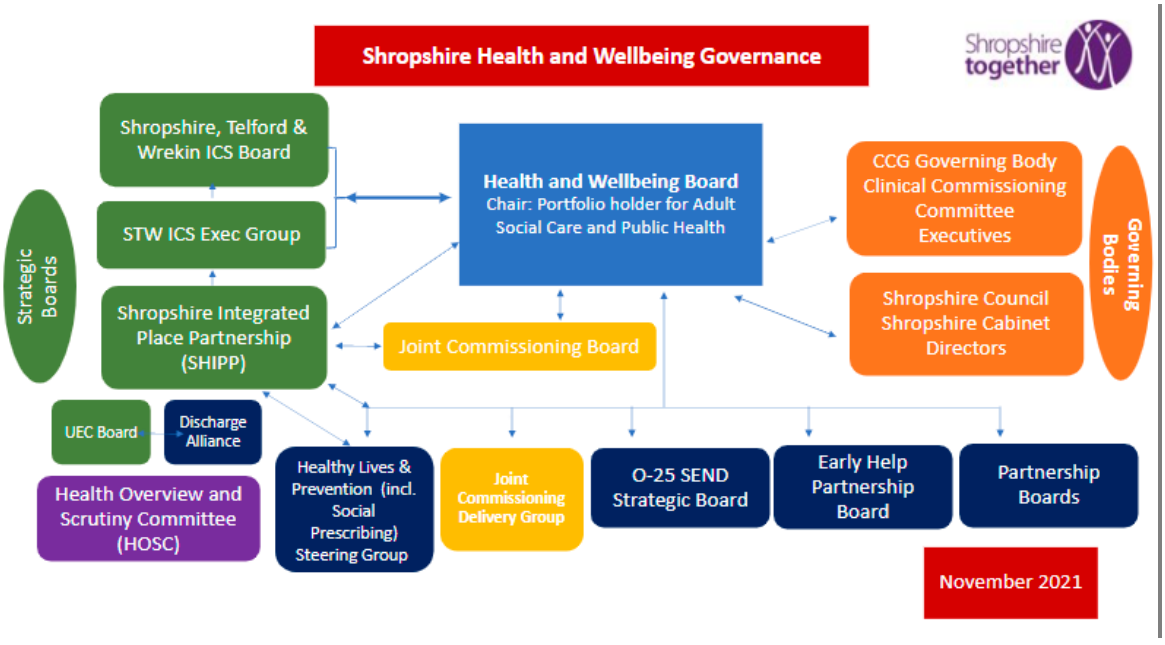
Please briefly outline the governance for the BCF plan and its implementation in your area.

The Better Care Fund programmes are developed through the Joint Commissioning Delivery Group, with governance through the Joint Commissioning Board, the Shropshire Integrated Place Partnership and the HWBB. 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 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 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

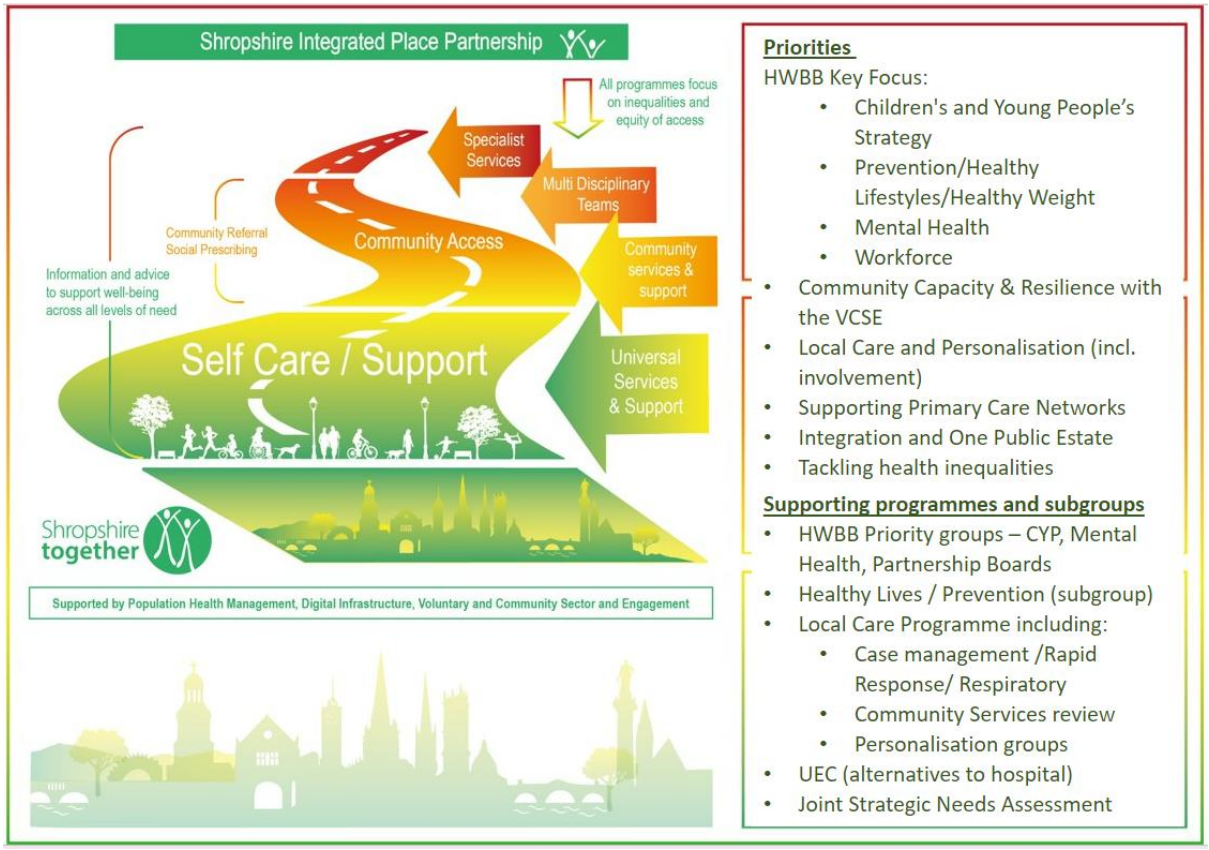
The BCF planning and delivery, the Better Care Fund work is delivered through the governance of the Joint Commissioning Board, HWBB and additionally with a focus on integration, the Shropshire Integrated Place Partnership (SHIPP). The Shropshire Integrated Place Partnership is a sub-group of our ICS 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, 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.**



The BCF is central to delivering the aims and priorities of the ICS, HWBB and SHIPP. The work of the BCF 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), 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).

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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	Personalised Care	Cross Cutting, system flow
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

Strengthen Leadership and Governance	Joined up working	HWBB Governance, Prevention Board, Joint Commissioning Board
Enhanced engagement and accountability	Strong and Vibrant Communities	SHIPP Principles
Creating system sustainability	Joined up working	Cross cutting
Workforce *** Workforce Transformation**	Workforce	Cross cutting

As described above, our approach to collaborative and integrated working is delivered through joint planning and commissioning of services and governed by the Joint Commissioning Group and Board. Additionally, the system develops it's approaches through workshops and jointly agreeing ways of working and principles, and through jointly funded posts. (Shropshire Council and STW ICB) and appointed posts. These are:

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

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue 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.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Answer:

The national objectives of 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. 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. Our new Prevention Board provides strategic oversight and impetus for this work and 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, integrating services where possible. 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 and work since have 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 contracts 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.

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 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
- 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 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.

Local Care 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

This is the period whereby our system will focus our efforts on the codesign, testing and where applicable the implementation of our new models of care. We will continue to work in partnership with our residents, communities and staff across health and care, to drive forward the delivery of new models of care and ways of working in the following areas:

Jo

Neighbourhood teams (adults)	•Create integrated teams within neighbourhoods working with a range of partners such as the VCSE, and in partnership with residents and communities •This will ultimately lead to care that is coordinated, targeted and contributing to addressing health inequalities and improving health outcomes for adult residents.
Neighbourhood teams (children)	•Create integrated teams within neighbourhoods working with a range of partners such as the VCSE, and in partnership with residents and communities. •This will ultimately lead to care that is coordinated, targeted and contributing to addressing health inequalities and improving health outcomes for children, young people and families.
Ageing well	•Building in the existing strategies and plans in place for each place. •This will promote the positive aspects of ageing: supporting people to stay well and healthy, at the sametime transforming service for people who become frail.
Integrated discharge team	•Implement a sustainable discharge to assess model. •This will ensure no decision about long-term care needs is taken in an acute setting, providing continuty in rehabilitation and reablement, maximising individuals potential in their home setting
Integrated therapy/AHP service	•Embed a comprehensive and integrated therapy service, with a focus on the provision of continuity in rehabilitation and reablement. •This will enable effective interdisciplinary working across the county, over a seven-day working week.
Primary Care alignment to integrated care	•This is currently a gap. •Engagement and involvement sessions are commencing 30 June 2022.
Proactive prevention	•Develop a model based on the St Helen's best practice model. •This will help achieve better outcomes through promoting independence and championing residents.
Anticipatory care	•Build a model which involves structured proactive care and support from our integrated neighbourhood teams and wider community based offers. •This will help people to live well and independently for longer.
Virtual ward	•Build on existing good practice and develop a safe and sustainable model of care responsive to patient need. •This will provide care, now delivered onsite, in the place of residence.
Community bed based model	•Develop a fit for purpose community bed based model. •This will support equitable access to community beds where health and care needs cannot be met at place of residence.
Respiratory transformation	•Co-design and implement a safe and sustainable model of care. •This will be responsive to population health needs and aligned to wider transformation plans across STW.
Integrated care home interventions	•Implement and widen A2HA approach to include nursing homes. •This will help reduce care home NEL admissions, leading to better outcomes for residents.

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

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 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 Hubs (described below)
- Joint Commissioning of Reablement beds (described below)
- Community Mental Health Transformation (connected but not funded by BCF)

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.

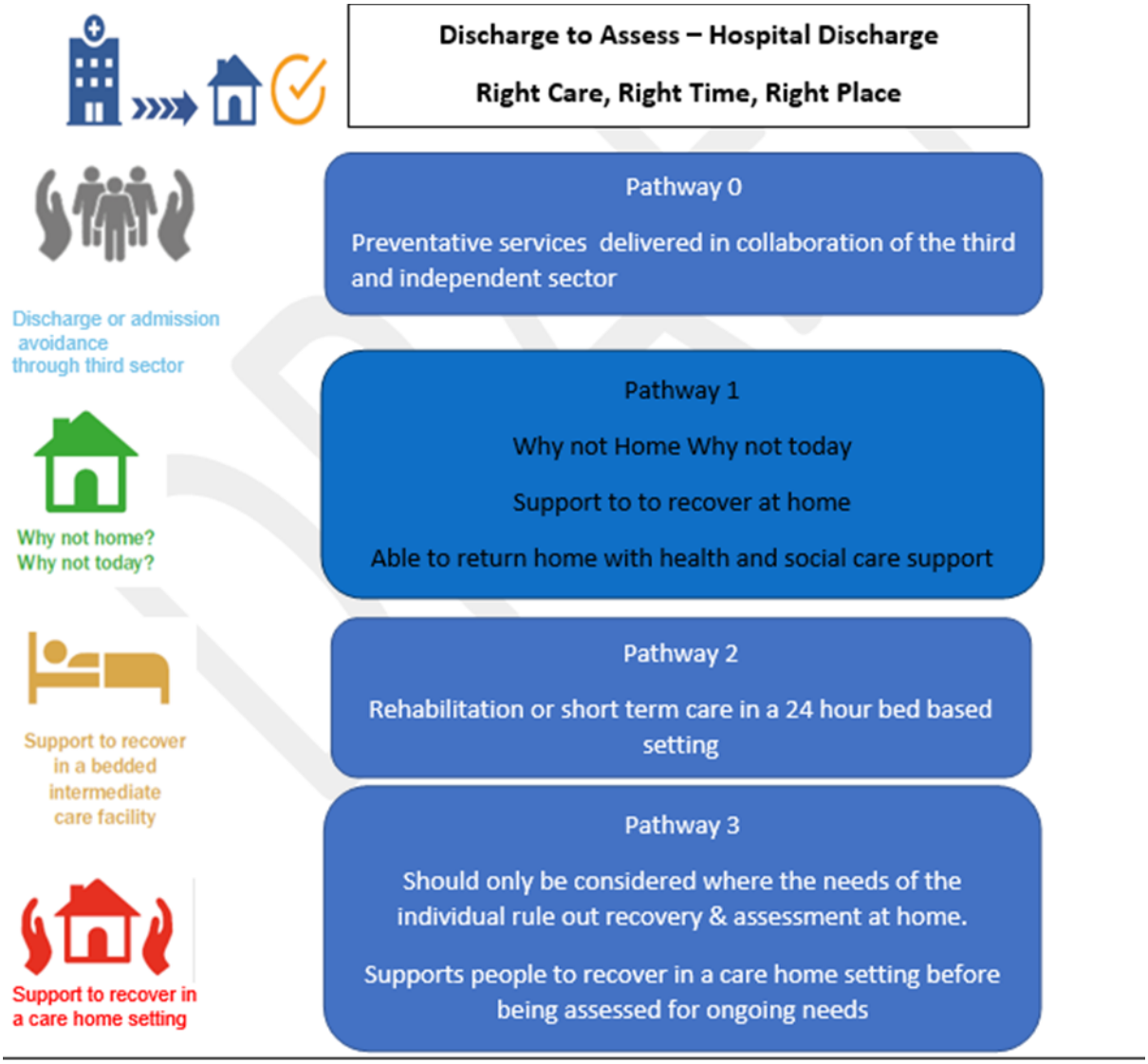
As a system we have come together to work differently to respond to the current and future challenges by;

- 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

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.



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.

System Discharge Alliance Work programme and action plan

The System Discharge Alliance (SDA) is a sub-group of the Urgent Care Operational group. The 'Alliance' recognises the collective responsibility and contributions across statutory and independent sector organisations to deliver the workstream priorities. The SDA

Workstream	Project Area	Milestones What do we want to achieve?	Key actions	Lead
Joint commissioning strategy	Community capacity	Short term, urgent requirement to model community capacity and configuration to meet beg Jul target date and funding. Long term planning to consider needs across the geographic areas, demographic complexities, target and at risk groups.	Demand and capacity modelling data in place to support planning Identify additional data ened to predict demand and future capacity needs Utilise JSNA data to predict future demand Identify similar and differential needs across Telford and Shropshire Places to support future planning. Place Based Joint Commissioning modelling will also feed	Sarah Bass/ Deborah Webster/Laura Tyler
	SDA	SDA draft plan 22/23 to be considered in line with ICS action plans and programme of work to be planned, ensuring sufficient resources in place to lead change well. SDA terms and references on roles and the right health funding to support programme work.	Development of a SDA plan that support Urgent Care Priorities Review of the ToR.	SDA
Review of re-ablement care	Enhancement of service	Short and long term plans to consider enhancement and strengthening service provision across Shropshire and Telford Review of future recruitment needs and capacity increase, winter priorities considered Review current models and look at other approaches and options with partners	Review of re-ablement care against NAIC and other Benchmarks and good practice guidelines	System Partners - LA's pending decisions re business cases
Enhanced integrated discharge	Target Operating Model	Review of our current TOM and funding offer. The review will look at current approach and benchmark our approach against others.	Review of the IDT processes and performance against national guidance and Good Practice guidelines Benchmark discharge and LOS performance System agreement of future IDT model and subsequent approach	Gemma McIver
	Alignment with community services	Community support services review to consider alternative triage options.	Review of IDT to include community capacity	Gemma McIver
Improving flow	MADE	Implementation of MADE planning to support improved patient flow across the system, recognise and unblock delays challenge, improve and simplify complex discharge	Learning Lessons report from SATH MADE events Learning Lesson Events from SCHT MADE events	Karen Evans/ Sam Townsend
	DTA model	Review DTA model to determine cost implications and options for alternative models being used	Review D2A processes and performance against national guidance and Good Practice guidelines Benchmark discharge and LOS performance System agreement of D2A model ie Pull or Push model and subsequent approach	Gemma McIver/Karen Evans
	Criteria led discharge	Discharge Goals (Outcomes) Review. System Discharge BCP Tactical Planning – forward look at pressures over key times of the year.	SATH Flow programme regular update to SDA Review of actions based on the Nine High Impact Change Metrics (HICMs)	Vanessa Whatley to confirm lead
	FFA review	Review of all current models to consider costs implications, beds capacity reviews, assessment pathways and preventative/provider offers A single assessment, that supports clear pathway flows Removing any duplications in process/ pathway	Previous benchmarking against other Good Practice areas Review of FFAs completion and reources utilised Confirm processes to complete FFAs Agree baseline metrics to measure performance	Richard Allam-Evitts
	Independence at home	Digital and community technology / wearables – that supports independence at home review – local offer	Identify opportunities for utilisation of digital and assistive technologies aross health and social care Highlight utilisation of local prototypes	Helen Cottrill/ SCC btc
	Pathways	Review & monitor high impact / performance matrix driving current pathways, with a clear focus also on zero activity and in seeking the right health funding to support each pathways	Review of current 0-3 Pathways Review of NHS processes to agree Fast Tracks, Temporary funding. Review of CHC process by the ICS Joint Commissioning	SDA

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 July 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.

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

Outcomes to date of Integrated Discharge Hub

- A total of 8,051 Fact Finding Assessments were completed in 2021/22 (in comparison to 6,714 FFAs in 2020/21).
- 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 reduced to an average of 2.4 days for the 2020/2021 fiscal year, however increased again in 2021/22 to 5 days (this can

partly be attributed to the increase in Covid 19 contact and positive patients where isolation period was 14 and then 10 days before placement)

- 68% of total discharges from point of referral occurred within 72hrs plus. 68% of FFA referrals were completed within 24hrs.
- 54% of all Fact Finding Assessments were discharged through Pathway 1.

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.

The other key programmes of the BCF which support the System flow are the DFG and the Discharge Alliance, both described below.

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. Performance to date (in the 44 weeks: (08.11.2022-09.09.2022):

- 1794 requests have been received by the "bed hub" team from ICS workers. All requests have had at least 2 options sent back to them.
- The bed hub team have made over 6000 calls to care homes to source placements.(Whilst still utilising the placement map and SPiC bed checker)
- The average time to source a placement is now an hour, based on this number the team have saved close to 12,000 hours for operational workers by sourcing the placements.
- At points only 11 homes have been open to admissions with vacancies.
- Owing to the ongoing outbreaks in Care Homes the team have been required to explore Out of County options.

In addition, we jointly commissioned reablement beds - have been jointly commissioned to support hospital discharge. This service is working closely with Local Care and developing wrap around support in partnership with Primary Care. The service aim is to maximise the resident's capacity to become independent to enable their future needs to be met their own home. The resident's pathway after leaving a bed-based service may continue, accessing different home-based services. A service commissioned in a care home which has GP and therapy support which will enable people through a maximum stay of 4 weeks.

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). 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

- Information Line – operated daily Mon- Fri 9-00am till 5-00pm. 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 LAS, if not, with their permission, we add them to LAS. We currently have 771 carers on the Carer register - numbers are increasing by approx. 180 per quarter.
- 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 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

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social 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.

Through the DFG, Shropshire has made assistive tech easy to access and understand. A new directory is helping Shropshire residents access health and social care services and includes advice for how people can access assistive technology products and services.

The fund provides assistive technologies that support with preventing conditions from worsening and facilitating independent living. Assistive tech can provide reassurance to carers who are concerned for their loved ones and alleviate pressure from carers who are struggling to cope in their role. There are a range of assistive technology and telecare devices. For example, specialised bath plugs, remote monitoring devices, and falls alarms. Residents are required to have a needs assessment through the council to determine whether they are eligible for assistive products. The directory further provides an assistive technology checklist for people to go through 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 started in 2021 to identify how some of the more advanced technologies could be of benefit in Shropshire to the users 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

- Care staff and providers are seeing the benefits of how tech 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 removed / reduced safely
- SW's are learning through the implementations, how tech can benefit users which promotes more creative approaches to commissioning care
- Significantly reduced spend on care packages

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 BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

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:

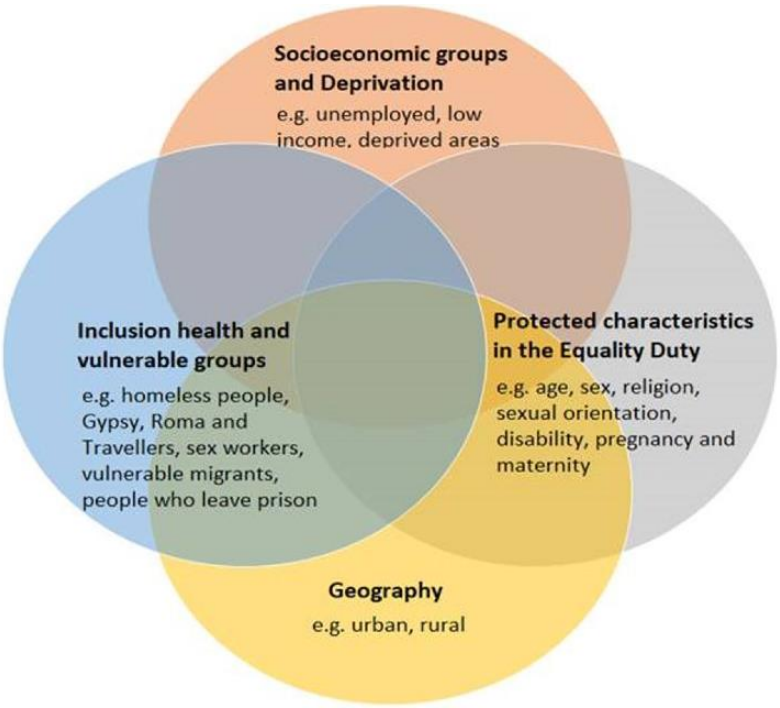
- Asian or Black pensioners
- Single female pensioners
- Pensioners with disabilities.

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 deprivation .

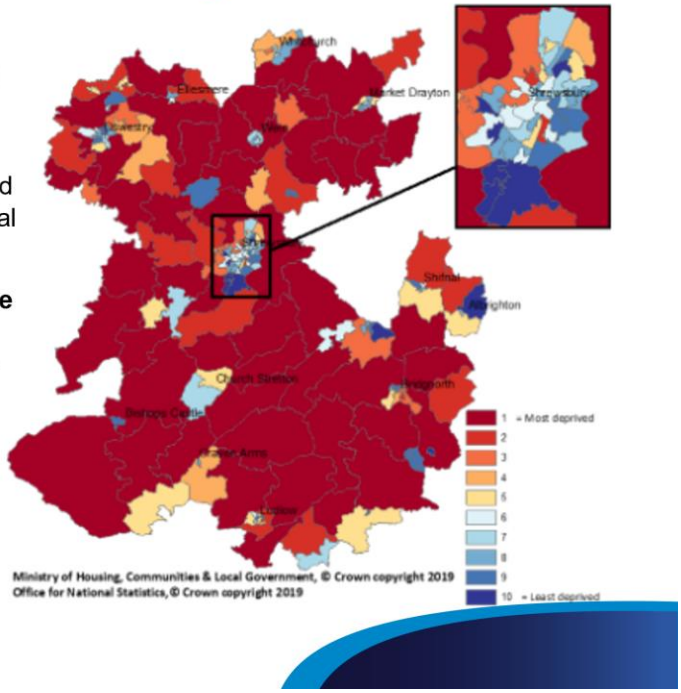
Shropshire Council

IMD - Barriers to housing and services

This domain measures the physical and financial accessibility of housing and key local services.

Shropshire has an average score of 25.4 and is ranked 68th most deprived local authority in England out of a total of 317 lower tier authorities.

Forty seven Shropshire LSOA's are within the 10% most deprived nationally, **35 LSOAs in Shropshire are ranked within the 5% most deprived** for the Barriers to Housing and Services Domain nationally



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 include 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 champions, with a focus on those geographi c 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
- 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 4700 referrals from beginning August 2021 to end July 22, 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
    - 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