Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1	HWB area 2
HWB	**Shropshire Health and Wellbeing Board**	Not applicable
ICB	**NHS Shropshire, Telford and Wrekin**	Not applicable
ICB	Not applicable	Not applicable
ICB	Not applicable	Not applicable

Section 1: Overview of BCF Plan

This should include:

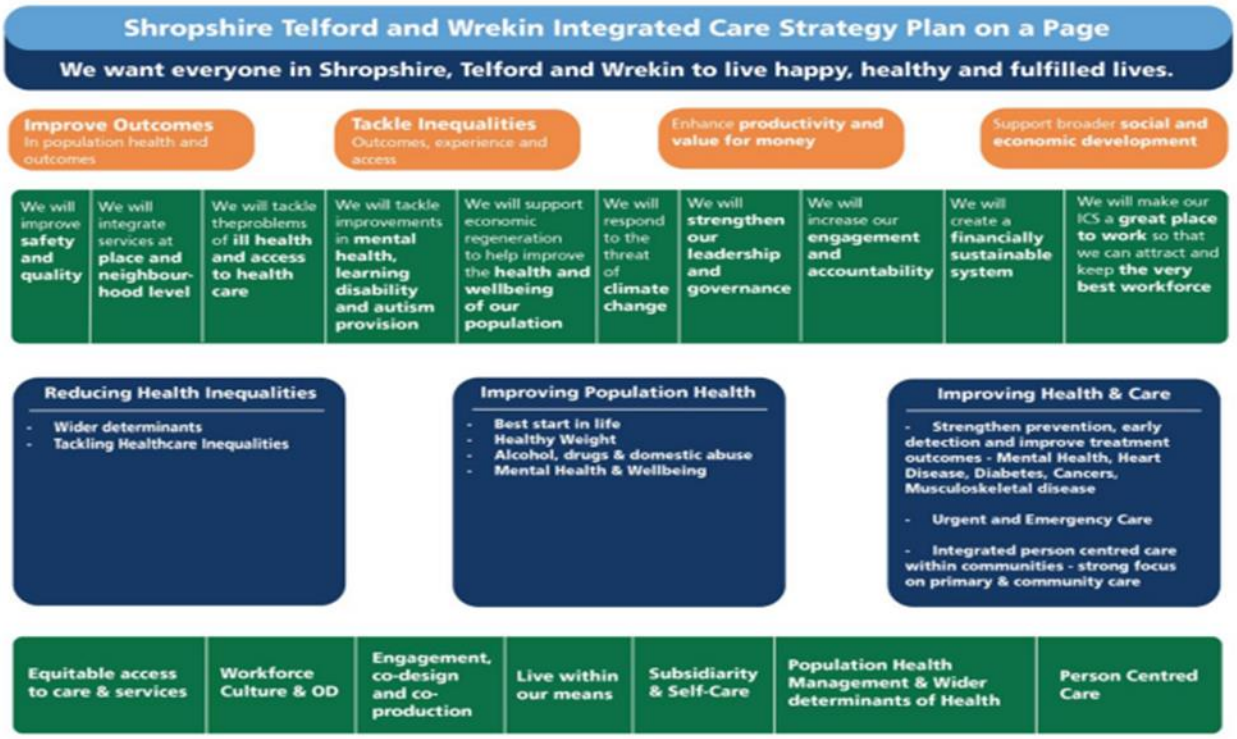
- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

- **Key Priorities for 2025-26**

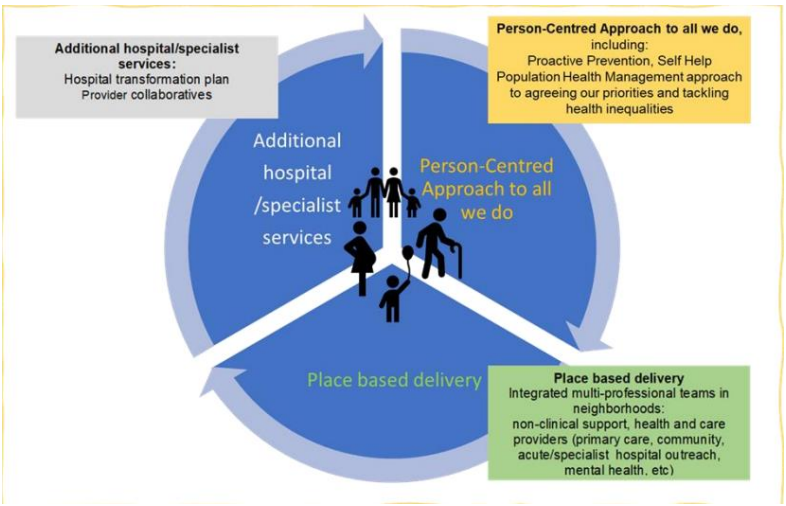
Local priorities are aligned to the Better Care Fund (BCF) priorities to shift from 'sickness to prevention' and to support people to live independently and make that shift from 'hospital to home'.

Shropshire, Telford and Wrekin (STW) Integrated Care Board (ICB) and the local place-based board, Shropshire Integrated Place Partnership (SHIPP), alongside the Health and Well-Being Board (HWB) are aligned and refocussing their work priority areas to support this shift and ensure the right plans and governance structure is in place to assure delivery against plans.

STW Integrated Care System (ICS), HWB and SHIPP have aligned priorities and principles including reducing health inequalities, engagement, co-design and co-production, a focus on preventative approaches and person-centred care. Further details are set out within the System's Plan on a Page below.



In line with this, the key elements of the Joint Forward Plan are detailed in the below diagram:



STW ICB, HWB and SHIPP share the key priorities that system partners worked collectively on developing to address the evolving needs of the community. Emphasis is placed on enhancing the strategic neighbourhood planning and delivering proactive care through integrated teams.

In addition, system partners have developed a prevention and integration framework, the commitments of which are set out below:

Our commitments for prevention and integration

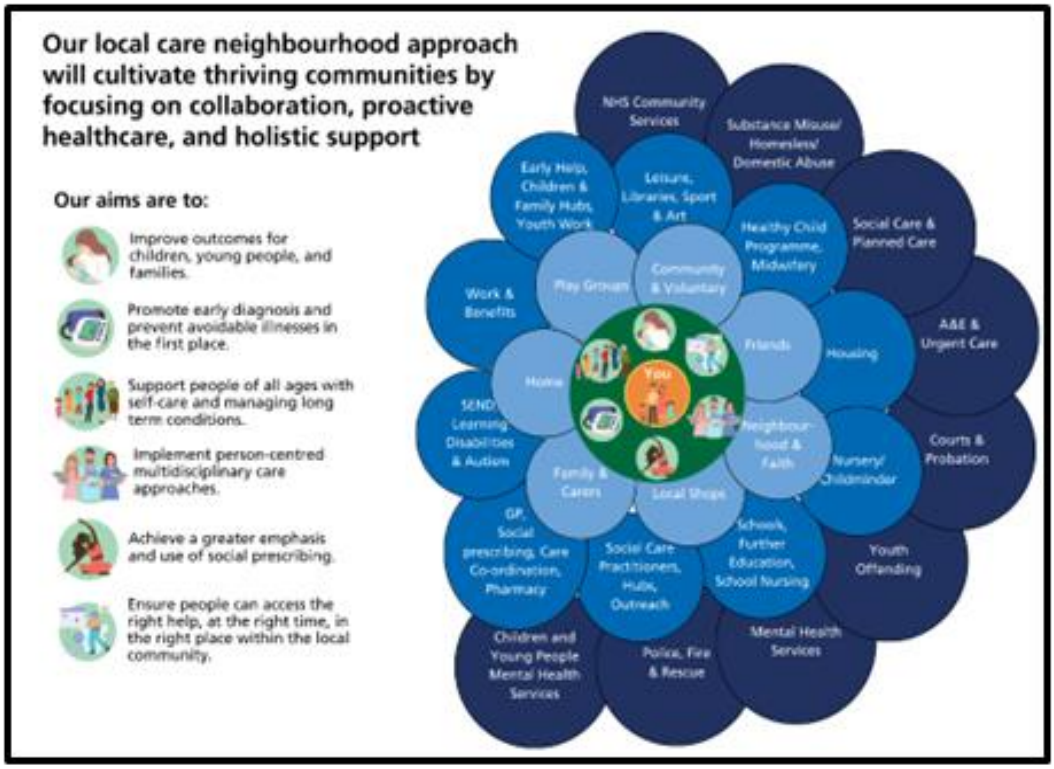
1. Proactively working with people of all ages, their families, and carers to improve wellbeing (eyes and ears on vulnerable people)
2. Ensuring that we take a person -centred approach, putting people at the centre of what we do
3. Work to develop a more comprehensive community -based prevention offer which includes universal, early help and targeted and specialist system services – One Shropshire *(community hubs/spoke/neighbourhood team)*
4. Work across service areas, integrating where possible, embracing partnership and collaborative working, creating a culture of working jointly across professions, organisations and teams for the benefit of our communities
5. Ensure evidence -based activity, population health data and other insight data (from services, locality JSNA, local consultations and the community) is used to inform planning and delivery; using data to find those most in need, focussing on inequalities
6. Adopting a test and learn approach, allowing projects time to evolve and deliver outcomes, embedding evaluation in all development programmes from the start

The following three key priorities are based on the areas of focus that align BCF, HWB, SHIPP and the Joint Forward Plan.

Strategic neighbourhood planning and delivery; proactive care and integrated teams

- In partnership with the Voluntary, Community and Social Enterprise (VCSE) sector, develop and implement a VCSE framework.
- In partnership with the local authority (LA) Integrated Place Partnerships (SHIPP) and Primary Care Networks (PCNs), continue to develop the integrated neighbourhood team delivery model, aligning existing LA, NHS and community assets/meeting places informed by the needs of local populations.
- Working with providers through a lead provider model to expand the range of services delivered through provider collaboratives.
- Left shift from illness to prevention, hospital to community and analogue to digital.

Please see the diagram below for further details regarding the System's neighbourhood approach.



Urgent and emergency care

- Improve care coordination.
- Improve acute flow.
- Improve system discharge.
- Winter planning to meet demand.

Prevention, early help and transformation;

- Improved oversight of data and information e.g. Joint Strategic Needs Assessment (JSNA) development at neighbourhood level.
- Development of family and community hubs.
- Review and redesign of the Prevention contract (currently known as WIPS).
- Improving access to support and advice, including directory of services.
- Development the digital offer and includes online carers assessment, directory of services.
- Improve customer journey and outcomes.
- Analysis on accommodation need and models required for Shropshire.
- Review of falls pathway.

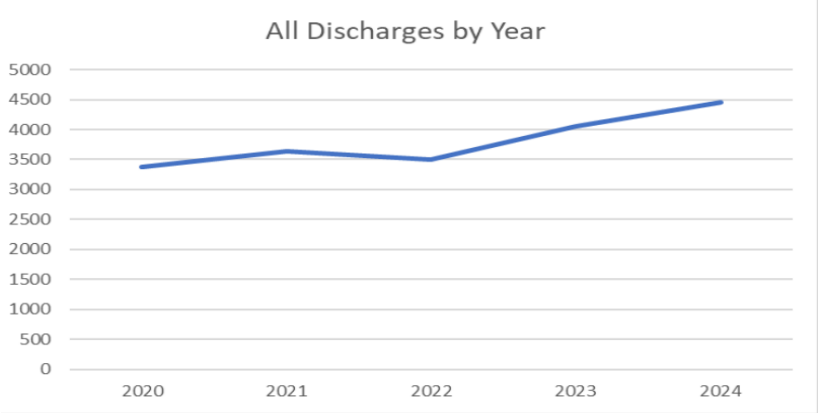
- **<u>Key changes since previous BCF plan</u>**

BCF governance structure

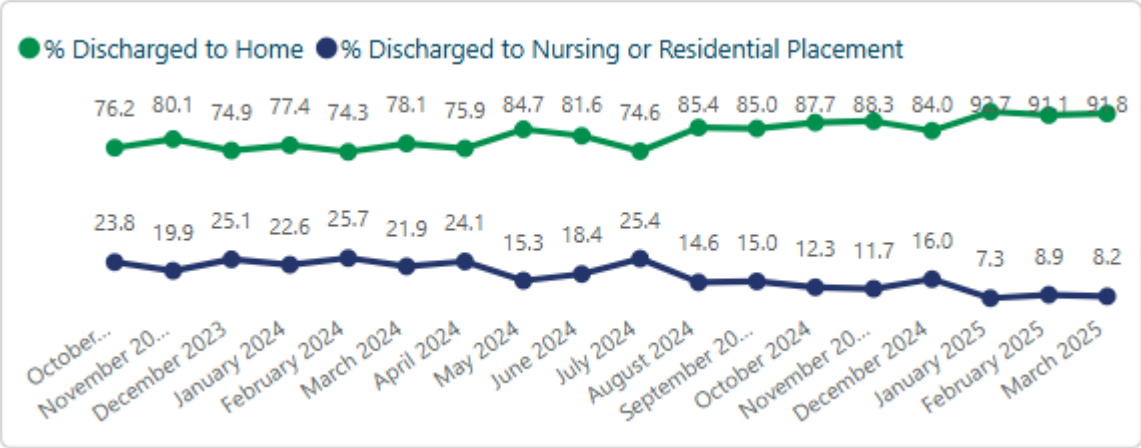
System capacity has been added to manage the BCF across both health and social care. This includes new terms of reference and governance meetings jointly chaired by health and social care.

Urgent care

Shropshire Council continues to deliver improved discharge performance year on year, increasing the number of people supported through complex discharge in 2023 by 16% when compared to 2022, and by 28% in 2024. Please see the graph below.

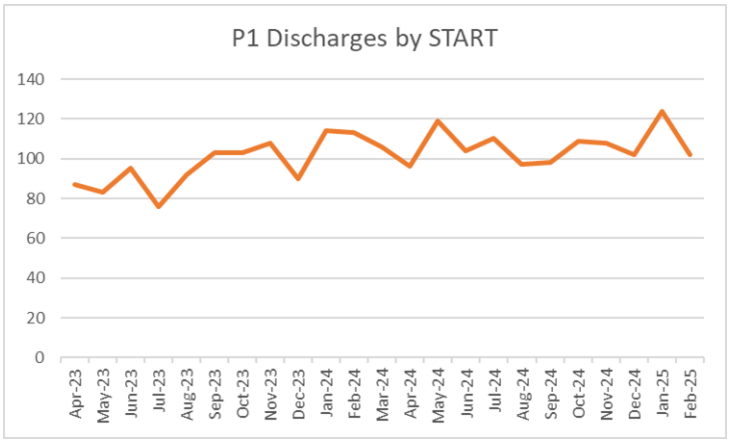


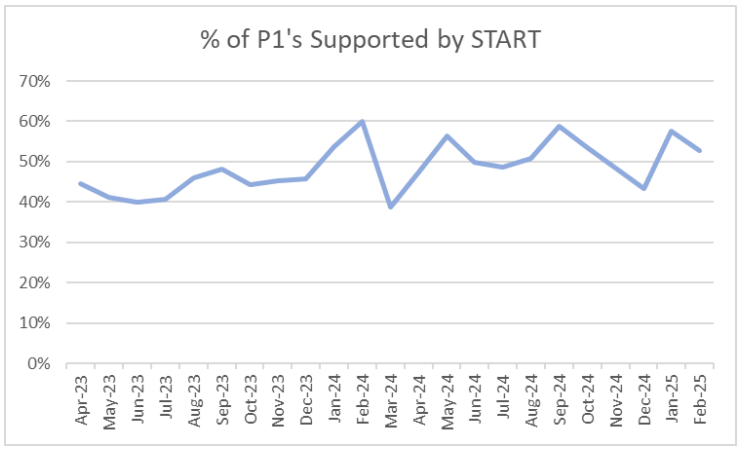
Work completed with the new Care Transfer Hub to improve the outcomes for people being discharged from Shrewsbury and Telford Hospitals NHS Trust (SaTH) has started to show sustainable trends now, with more people are being supported to return home. Please see the graph below.



Reablement

Increased numbers of people are being supported through the Short-Term Assessment and Reablement Team (START) service. Not only is START supporting more people, the team is also supporting more of the demand for pathway 1 from all hospitals. Please see the graphs below.





Falls

The falls service is a good example of joint system working and learning from a pilot; see the graph below for the increase in the referrals to the service.

Shropshire Community Health NHS Trust

Referrals by Month

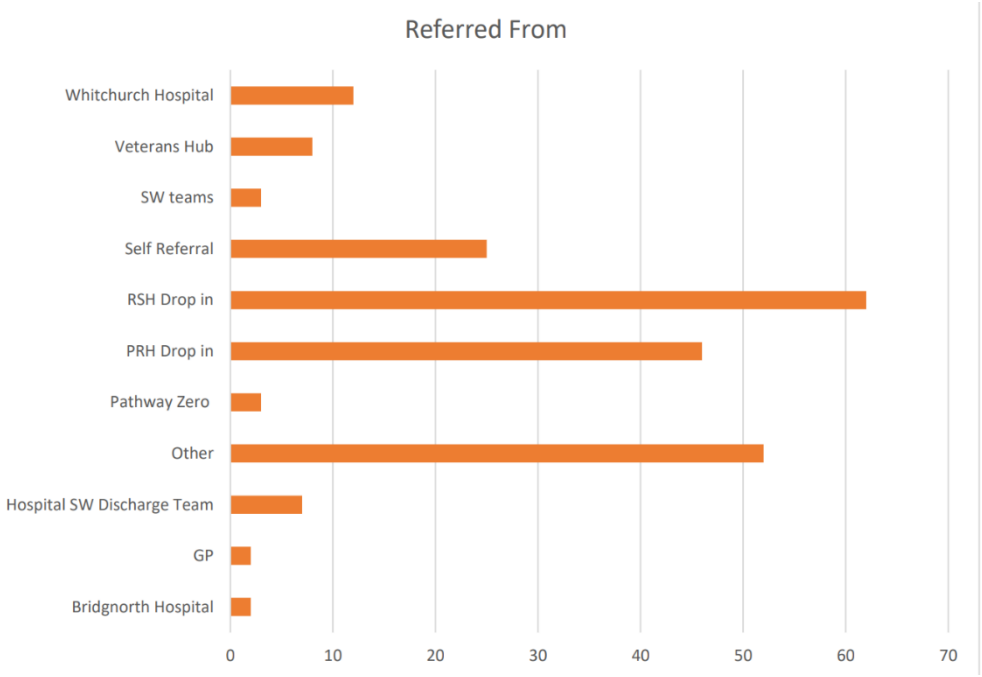
The number of referrals for "Falls" into the Shropshire & Telford Rapid Response Services by month

No. Referrals		Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Total
Accident / Trauma – Fall – 1 Person Response (assessment only)	E-zec (Out of Hours Fall)	40	23	3		82	53	56	68	87	94	132	82	**720**
	Other	84	64	61	80	89	101	68	95	100	81	76	94	**993**
	Total	**124**	**87**	**64**	**80**	**171**	**154**	**124**	**163**	**187**	**175**	**208**	**176**	**1,713**
Accident / Trauma – Fall – 2 Person Response (lift)	E-zec (Out of Hours Fall)	9	6			7	4	11	2	2		3	4	**48**
	Other	30	31	31	35	32	46	24	28	24	26	24	30	**361**
	Total	**39**	**37**	**31**	**35**	**39**	**50**	**35**	**30**	**26**	**26**	**27**	**34**	**409**
Total		**163**	**124**	**95**	**115**	**210**	**204**	**159**	**193**	**213**	**201**	**235**	**210**	**2,122**

Carers

The young carers contract is now provided by the local authority as part of an all-age support team to align and ensure consistency in approach.

The number of people on the carers register is the highest to date, with increasing referrals from the hospital evidencing the link with carer support upon discharge. Please see the graph below for details of referral source.



Prevention

System partners have created a prevention and integration framework, this includes the following key priority areas:

- Access: Ensuring a well understood front door with access to information and advice, that focusses on self-care.
- Integration: Enable communities and the voluntary and community sector to take more of central role in the development and delivery of prevention programmes, ensuring all age groups are at the centre of the implementation of the framework.
- Person Centred Care: Embed Person Centred Care and approach across all organisations and partners.
- Communities: Bolster the voluntary and community sector to work with partners across the system to support those in need.
- WIP Prevention contract; commissioners and stakeholders are reviewing the current contract to ensure alignment and support at front door with the VCSE.

System integration

The development of local community and family hubs will support early intervention and avoid crisis across all ages. To date, there are five Integrated Practitioner Teams delivering across Shropshire, five Community and Family hubs (and two in development), one Health and Wellbeing centre, and Women's Health Hub activity across the five Primary Care Network Areas. The hubs are complemented by mini-hub support in smaller communities, where connection has been made with other local offers to provide additional support.

There is an all-age core offer at each of the hubs and this core offer is developed further depending on the needs of the local communities. As such the activity in the hubs is continuing to develop, improving the offer in local areas.
The offer includes:

- Open access health visiting clinics (approximately 490 children seen per quarter).
- Early Help drop-in, Stay and Play and Coffee and Chat sessions.
- Support into work (Department for Work and Pensions/Enable).
- Let's Talk Local – Adult Social Care.
- Family Learning Courses.
- Housing Support.
- Stop Smoking Clinics.
- Blood Pressure Checks.
- Pilot of an all-age Autism Hub.

There is an Integrated Practitioner Team for Children Young People and Families that covers the whole county and is delivered by NHS, Local Authority and VCSE partners.

Proactive Care is up and running in the south-west PCN, developing lessons learned.

Dementia MDTs are up and running in the south–east PCN and developing a county-wide approach.

Digital
A virtual care delivery team is now in place. The team uses technology to support people at home, currently supporting in the region of 100 individuals with technology and virtual calls.

DFG
A total of 277 grants have been completed to date in 2024/25.

Joint commissioning
A joint equipment contract between Shropshire council, Telford and Wrekin Council and STW ICB began in April 2024, with Shropshire as the contract lead. A section 75 agreement is in place.

Shropshire Council leads on the brokering of fast-track packages from hospital.

Joint care contracts for the Two Carers in a Car are in place across Shropshire.

A recommissioned autism support contract will begin in 2025. In addition, the System is currently working on a Joint Autism Strategy, commissioning intentions and Special Educational Needs and Disabilities (SEND) strategy.

- **A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process**

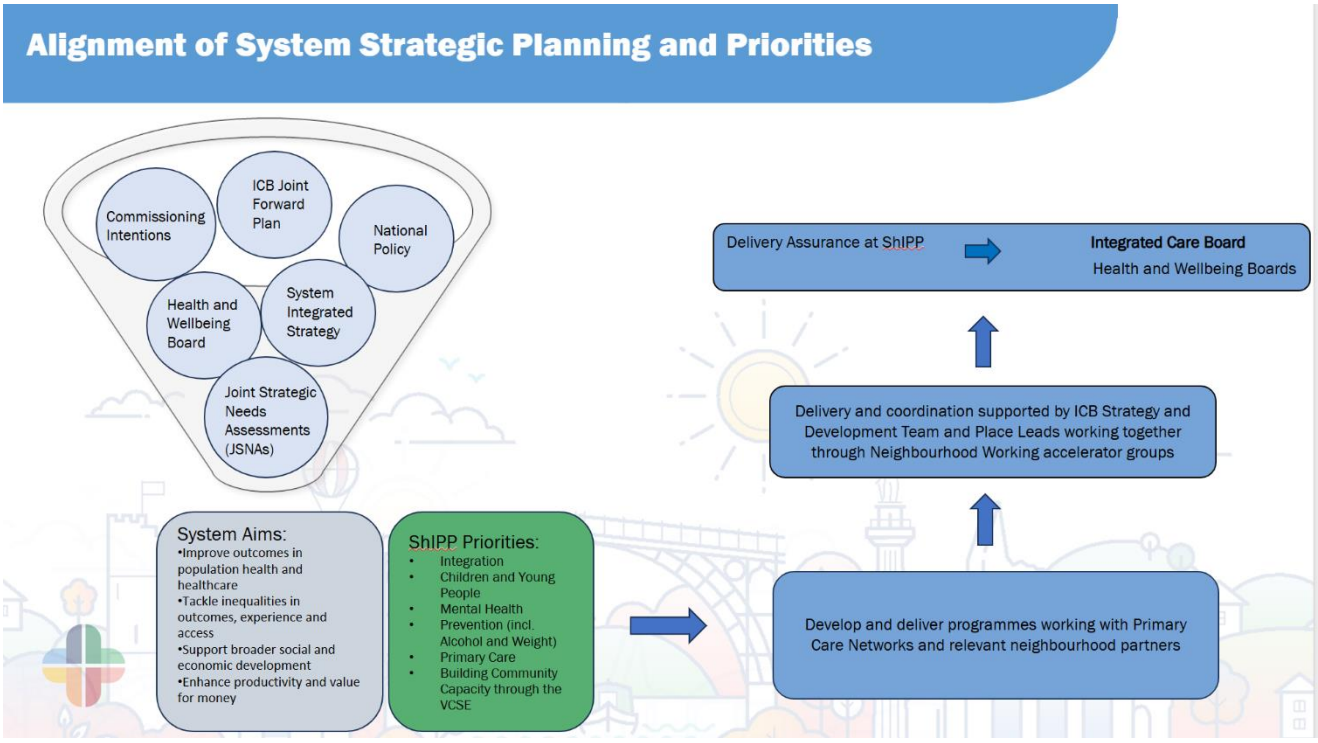
  The Shropshire BCF Operational Delivery Group members, made up of local authority and NHS representatives, worked collaboratively with system partners to develop the plan.

Following a 360-degree audit in 2024, the following work has been done to strengthen the governance arrangements to support delivery of the plan.

- A revised governance structure has been implemented which is line with that of system partners Telford and Wrekin.
- Aligned reporting processes and procedures have been implemented.
- Shropshire BCF Operational Delivery Group's Terms of Reference have been aligned with Telford and Wrekin BCF Board's Terms of Reference. They include clear governance arrangements.
- Shropshire BCF Operational Delivery Group is now co-chaired by STW ICB and local authority senior commissioners.
- Bi-annual joint meetings between Shropshire and Telford and Wrekin will establish a more joined up approach.
- A BCF Commissioner has started in post with STW ICB to support the system reporting.

The BCF Commissioner will provide a first point of contact for the BCF oversight and support process and use established escalation routes to ensure the right level of involvement is engaged.

In addition, the system strategy and priorities are aligned through the work of SHIPP and HWB. Accountability for delivery is through the ICS Board and includes BCF planning and quarterly reports. Please see the diagram below for more details about the alignment of System strategic planning and priorities.

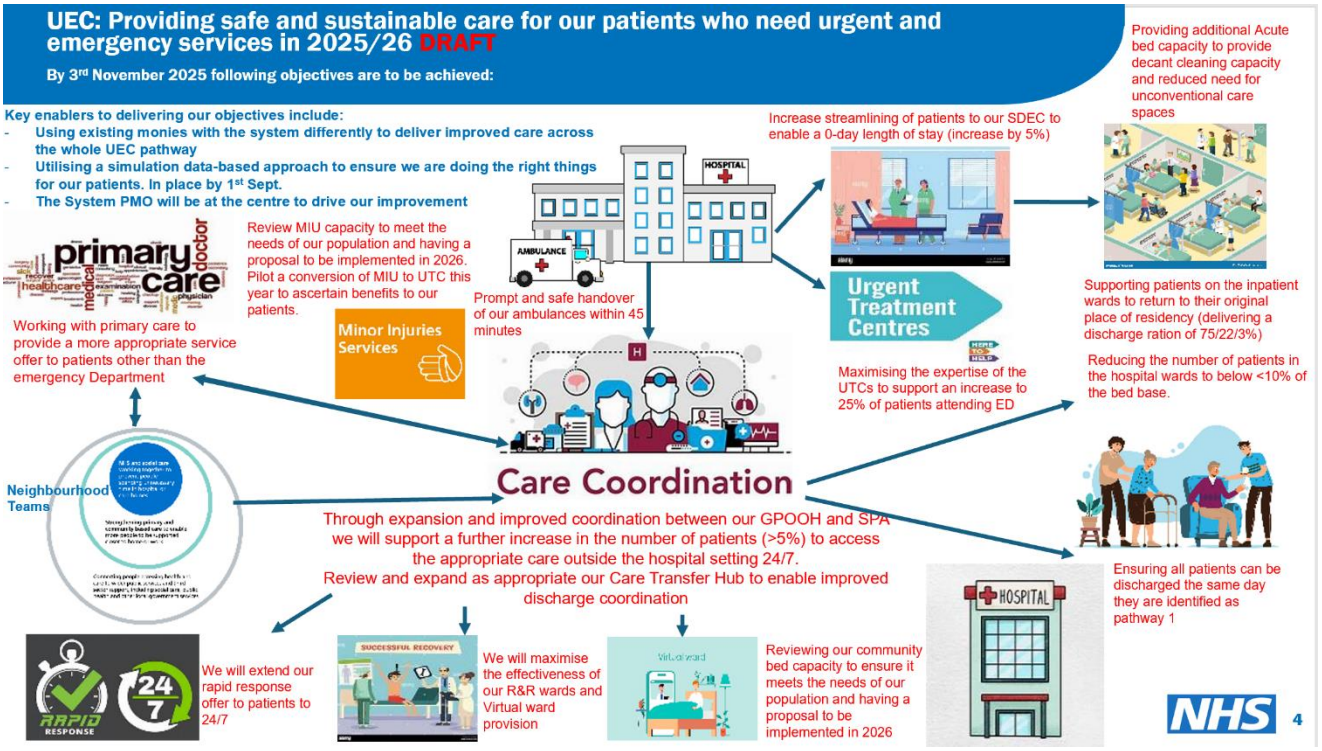


- **<u>Specifically, alignment with plans for improving flow in urgent and emergency care services</u>**

Urgent and emergency care has been and continues to be an area of pressure for partners. However, partners are committed to developing the care transfer hubs which has led to improvement in performance despite a very pressured winter.

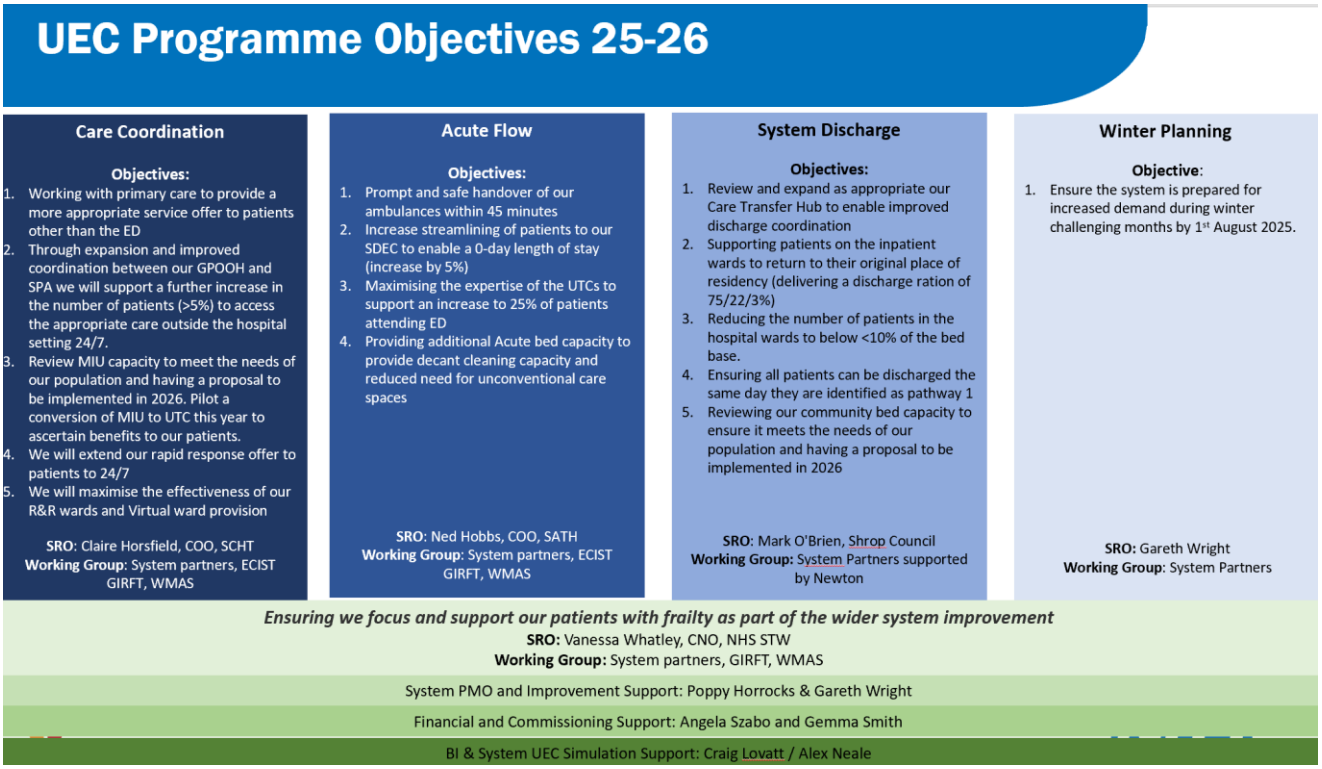
Please see the below diagram for detail about the urgent and emergency care related objectives to be achieved. System care co-ordination joins up the work to prevent admissions, improve system flow and importantly improve the customers/patient experience through the various pathways. Speeding up discharge as soon as people are fit to be discharged is a system priority with a focus on same day discharge.

Partners continue to develop reablement support, review community bed capacity and step up rapid response to 24/7 to ensure continued flow and safe ambulance handover times.



The priorities for the Urgent and Emergency Care (UEC) Board are focussed on the four themes as shown in the diagram below:

- Care coordination.
- Acute flow.
- System discharge.
- Winter planning.

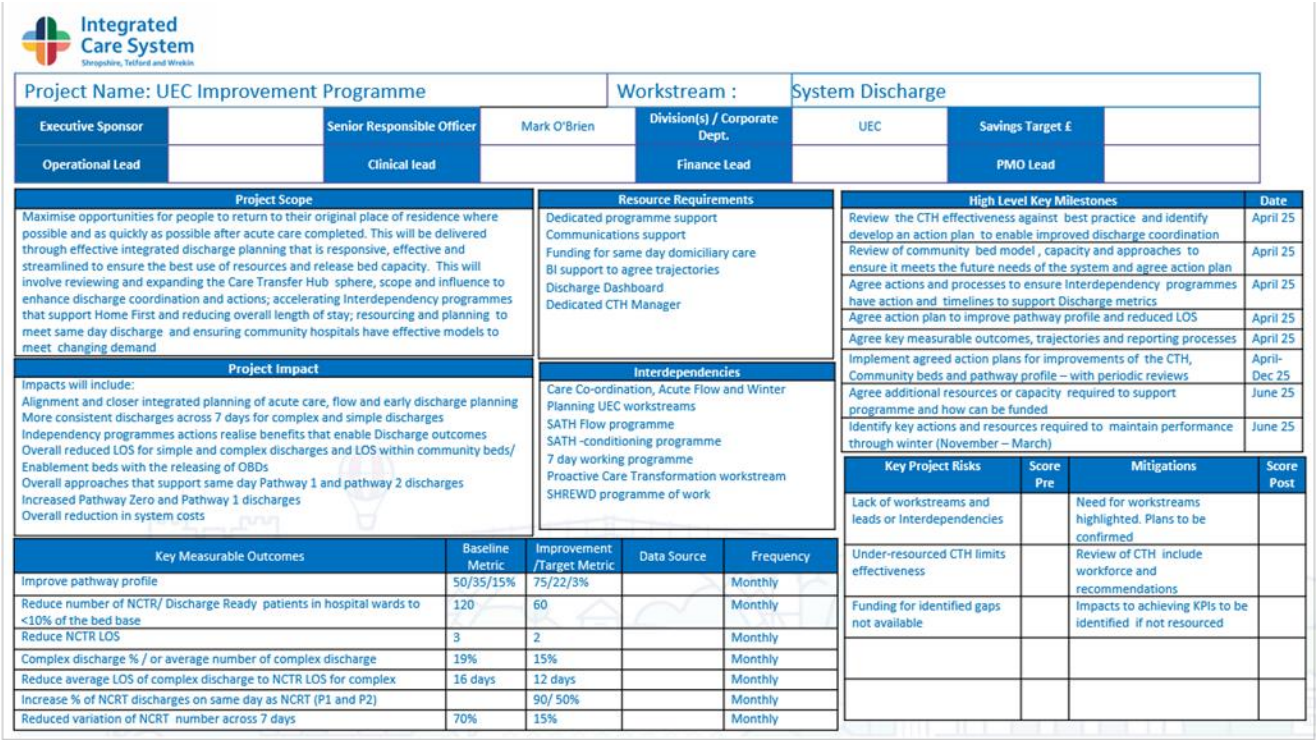


Each theme has a working group and Senior Responsible Officer (SRO) who leads the action plans.

Members of the UEC Board are also represented within the BCF Operational group and work with commissioners and system leads to co-ordinate activity and report into the other boards such as HWB.

SHIPP in particular leads on the neighbourhood development for the system ensuring prevention and admission avoidance.

System plans are in place to support this work, with a Shropshire Council senior manager taking a lead role in planning and implementation. Please see the diagram below for details about the UEC Improvement Programme.



Integrated Care System
Shropshire, Telford and Wrekin

Project Name: UEC Improvement Programme				Workstream :	System Discharge		
Executive Sponsor		Senior Responsible Officer	Mark O'Brien	Division(s) / Corporate Dept.	UEC	Savings Target £	
Operational Lead		Clinical lead		Finance Lead		PMO Lead	

Project Scope

Maximise opportunities for people to return to their original place of residence where possible and as quickly as possible after acute care completed. This will be delivered through effective integrated discharge planning that is responsive, effective and streamlined to ensure the best use of resources and release bed capacity. This will involve reviewing and expanding the Care Transfer Hub sphere, scope and influence to enhance discharge coordination and actions; accelerating Interdependency programmes that support Home First and reducing overall length of stay; resourcing and planning to meet same day discharge and ensuring community hospitals have effective models to meet changing demand

Resource Requirements

Dedicated programme support
Communications support
Funding for same day domiciliary care
BI support to agree trajectories
Discharge Dashboard
Dedicated CTH Manager

High Level Key Milestones	Date
Review the CTH effectiveness against best practice and identify develop an action plan to enable improved discharge coordination	April 25
Review of community bed model , capacity and approaches to ensure it meets the future needs of the system and agree action plan	April 25
Agree actions and processes to ensure Interdependency programmes have action and timelines to support Discharge metrics	April 25
Agree action plan to improve pathway profile and reduced LOS	April 25
Agree key measurable outcomes, trajectories and reporting processes	April 25
Implement agreed action plans for improvements of the CTH, Community beds and pathway profile – with periodic reviews	April-Dec 25
Agree additional resources or capacity required to support programme and how can be funded	June 25
Identify key actions and resources required to maintain performance through winter (November – March)	June 25

Project Impact

Impacts will include:
Alignment and closer integrated planning of acute care, flow and early discharge planning
More consistent discharges across 7 days for complex and simple discharges
Independency programmes actions realise benefits that enable Discharge outcomes
Overall reduced LOS for simple and complex discharges and LOS within community beds/ Enablement beds with the releasing of OBDs
Overall approaches that support same day Pathway 1 and pathway 2 discharges
Increased Pathway Zero and Pathway 1 discharges
Overall reduction in system costs

Interdependencies

Care Co-ordination, Acute Flow and Winter Planning UEC workstreams
SATH Flow programme
SATH -conditioning programme
7 day working programme
Proactive Care Transformation workstream
SHREWD programme of work

Key Project Risks	Score Pre	Mitigations	Score Post
Lack of workstreams and leads or Interdependencies		Need for workstreams highlighted. Plans to be confirmed	
Under-resourced CTH limits effectiveness		Review of CTH include workforce and recommendations	
Funding for identified gaps not available		Impacts to achieving KPIs to be identified if not resourced	

Key Measurable Outcomes	Baseline Metric	Improvement /Target Metric	Data Source	Frequency
Improve pathway profile	50/35/15%	75/22/3%		Monthly
Reduce number of NCTR/ Discharge Ready patients in hospital wards to <10% of the bed base	120	60		Monthly
Reduce NCTR LOS	3	2		Monthly
Complex discharge % / or average number of complex discharge	19%	15%		Monthly
Reduce average LOS of complex discharge to NCTR LOS for complex	16 days	12 days		Monthly
Increase % of NCRT discharges on same day as NCRT (P1 and P2)		90/ 50%		Monthly
Reduced variation of NCRT number across 7 days	70%	15%		Monthly

- **<u>A brief description of the priorities for developing for intermediate care (and other short-term care).</u>**

  Shropshire has a strong reablement team called START supporting both hospital discharge and admission avoidance (rapid response). The service continues to perform well with an average length of stay of 14 days.

  Areas of focus will include:

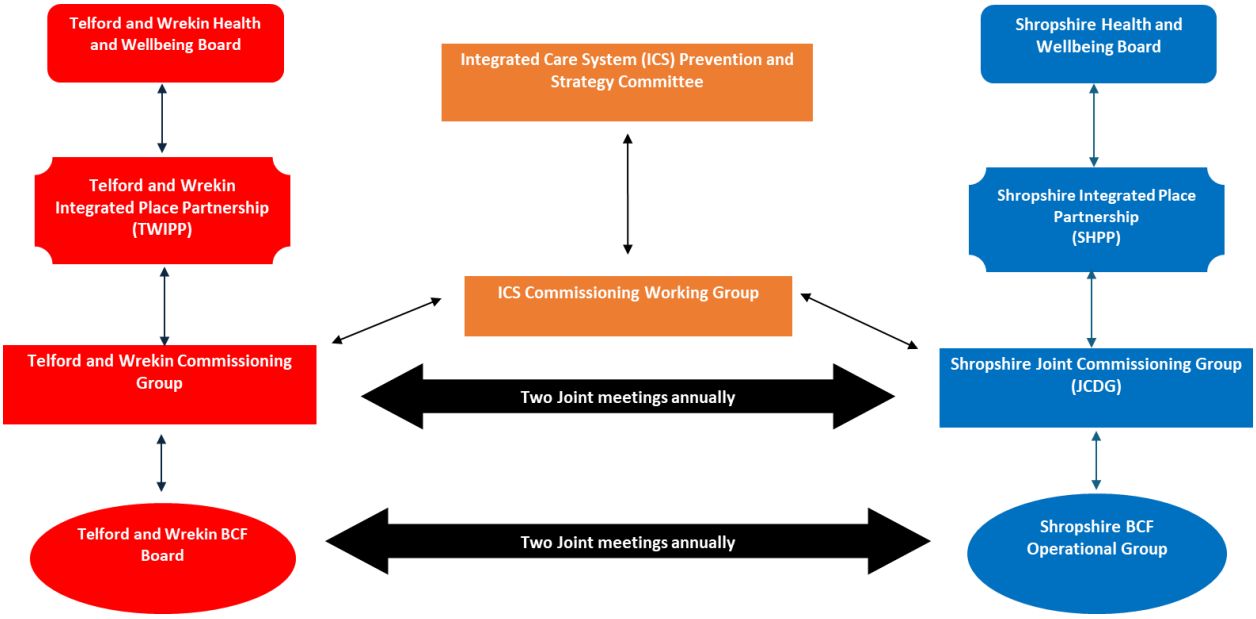
  - Information; create a clear suite of reporting outcomes to demonstrate what START achieves at a more granular level to evidence outcomes.
  - Rapid response to support both in hospital avoidance and discharge if necessary.
  - More focus on pathway 0 within the acute.
  - Increase use of technology within health and virtual ward support.
  - In addition, the local authority will continue to develop its technology offer and 2 carers in car contract to support more people at home and reduce the need for short term bedded provision where possible.
  - Therapy input to ensure wrap around support.
  - A wider review of community bedded provision will be carried across health and social care linked to the demand numbers and target set that are the cost effective and appropriate. This will inform a model and an approach for bedded provision across the ICS.

- **<u>Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs</u>**

and the governance processes completed to ensure sign off in line with national condition 1.

This plan covers Shropshire HWB however, system partners NHS Shropshire, Telford and Wrekin, Shropshire Council and Telford and Wrekin Council have worked collaboratively through joint meetings and written communication to help inform their plans. The NHS Operational Guidance is reflected in the plan and provides the golden thread for the development and delivery of the plan at Place level.

Oversight for the development of the plan is through SHIPP, which is the Place Board reporting into STW ICB and Chaired by Shropshire Council's Chief Executive Officer. Approval of the plans and quarterly reports sits with HWB. A BCF Operational Delivery Group works with the Joint Commissioning Delivery Group and other system groups to determine the plan. The governance diagram below demonstrates the interconnectedness of the programme boards, HWB and the ICS. Endorsement and approval of the Better Care Fund plan sits with HWB.



Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- **A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money**

Following system support from John Bolton, the system has worked collectively to support swifter discharge and increase the numbers of those being discharged home. The health and social care system has since seen changes with more people going home with support and less going into bedded provision, improved virtual ward and improved care management across partners. A joint equipment contract across the ICS was put in place in April 2024 has seen improved outcomes for people getting equipment in a timely manner reducing delayed discharges.

In addition, Newton Europe was commissioned to support the system to develop the Care Transfer Hub (CTH) supporting systematic discharge planning between health and social

care and to start discharge planning as early as possible. This includes a home first ethos across all teams focussed on personalised care.

Following a 360-degree assessment, STW ICB has worked with Shropshire Council and Telford and Wrekin Council lead commissioners to align governance and system monitoring. Shropshire Operational Delivery Group (formerly BCF Board) and Telford and Wrekin Board will now meet twice a year to look at areas for efficiency and joint commissioning opportunities. This approach is supported by a line-by-line review of each of the commissioned schemes to avoid duplication of expenditure and ensure each scheme is providing and meeting the current needs of the community as they evolve over time.

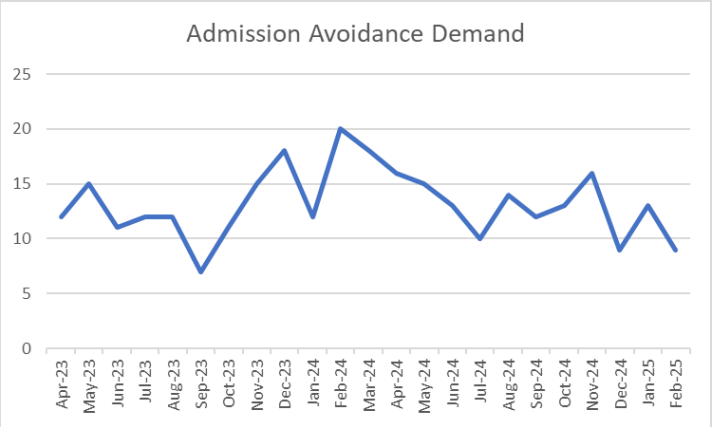
- **Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans**

  Emergency admissions

  As highlighted in the Planning Template (metrics worksheet 6), the data source provided has been utilised and checked against local SUS data sets. However, due to data loss through implementation of an electronic patient record (EPR) system, there is no complete, reliable data from 2024/25 to use as a baseline. This has been highlighted previously in 2024-25 quarterly reports. It is expected that the issue will be rectified by the end of 2025-26 quarter one (June 2025). Subsequently, reliable data will again be available.

  The figures provided use 2023-24 data with a linear forecast. During 2024-25, admission reduction schemes were implemented to improve access to alternative pathways. Therefore, an agreed impact of these schemes of 5% has been applied to the linear forecast to provide the figures in the table. The work Shropshire Council is doing within the 25/26 STW UEC Improvement Programme, which is an ICB led transformation program that includes system partners and focuses on alternatives to ED and inpatient acute processes and flow, and discharge process for simple and complex discharges will support this metric.

  The below is the number of admission avoidance cases Shropshire Council received referrals for, all were supported and therefore reducing emergency admissions through the rapid response team.



Delayed discharges

As for emergency admissions, there is no reliable data from 2024-25 to use as baseline to plan for the delayed discharge metric.

In addition to this data issue, the System currently monitors no criteria to reside (NCTR) as opposed to discharge ready date (DRD). Discharge length of stay data includes patients discharged on the same day as they become classed as having NCTR; the metric requires patients discharged on the same day to be excluded. Work continues to improve the data set and data quality. It is anticipated that DRD data will be available from June 2025, when the data loss issue described above is rectified.

For 2025-26 planning (target setting and capacity and demand planning), providers have provided locality and System level NCTR data. Discharge average length of stay targets exclude patients discharged on day zero. However, they will be at System level (not Health and Wellbeing Board level) and do not align to DRD.

An alternative way to evidence discharge delay performance monitoring using robust, reportable data is already in place. The system currently monitors NCTR and uses this for performance monitoring relating to discharge. Monthly reporting includes:

- Average time from NCTR to discharge by pathway.
- NCTR to transfer document completion by pathway.
- Transfer document completion to discharge.

This local arrangement will be used to provide assurance that discharge delay performance is robustly measured and monitored. When DRD data becomes available from June 2025, the Plan will be refreshed to provide an accurate target trajectory. The

West Midlands Better Care Fund Manager will be kept updated on progress and if circumstances change which mean the date for resolution needs to be revised.

To provide an example of the information monitored and reported, the following data and chart show the average time from no criteria to reside status being given to discharge, broken down by pathway, from April 2023 to December 2024. Targets for length of stay and pathway profile are being developed through the current Urgent Care Planning process.

Average time from NCTR to discharge (days)			
	Pathway 1	**Pathway 2**	**Pathway 3**
Apr-23	6.42	7.08	17.46
May-23	5.75	7.11	13.68
Jun-23	5.46	5.66	11.85
Jul-23	4.40	4.47	12.43
Aug-23	3.55	4.07	8.54
Sep-23	3.75	3.75	7.34
Oct-23	5.38	6.05	9.83
Nov-23	5.47	6.74	10.85
Dec-23	4.65	5.09	9.49
Jan-24	4.31	4.63	10.07
Feb-24	4.57	5.02	7.80
Mar-24	3.48	2.99	8.31
Apr-24	3.59	4.93	8.23
May-24	4.52	4.94	10.65
Jun-24	5.72	5.07	8.97
Jul-24	3.57	3.12	8.04
Aug-24	3.76	3.21	5.40
Sep-24	3.68	2.49	8.53
Oct-24	3.98	3.06	8.52
Nov-24	4.11	3.12	7.65
Dec-24	3.26	2.93	5.58
Average (days)	**4.45**	**4.55**	**9.49**

Local partners are working to address the NHS priorities for 2025/26; improving waiting times in A&E and patient flow.

Work is ongoing to develop mental health support services for adults, children and young people to ensure system flow.

Residential and nursing admissions for over 65s

Shropshire has a proportionately high ageing population in comparison to England as a whole. Whilst reablement numbers have increased, there are high levels of complex need which may result in long term admission. Please note that Shropshire is already in the top quartile for maintaining low levels of long-term admissions into care homes. This has been considered along with the aging demographic when setting the target for 2025/26. Whilst it is recognised the number of long-term admissions has increased this last year, increased complexity has increased the need for 24-hour provision. It is expected that the work collectively as a system will bring this down for 2025/26.

System planning to support people within their own homes and the community are key priorities in the forward plan, and of SHIPP and HWB. Integrated neighbourhood teams aligned to family hubs offer early intervention and support. In addition, system partners are working on redesigning the service specification for prevention. This will facilitate admission avoidance, support to carers and reduce isolation across our rural county.

The Two Carers in a Car service aims to provide nighttime support for people in their own home rather than result in a short-term admission into a care home where it is likely they will remain longer term.

The council is working with domiciliary care and supported living providers to use technology options to avoid admissions and support people in a more creative and flexible way. This aligns with the NHS 2025/26 plan and local UEC plans as described in section 1; improved outcomes for residents.

- **Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care**

The System has created a Care Transfer Hub (CTH) which links organisations across the STW footprint. The CTH is a multi-agency and inter-disciplinary discharge team. It works in a seamless and integrated way across partner organisations, spanning health, social care and the voluntary sector. The CTH will proactively 'pull', and case manage the needs of a

range of people with moderate and complex care needs and support these people safely to transfer via the most appropriate discharge pathway.

Having a multi-agency staff mix with a range of professional experience across the acute, community, mental health and social care, supported by an administrative team which is co-located and empowered to make autonomous and accountable decisions that are respected across all partner organisations will facilitate the above and deliver the CTH vision as well.

Systematic discharge planning between health and social care principles include:

- Start from the point of admission by identifying patients with complex discharge needs (pathway 1, 2 and 3) as early as possible in the patient journey.
- Work with the Multidisciplinary Team (MDT) to set an Estimated Date of Discharge (EDD) and tracking patients (particularly those at risk of deconditioning or delay) to combat any potential avoidable situations where EDD is at risk of being achieved.
- Personalised care with the patient, their families, and carers to plan and prepare for discharge.
- Promote a Home First approach and agree discharge pathways with patients, their families and carers to support a safe and timely discharge from hospital.

These four components form the foundations of the CTH model. Focusing on a strengths-based model also supports a culture of confidence, healthy risk management and a less restrictive model of care for patients which is empowering, attainable and cost effective.

The system continues to invest in the START team to support people to go home with reablement. We have qualified Social Workers and START staff aligned to admission avoidance; focus is to ensure that people can return home instead of being admitted into bed base provision.

Shropshire Council's Admission Avoidance demand is led by decision making in emergency department and the new Frailty Assessment Unit (FAU). Principally, this demand is after a decision to discharge has been made.

In 2023 we supported 22% more people to avoid admission into SaTH (acute). In 2024 this increased to 63% more people, in part because of the FAU began in the summer.

In 2025 we have commenced with a 2-hour response time from referral to discharge plan in place for all FAU admission avoidance; this is working effectively.

- **Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.**

The funding will continue to support START and pathway 1 discharges as a priority, reducing the numbers set against bed provision. The demand work has set a realignment of budgets to increase against pathway 1 provision and with support such as the Two Carers in a Car contracts across the county improving outcomes for residents across Shropshire. Historically the main proportion of the budget was aligned to bedded provision, and we have seen a step change on this as described on section 1 set against local plans.

Increased capacity into the frailty team at SATH has resulted in improved experiences for patients.

In addition, the BCF plan supports the transition to prevention; this includes the current Wellbeing and Independence Service (WIPS). Partners are working collectively to redesign this service to support admission avoidance and general wellbeing.

Social prescribing is very strong across Shropshire; located with neighbourhood teams, the MDTs are working together to avoid crisis points being reached. The family hubs model is being developed across the rural county, pushing a culture of 'how can we help' and sign posting people to access the right information, advice and support where they need it. One key area for 2025/26 will be embedding dementia support and developing the carers offer at a neighbourhood level. It is recognised that carers development and support is essential across Shropshire where rurality plays into issues in accessing the right support when it is needed. Shropshire has a dedicated carer role that supports the acute hospitals, supporting people to access support upon discharge and connecting them to the local voluntary and community support services. Rural isolation is high in Shropshire and therefore within prevention services, befriending services are a lifeline for people and help avoid crisis points being reached and access wider support.

These services are vital in supporting the system flow; whether through admission avoidance or step-down support within the community. This aligns to improved resident experience with wrap around support provided in the community.

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- **how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26).**

Demand has been modelled by the Council in conjunction with the ICB to ensure that the predicted level of demand is a shared view. The 2025-26 modelling is based on the improvements made in 2024-25 in length of stay and pathway profile. Data from 2024-25 is the basis on which the improvement trajectories has been developed. Partners have worked together and made improvements to the trajectories; these have been developed in line with the 2025-26 STW UEC Improvement Programme, which is an ICB led transformation program and matches the workstream plan locally.

Modelling has not identified capacity issues for admission avoidance or discharge which require mitigations; the focus is on improving flow and reducing length of stay.

Joint work is being undertaken and will continue in 2025-26 to understand the interdependencies between the workstreams of the 2025-26 UEC Improvement Programme.

- **how capacity plans take into account therapy capacity for rehabilitation and reablement interventions**

The Care Transfer Hub includes acute based therapy who support activity and assessment. The therapeutic reablement pathways to reablement at home and in intermediate care beds are supported by therapists, these include ward and community-based therapists. START has trusted therapy assessors who support reablement with an average length of stay of 14 days and evidenced outcomes in respect of increased levels of independence. This LOS has been factored into the demand and capacity work programme.
Therapy is involved in deconditioning work to shorten LOS within an acute and intermediate bed base. Social Care Therapy is involved in the provision of equipment and home assessment for the provision of adaptations ranging from rails to bigger projects such as wet rooms.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- **to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.**

NHS STW and Shropshire Council are dedicated to promoting equality and reducing inequalities as per the Equality Act 2010. In both the planning and delivery stages for BCF, each organisation ensures compliance with the Public Sector Equality Duty (PSED) by considering the impact of their policies on people with protected characteristics.

Both organisations proactively collect and analyse equality and diversity data across the system, to understand community needs better. This data is incorporated in Shropshire's Joint Strategic Needs Assessment which informs the BCF planning and delivery process, ensuring focus in the right areas and fair access and outcomes for all.

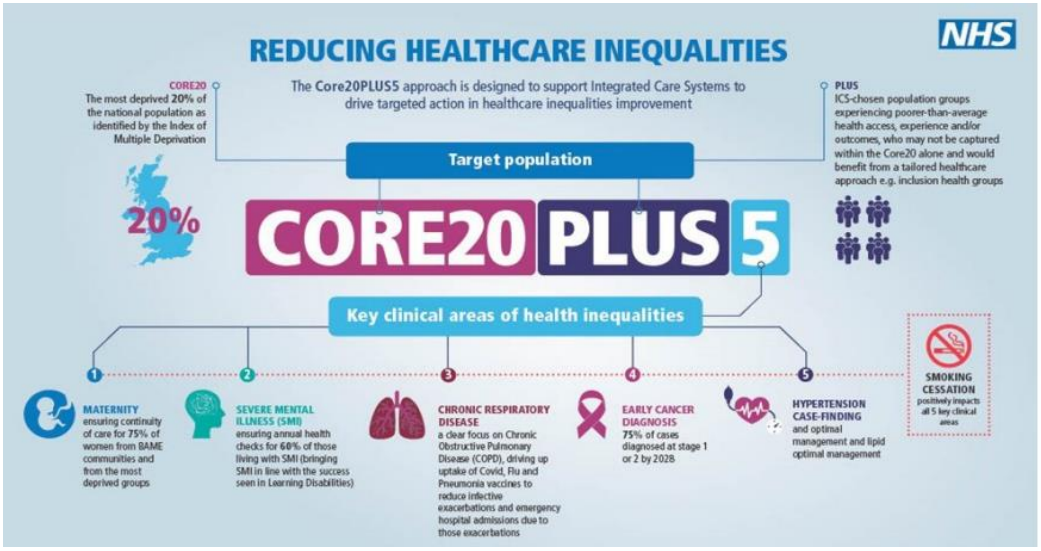
Shropshire Council's Equality Objectives Action Plan 2020-2024 and NHS STW's Equality Diversity and Inclusion Policy outline actions to ensure equal treatment in employment and services.

The Shropshire ICS Equality, Diversity, and Inclusion (EDI) Steering Group focuses on promoting fairness, diversity, and inclusion within the social and health care system through

various joint and individual initiatives and sharing best practice. The group holds collective responsibility for providing fair services, creating an inclusive work environment, working to increase diversity within the workforce, making sure employees understand their responsibilities regarding EDI and ensuring compliance with the Public Sector Equality Duty.

The Shropshire Inequalities Plan 2022-2027 recognises that several communities experience systematic differences in health outcomes due to societal inequalities and aims to improve health for those with the worst outcomes fastest by working collaboratively, with shared reporting to the ICS Inequality group and Shropshire Health and Wellbeing Board.

The Core20PLUS5 framework, introduced by NHS England, is being used in Shropshire to drive a reduction in health inequalities in the Core20 population cohort in addition to a PLUS focus on rurality for Shropshire, which sit alongside five clinical areas requiring accelerated improvement. Please see the diagram below for more detail.



In addition to the Core20PLUS5 approach, each Primary Care Network is required to have specific plans to tackle neighbourhood health inequalities. Shropshire Council's Public Health team is supporting them in taking forward this commitment.

Equality, Social Inclusion, and Health Impact Assessments (ESHIA) ensure BCF projects consider the needs of all community members, especially those with protected characteristics. Potential impact of proposed changes to policy are captured in detailed business case and subject to robust governance arrangements, requiring approval from both organisations. The close collaboration of system partners in the development of the BCF plan helps ensure full buy in to address broader social inequalities and promote greater inclusivity.

- **to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.**

STW ICB developed a People and Communities Strategy which sets out the joint ambition and commitment for embedding a culture of involvement within our ICS. It places a system-wide focus on encouraging a creative, positive and welcoming environment where people can contribute in a meaningful way and acts as the platform for further work to plan how we will put our principles and approach to involvement into practice. The principles were developed and shaped by rich conversations which took place across system partners, the public and the community and voluntary sector.

There are detailed communications and engagement strategies outlining each organisation's commitment to ensuring effective communication with public, partners and wider stakeholders, and approaches to involve communities in the planning, purchase and monitoring of local health and social care services. The development and successful delivery of these strategies are overseen by Cabinet, senior leaders and NHS STW Board, ensuing a structured and accountable approach to public involvement, with clear reporting and transparency. Any significant change in policy or approach is required to be documented in a detailed business case. This is closely scrutinised in relation to how communities have been consulted and have influenced proposals before approval is granted.

STW's strategies have an emphasis on the importance of understanding the hopes, needs, and experiences of local communities and commissioned service providers, which is achieved through a variety of involvement methods, including public meetings, formal consultations, surveys, focus groups, and online platforms. Close working with community groups and their representatives ensures that the needs and experiences of diverse populations are heard. This is particularly helpful approach to engaging harder to reach groups to ensure that their views are represented in the planning and delivery of BCF and other initiatives.

Shropshire Council hosts regular provider forums attended by a diverse range of regulated and community health and social care providers and co-chaired by Partners in Care (an independent provider representative). This ongoing communication has been vital in building strong relationships and understanding financial and wider market pressures, as well as identifying opportunities for joint working and market support. Regular feedback is also sought from users of services, their families and the wider community. This information is used to ensure that health and care services are meeting the needs of the community and to inform ongoing improvement. Recent examples include annual adult social care service user

and carer survey and consultations, surveys and focus groups on the transformation of day opportunities and All Age Carers Strategy.

NHS STW is committed to co-design, which involves working collaboratively with service users, carers, and the community to design and deliver health and care services. This work is underpinned by development of a set of agreed principles and standards, recently published in Shropshire Co-production Framework, that all partners are expected to adhere to. These standards ensure that co-design is at the heart of service delivery and that the voices of those with lived experience are central to decision-making. This is achieved through involving a wide range of stakeholders, including patients/service users, carers, and community representatives, in the development of strategies and plans and working in collaboration with local organisations, such as the Parent and Carer Council (PACC), to ensure that the needs of specific groups, such as children and young people with SEND are met.

'What does Co-Production mean to me?'

Word cloud created by People with lived experience

Shropshire Council and STW ICB are committed to learning from past experiences, incorporating best practices, and adapting to the changing needs of the community. Adopting mixed approaches to engagement ensures that a wide range of voices are heard and considered in decision-making processes and the ongoing monitoring and improvement of services. By embedding co-production into our practices, the system aims to create more responsive and effective health and care services that truly reflect the needs and preferences of the communities they serve.

- **for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.**

In January 2023, STW ICB undertook an evaluation to provide an early and detailed assessment of how well the dispersed approach to the implementation of the system

priorities was working. Significant progress has been achieved during the first year of implementation and the process of evaluation has helped to focus on providing additional opportunities to improve knowledge, increase coordination, accountability and commitment. The system is working up a rolling programme of data analytics that will be used to identify key health inequalities by programme area, for example, cancer, UEC, mental health, and children and young people. This will inform our ongoing programme of work to reduce inequalities across STW. This programme will align with the needs assessments being undertaken by Public Heath colleagues to give a holistic view of our inequalities and their wider determinants and inform the actions required across the system to reduce inequalities over time. This programme will be agreed in line with the priorities identified within the Integrated Care Strategy.

STW ICB is committed to reducing inequalities in access to NHS services and outcomes and achieves this through system wide approaches across several key strategies.

The Shropshire Integrated Care Strategy focuses on improving health outcomes and reducing inequalities through collaboration among health and social care organisations, joining up services to ensure seamless coordination and holistic care. The strategy aligns with BCF priorities to shift from sickness to prevention with focus on preventive measures to reduce the incidence of diseases and promote healthy lifestyles, and to shift care closer to home and within communities to make services more accessible.

The Health Inequalities Plan outlines specific actions to address health disparities through targeted support, focusing on socially excluded groups and areas with the highest levels of deprivation. Current targeted initiatives aligned to BCF priorities include weight management programmes and smoking cessation being integrated into routine healthcare, to provide individuals with personalised support and resources. Targeted mental health services, particularly for children and young people, address the increasing demand for mental health support and ensure timely access to care. Waiting well initiatives support focus on improving the health and well-being of individuals who are waiting for medical interventions, such as musculoskeletal (MSK) treatments, to support patients at home during their wait and enhance their overall health outcomes. Plan priorities are data driven, using Shropshire's JSNA and a range of local data to identify and address specific health inequalities, addressing factors such as housing, employment, and education that impact health outcomes.

Engaging with local communities and consultation with people affected by health inequalities is vital in understanding their needs and tailoring services. A range of mechanisms are used to maximise engagement opportunities, including regular consultations with residents to

gather feedback and identify areas for improvement, outreach programmes to reach socially excluded groups, and health education campaigns to raise awareness about health issues and available services through community events and campaigns.

STW ICB undertakes regular monitoring and evaluation work to ensure high quality services and track progress in reducing health inequalities. Life expectancy metrics are used to monitor differences in life expectancy and healthy life expectancy across different populations. Regular performance reviews and engagement with affected communities help ensure that service accessibility is equitable and effective ensuring improved health outcomes for residents.

- **for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022**

Involving people and communities in a meaningful way brings many benefits. It increases the legitimacy of decision making, builds the reputation of public bodies, and makes them more accountable and transparent. It is the right thing to do. SWT ICB proactively involves patients, public, carers, and service users when making plans to change services.

STW ICS has developed a Joint Forward Plan to outline how the health and care system will work together to deliver the joint priorities over the next five years. The Plan is reviewed annually to reflect the needs of communities and align its delivery at a local level to meet local needs. This can only be achieved by ongoing dialogue with local people and stakeholders a Place and neighbourhood team level.

Engaging communities has been a key part to developing the Joint Forward Plan, which highlights the work that is being undertaking across the ICS to improve the care provided for the citizens of Shropshire, Telford and Wrekin. STW ICB held The Big Conversations with patients, carers, and targeted those conversations in towns, villages and hamlets. These new arrangements empower us to deliver more joined-up health and care services, improve population health and reduce health inequalities.

Joint priorities are:

- Taking a person-centred approach (including proactive prevention, self-help, and population health to tackle health inequalities and wider inequalities).
- Improving place-based delivery, having integrated multi-professional teams providing a joined-up approach in neighbourhoods, supporting our citizens and providing care closer to home, where possible.
- Providing additional and specialist hospital services through our Hospital Transformation Programme.

The Shropshire All Age Carers Strategy was co-designed with local carers and emphasises a holistic approach to supporting carers, aligning with the broader Shropshire Plan 2022-2025 and Health and Wellbeing Strategy to tackle inequalities and promote healthy communities. Please see the diagram below for further details.

The strategy aims to support unpaid carers of all ages across Shropshire by fostering integrated working across health and social care sectors, voluntary sector, and community groups, to promote carer wellbeing, engagement and involvement and development of comprehensive support services for carers.

The strategy's key objectives are to ensure all carers are identified and recognised and supported through different stages of their caring role, by providing timely and easy to access and navigate information, advice, and support services. A key priority of the strategy is to develop and promote carer networks and engage and listen to carers' experiences and knowledge in the planning, commissioning and delivery of services for both the carer and the person they care for.

STW ICB recognises the vital role that unpaid carers perform and is committed to ensuring that they are supported to be involved in shaping the services they rely on. This commitment is reflected in Shropshire's Integrated Care Strategy and the specific measures designed to support unpaid carers, including training, information and support services, that enable a carer to continue to fulfil their role while preventing a deterioration in their own health and wellbeing and that of the person they care for.

Alongside wider engagement and consultation efforts, the ICB aims to ensure that unpaid carers are involved in decision making processes, especially when changing or developing services that impact them and/or the person they care for. Various mechanisms are used to promote engagement and coproduction opportunities, including carer involvement in Shropshire Carers Partnership Board and wider collaboration with local carer organisations and community groups to ensure that carers' needs are met, and their voices are heard.

STW ICB ensures that carers are fully involved in discussions about the prevention, treatment, diagnosis and care of the person they care for, working with local NHS hospital trusts to provide opportunities to enable unpaid carers to be involved as soon as feasible when planning a patient's discharge from the hospital.