Better Care Fund Narrative Plan template

Health and Wellbeing Board(s)

Telford and Wrekin Health and Well-Being Board

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

How have you gone about involving these stakeholders?

The Better Care Fund (BCF) Plan has been jointly developed and agreed between NHS Shropshire, Telford and Wrekin CCG (CCG) and Local Authority through the BCF Board. The BCF plan was initially developed and agreed within the BCF Board as an annual planning workshop. The Plan was subsequently presented to the Telford and Wrekin Integrated Place Partnership (TWIPP) for agreement. TWIPP has representation from the CCG, Shropshire and Telford Hospitals Trust (SATH), Shropshire Community Health NHS Trust (SCHT) and the independent and voluntary sector; Healthwatch, Adult Social Care and Public Health.

The Plan demonstrates a clear integration with the Place based (TWIPP) and wider system Shropshire Telford and Wrekin ICS Urgent and Emergency Care Plan 21-22. Development of the Plan and key metrics were considered multi-stakeholder system meetings (representatives from organisations indicated above) including the Discharge Alliance, Urgent Care Delivery Group and Urgent Care Board, Local Care Transformation Programme as well as TWIPP.

Planning Requirements and Templates were shared with system partners in October 2021. The BCF Narrative Plan was presented at TWIPP on 11th November 2021; Chair of HWBB on 12th October and approved by the Executive Director and Chair of HWBB, who have delegated authority to approve. The Narrative Plan and Template are timetabled to be formally presented at the next HWBB meeting on 9th December 2021.

Strategic and operational involvement from Healthwatch, the voluntary and independent sector includes membership and representation in HWBB, TWIPP, the Discharge Alliance, Older People Strategy Governance group and Urgent Care Board. Independent and voluntary sector representatives are also part of the DFG and housing meetings. The involvement includes detail of the development of the overall BCF programme and individual schemes. BCF programme themes and programme development are also presented to the Making It Real Board and Carers Partnership Board.

Formal approval of the BCF Programme is through the Health and Well-Being Board (HWBB). Regular formal reporting is also a requirement.

Executive Summary

This should include:

- **Priorities for 2021-22**
- **key changes since previous BCF plan**

The Better Care Fund (BCF) Plan has been jointly developed and agreed between NHS Shropshire, Telford and Wrekin CCG (CCG) and Local Authority through the BCF Board and partner organisations across statutory and the independent and voluntary sector.

The Plan brings together a clear integration with the Place based Boards and wider system Urgent and Emergency Care and ICS Plans and stakeholder groups through agreed Governance arrangements.

The BCF programme for 2021/22 has evolved over the last three year. The previous programmes have sought to establish and embed key integrated teams and approaches. It has also established and embedded Place, integration of teams and clear alignment to system programmes, while supporting Urgent Care and wide ICS priority programmes. This years programme is seeking to:

- Maximise integrated working post covid within localities;
- Enhance Proactive Prevention including ILC as a driver of Strengths- based assessment and Early Help Hub; Virtual House to showcase technology enabled care, Community MDT to provide risk appropriate interventions; use of technology enabled care as an alternative to formal or personal care calls
- Maximise the impact of integrated teams as many are now established;
- Consider next steps for integrated working of teams.
- Consider options to Level Up Enablement services
- Ensure sustainability of key schemes through longer term contracts. Some programmes will extend over more than one year (expand)

The key priorities for 2021-22:

- Maximise potential for admission avoidance
- Community Teams further integrated
- Develop specific approaches with PCNs including MDTs supporting risk stratification/ active case management
- Development towards a Single Referral Point
- Maximise ILC and wider Prevention models
- Develop the Older People strategy
- Review options for delivery of bed based Enablement services
- Review alternatives and options for building capacity to meet demands eg
- OTs reducing LOS in Enablement beds
- OT working as one NHS and Council team
- Domiciliary care development and expansion to further promote Home First
- Develop processes to agree funding of specific contracts for more than 12 months

BCF programmes continue to be integral to delivery of specific Place and system work programmes. Specific and shared priorities of the system can be clearly through:

- BCF Board and Programme
- TWIPP plan supporting integration, community resilience, prevention and tackling health inequalities at Place while supporting system priorities
- BCF programmes aligned to Urgent Care priorities
- BCF identified as an Enabler / Associated Programme within the STW ICS UEC Plan 21/22
- High impact Changes Action Plan reviewed through the system Discharge Alliance and Urgent Care governance
- Tackling health inequalities through the updated Health Inequalities Plan learning from the impact of Covid-19 Review

Governance

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

BCF Board has an agreed set of principles for joint commissioning arrangements. Clear processes have been developed to share local commissioning strategies and identify commonalities in order to address strategic issues across the Place and wider health and social care economy.

The BCF Board is made up of senior representatives from TWC, STWCCG and SCHT. (latest Terms of Reference 2020/21 except and Governance chart included)

Aims and Objectives

Commissioners and operational managers from Telford and Wrekin Council (TWC) Commissioners from Telford and Wrekin Clinical Commissioning Group (T&WCCG) and operational managers from Shropshire Community Health NHS Trust form a Board to

- Establish a joint governance structure to agree joint priorities
- Monitor existing Programmes of work and future agreed jointly agreed areas of work
- Inform commissioning within a whole system integrated care
- Delegate commissioning and / or contracting responsibilities to a coordinating representative where identified
- Make recommendations and decisions
- Monitor joint financial arrangements
- Understand the priorities of each organisation
- Agree risk sharing arrangements.
- Provide scrutiny and assurance support

The Board will provide scrutiny and assurance to their respective organisations and the Health and Well-Being Board of the agreed areas of work whilst respective organisations retain oversight and accountability for service planning, quality and outcomes.

Membership

The membership of Board will be:

15

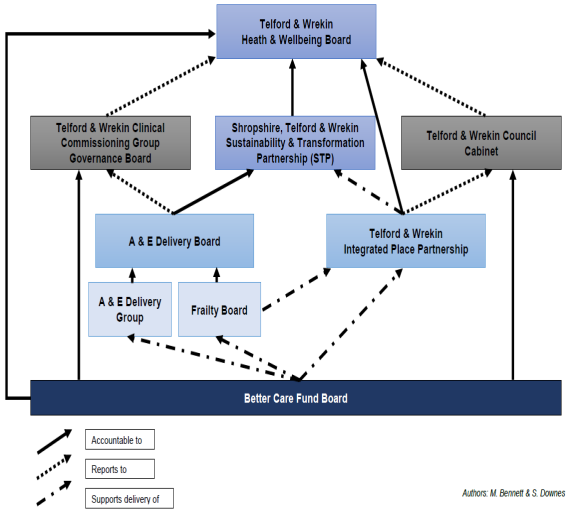
Telford and Wrekin CCG
Director of Partnerships
Programmes Director
Head of Commissioning
Head of Finance

Telford and Wrekin Council
Director – Governance, Procurement and Commissioning
Director - Health & Wellbeing
Service Delivery Manager – Finance
Service Delivery Manager – Governance, Procurement and Commissioning
Service Delivery Manager – Enablement

Shropshire Community NHS Trust
Telford Locality Manager

Better Care Fund Board Governance and Relationships Structure

(as at Sept 2019)



Authors: M. Bennett & S. Downes

BCF Board formally reports to TWIPP through a combined Programme and performance reporting Dashboard (excerpts below) and regular full programme updates

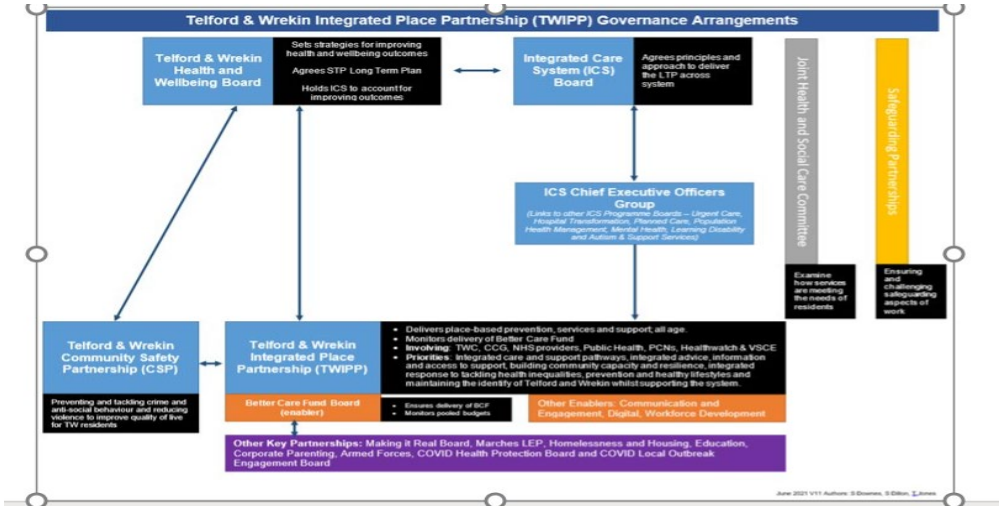
BCF Performance Dashboard September 2021

Key metrics	Performance/ position	Trends	Comments
NEL admissions/ avoidance	Details to be confirmed		BCF metric will be related to admission avoidance as indicted in Policy Guidance. Details tbc
LOS on MFFD	Average LOS Days on FFT list: NHS Shropshire CCG / NHS Telford & Wrekin CCG / Powys Teaching Health Board Apr-20: 2.85 / 2.97 / 3.18 May-20: 3.26 / 2.86 / 4.23 Jun-20: 2.79 / 3.47 / 3.92 Jul-20: 5.54 / 4.92 / 5.30 Aug-20: 4.04 / 4.68 / 8.31 YTD: 3.70 / 3.78 / 4.99 Discharged within 24 hrs / Discharged within 48 hrs / Discharged within 72 hrs + System: 17% / 24% / 59% Shropshire: 18% / 27% / 55% Telford & Wrekin: 16% / 21% / 63% Powys: 11% / 18% / 71%		Baseline of 3.8 days ave (Jan-March 2020) Target 2.4 days Domiciliary care have reduced capacity impacting on flow (national issue). Action Plan in place reported to Discharge Alliance and UCDG Monthly analysis of all factors impacting of MFFD LOS through beds
Pathway profile	Base Line PW0 / Now PW0 / Base Line PW1 / Now PW1 / Base Line PW2 / Now PW2 / Base line PW3 / Now PW3 System: 50% / 67% / 45% / 7% / 4% / 3% / 1% / 3% Shropshire: - / 48% / 59% / 40% / 26% / 12% / 15% Telford: - / 50% / 59% / 35% / 26% / 15% / 15% Powys: - / 49% / 13% / 38% / 78% / 13% / 9%		Profile up to August 2021 Pathway profile against national metric included (needs to be separated from T&W) Pathway profile of P1:2:3 has not changed significantly Some increases in Pathway Zero since re-launch
Permanent admissions to care homes	Previous Performance / 2017-18 / 2018-19 / 2019-20 / 2020-21 / 2021-22 Telford & Wrekin: 307.3 / 548.9 / 472.7 / 391.2 / 306.0 National: 585.6 / 579.4 / 584.0 / 584.0		Target of 404/ 100,000 population. National levels (579/100,000) Outturn for 2019/20 was 472/ 100,000 142 people; Outturn for 2020/21 was 391/100,000. (127 people) Some increase in EMI related long term care placements
At Home 91 days after Reablement	Previous Performance / 2017-18 / 2018-19 / 2019-20 / 2020-21 / 2021-22 Telford & Wrekin: 61.7% / 65.4% / 71.4% / 76.4% / 78.4% National: 82.9% / 82.4% / 82.0% / 82.0%		T&W target is 80% Monthly tracking in place. Upward trajectory remains. Metric based on October –December reviews through Q4

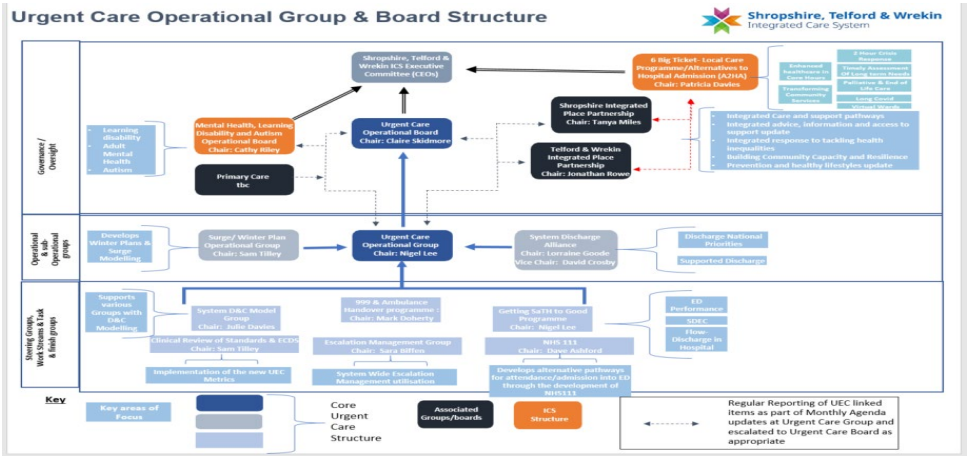
BCF programmes 2021		
Maximise potential for admission avoidance including Hospital at Home / Virtual Ward and HSCRRT		Business case for admission avoidance agreed. Funding for ASC and NHS staffing for HSCRRT identified. Paramedic and Therapist in place. ASC recruitment commenced. Increase in referrals to HSCRRT after a drop. Implementation Group in place. HSCRRT to share learning to support Shropshire's team development. Daily and weekly calls with Frailty Team
Community Teams further integrated - TICAT, IDT, HSCRRT, Frailty Team, Care Home MDT into a single function		IDT Hub has TWC, SCHT and SCC integrated within the new location. Further approach of the development of the future model to be considered in local planning meetings
Develop specific approaches with PCNs including MDTs supporting risk stratification/ active case management		MDTs in place with GP practice Linking with PCN Programme lead to further develop
Development towards a Single Referral Point		Work programme in place
Maximise ILC and wider Prevention models and alternatives to formal care/ services		3182 hits in Virtual House to date Gradual increase in Walk-Ins alongside OT, sensory Pathway Zero and Locality assessments Weekly programme continues to expand including ALD, Mental Health Sensory Impairment Drop-Ins with Sign Language Developing video for ADASS to showcase Virtual House and part of Digital Innovation Challenge Fund by ADASS and Microsoft.
Develop the Older People strategy		Workshops completed and presented to TWIPP and HWB Board Task Group in place and planning the development a Partnership Board and outline structure of the Strategy that will be form the Consultation

TWIPP provides formal updates to HWBB. Regular periodic formal BCF updates are presented to HWBB including the BCF Plan and end of year update.

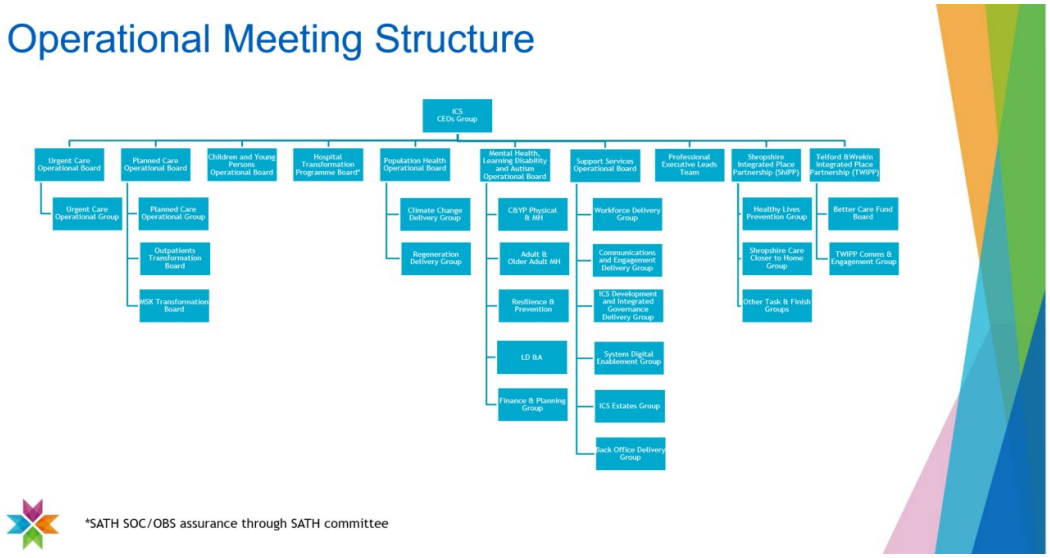
TWIPP is the Place Based Board with an agreed plans and ongoing work will create an integrated health and care system, working as a multi-organisational partnership both in terms of planning and commissioning services across the Place. Like the ICS, TWIPP seeks to integrate care across different organisations and settings, join up hospital and community-based services, physical and mental health, and health and social care. This joined up, integrated approach brings real benefits to patients.



TWIPP is recognised within the STW ICS Urgent Emergency Care Plan, Board (and its sub-groups within the Urgent Care governance arrangements) and within ICS Governance.



ICS Governance Chart (July 2021) highlights TWIPP as a direct report and BCF Board as a work-stream into TWIPP (below)



Telford &Wrekin Integrated Place Partnership (TWIPP)	Jonathan Rowe, Executive Director Adult Social Care, Health Integration & Wellbeing (T&W Counc..,	1. Better Care Fund (BCF) Board 2. TWIPP Communications & Engagement Group • Delivery of place-based prevention, services and support (all ages) in T&W • Integration between health and care

BCF funding and programmes are recognised as an Enabler/ Associated Programme within the Urgent Care programme and a sub-group of TWIPP within ICS governance.

Overall approach to integration

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

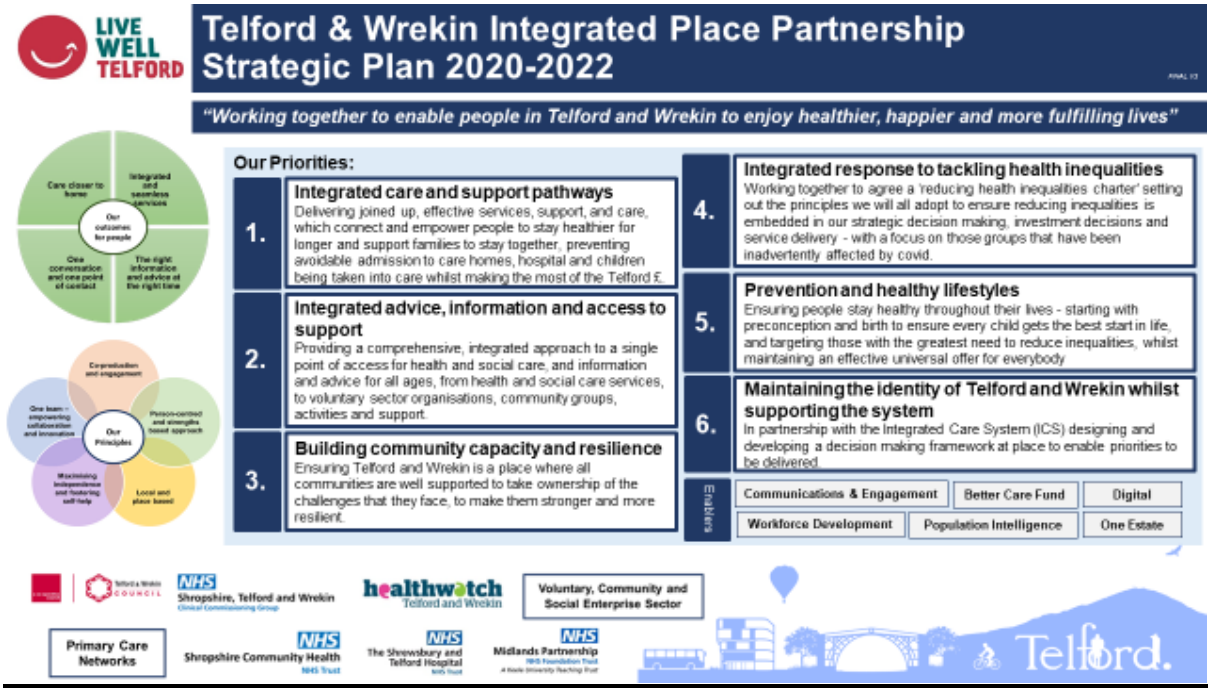
- **Joint priorities for 2021-22**
- **Approaches to joint/collaborative commissioning**
- **Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.**
- **How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 20201-22**

Joint priorities of the system can be clearly through:

- BCF Board and Programme
- TWIPP plan
- BCF programmes aligned to Urgent Care priorities
- BCF identified as an Enabler / Associated Programme within the STW ICS UEC Plan 21/22
- High impact Changes Action Plan

TWIPP has a set of strategic priorities (below) and Deliverables for 2021/22 that support Place and system priorities, intending to deliver services which connect and empower people to stay healthier for longer and prevent unnecessary admission to hospital. The Strategic priorities and Deliverables of TWIPP sets out:

- Person-centred approaches by TWC and partner organisations
- Strength-based community approaches to build community capacity and resilience
- Preventative, early interventions and Heathy Lifestyles including Making Every Contact Count and Community Hubs
- Maintaining independence
- Integrated approaches to care and support
- Tackling health inequalities through integrated approaches



Midlands Region Urgent and Emergency Care Recovery Priorities

Shropshire, Telford & Wrekin Integrated Care System

1. Manage ED Demand more effectively through NHS111;
o Increase utilisation of booked slots in A&E accessible via NHS111 – interim target of 70% of NHS11 heralded patients receiving a booked time slot.
o Increase the utilisation of directly bookable urgent secondary care services including SDEC and specialty hot clinics
o Establish clinical pathways via NHS 111 into urgent community and mental health services

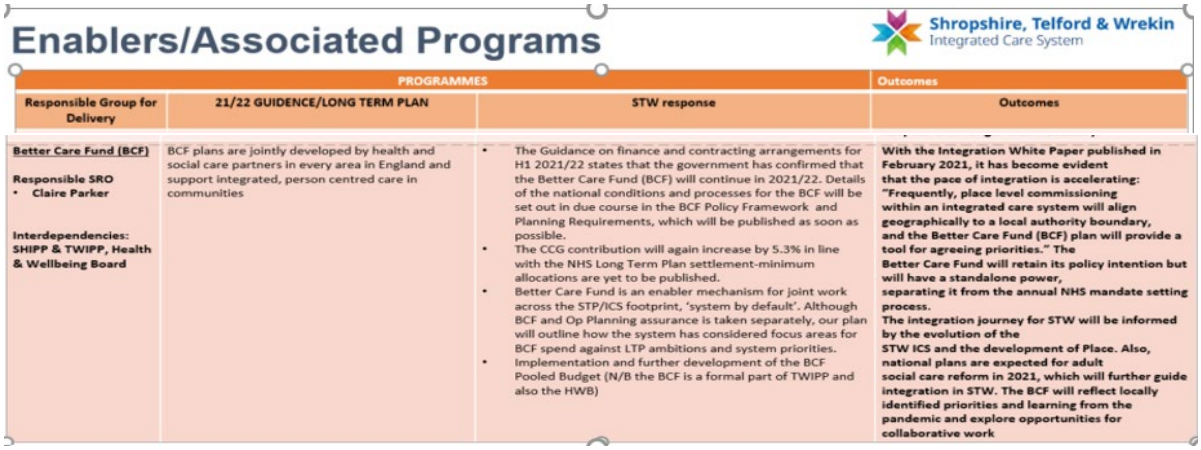
2. Manage ED demand more effectively through 999;
o Systems should continue to drive a safe reduction in avoidable conveyance, with particular consideration for alternative referral pathways.

3. Improve flow through hospitals through admission avoidance;
o SDEC and Acute Frailty Services physical estate and staffing resource, ensuring senior appropriate specialist support , should be restored to ensure that all Type 1 ED providers provide a minimum of 12 hours per day 7 days per week SDEC and a minimum of 70 hours per week Acute Frailty Services.
o Direct referral routes to secondary care, including SDEC and AFS, should be supported through 111/999/Primary and Community care
o Systems should safely maximise admission avoidance through use of "Clinical Criteria to Admit" and adoption of virtual wards to monitor patients remotely.

4. Improve flow through hospitals employing early assessment and admission;
o System should ensure acute facing specialties have consultant presence which reflects service demand across any 24h period.
o Ensure appropriate specialist support is available to all EDs and SDEC and assessment units, 7 days a week.

5. Maximise capacity through enhanced discharge
o All providers should continue to deliver timely and appropriate discharge from hospital inpatient settings and continue to seek an improvement in average length of stay with a particular focus on more than 7, 14 and 21 days.
o Provision of early follow up of patients with specialty needs should be made available for 48h, 7 day, or 14 day follow up to ensure continued recovery.

BCF programmes are integrated into the Core Urgent and Emergency Care work-streams that deliver the local, regional, and national priorities (above). BCF is identified as an Enabler/ Associated Plan within the STW ICS UEC Plan 21/22 (below)



Enablers/Associated Programs

Shropshire, Telford & Wrekin Integrated Care System

PROGRAMMES			Outcomes
Responsible Group for Delivery	**21/22 GUIDENCE/LONG TERM PLAN**	**STW response**	**Outcomes**
Better Care Fund (BCF) **Responsible SRO** • **Claire Parker** **Interdependencies: SHIPP & TWIPP, Health & Wellbeing Board**	BCF plans are jointly developed by health and social care partners in every area in England and support integrated, person centred care in communities	• The Guidance on finance and contracting arrangements for H1 2021/22 states that the government has confirmed that the Better Care Fund (BCF) will continue in 2021/22. Details of the national conditions and processes for the BCF will be set out in due course in the BCF Policy Framework and Planning Requirements, which will be published as soon as possible. • The CCG contribution will again increase by 5.3% in line with the NHS Long Term Plan settlement-minimum allocations are yet to be published. • Better Care Fund is an enabler mechanism for joint work across the STP/ICS footprint, 'system by default'. Although BCF and Op Planning assurance is taken separately, our plan will outline how the system has considered focus areas for BCF spend against LTP ambitions and system priorities. • Implementation and further development of the BCF Pooled Budget (N/B the BCF is a formal part of TWIPP and also the HWB)	**With the Integration White Paper published in February 2021, it has become evident that the pace of integration is accelerating: "Frequently, place level commissioning within an integrated care system will align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities." The Better Care Fund will retain its policy intention but will have a standalone power, separating it from the annual NHS mandate setting process.** **The integration journey for STW will be informed by the evolution of the STW ICS and the development of Place. Also, national plans are expected for adult social care reform in 2021, which will further guide integration in STW. The BCF will reflect locally identified priorities and learning from the pandemic and explore opportunities for collaborative work**

BCF programmes approach to integration spans hospital discharge and Enablement; admission avoidance; prevention and improving health inequalities:

Programme	**Approach to joint and integrated working**
Maximise potential for admission avoidance including Hospital at Home / Virtual Ward and HSCRRT	•HSCRRT as an integrated health, social care and independent sector team based in a single location and shared approach
Community Teams further integrated - TICAT, IDT, HSCRRT, Frailty Team, Care Home MDT into a single function	•TICAT aligned to the Urgent Care programme supporting discharge from hospital •HSCRRT was developed through an Place-based prioritisation It is now being replicated by Shropshire colleagues •Care Home MDT was developed in TWC and is now being replicated by Shropshire colleagues •Joined up approach to Pathway Zero linking acute leads to ILC and independent sector First Point provider
Develop specific approaches with PCNs including MDTs supporting risk stratification/ active case management	•Further developing Community MDTs including
Maximise ILC and wider Prevention models and alternatives to formal care/ services	•Piloting Technology Enabled Care as alternatives to personal care and including NHS to integrate health technologies •ILC partnership with independent sector and accessible to NHS colleagues •Proactive Prevention (strength based approaches to prevention) identified as priority in Local Care Programme
Develop the Older People strategy	•Stakeholder workshops held and Steering Group with wide statutory and non-statutory stakeholder representation
Review options for delivery of bed based Enablement services	•SCHT lead to review Benchmarking data •SCHT agreed recruitment of staff at risk to support Winter scheme
Review alternatives and options for building capacity to meet demands eg	•91 day OT review post Enablement

OTs reducing LOS in Enablement beds OT working as one NHS and Council team	• TWC and SCHT OTs jointly developing single handed care assessments
Domiciliary care development and expansion to further promote Home First	• Independent provider leading recruitment at risk to increase domiciliary care capacity • Independent provider utilising community alarms as part of Planned Overnight Care offer
Develop processes to agree funding of specific contracts for more than 12 months	• BCF programmes planned with partners across more than one year to maximise potential of success

Two joint posts highlight the positive approaches to joint/collaborative operational delivery and commissioning:

- Service Delivery Manager for Prevention and Enablement is a jointly funded CCG and Council post providing operational delivery of services, operational leadership of integrated teams and services, BCF Programmes and reporting.
- The Place Based Commissioning and Procurement Lead is a joint post with STWGGC and TWC to work with partners to maximise purchasing potential with the care provider market and develop effective processes with partners and stakeholders

The BCF programme for 2021/22 has evolved over the last three year. The previous programmes have sought to establish and embed key integrated teams and approaches. It has also established and embedded Place, integration of teams and clear alignment to system programmes, while supporting Urgent Care and wide ICS priority programmes. This years programme is seeking to:

- Maximise integrated working post covid within localities;
- Enhance Proactive Prevention including ILC as a driver of Strengths- based assessment and Early Help Hub; Virtual House to showcase technology enabled care, Community MDT to provide risk appropriate interventions; use of technology enabled care as an alternative to formal or personal care calls
- Maximise the impact of integrated teams as many are now established;
- Consider next steps for integrated working of teams.
- Consider options to Level Up Enablement services
- Ensure sustainability of key schemes through longer term contracts

2019/20	2020/21	2021/22
TWIPP	TWIPP	Maximise potential for admission avoidance including Hospital at Home / Virtual Ward and HSCRRT
Intermediate Care Team	Integrated Teams	Community Teams further integrated - TICAT, IDT, HSCRRT, Frailty Team, Care Home MDT into a single function
Integrated Discharge Team function	Community Resilience	Develop specific approaches with PCNs including MDTs supporting risk stratification/ active case management
Pathway Zero	Neighbourhoods and Prevention	Development towards a Single Referral Point
Health and Social Care Rapid Response Team (HSCRRT)	Frailty	Maximise ILC and wider Prevention models and alternatives to formal care/ services
Frailty Front Door	Frailty Front Door	Develop the Older People strategy

Care Home MDT	Care Home MDT	Review options for delivery of bed based Enablement services
DTOC High Impact Changes	DTOC High Impact Changes	Review alternatives and options for building capacity to meet demands eg OTs reducing LOS in Enablement beds OT working as one NHS and Council team
Disabled Facilities Grant	Disabled Facilities Grant	Domiciliary care development and expansion to further promote Home First
		Develop processes to agree funding of specific contracts for more than 12 months

Integrated teams developed through the BCF programmes (HSCRRT and Care Home MDT) as well as system programmes have been recognised as good practice by the ICS and being replicated within the system.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?
How is BCF funding activity supporting safe, timely and effective discharge?

The approach to discharge is though specific BCF programmes and schemes and system wide processes:

Discharge to Assess (D2A) model and Trusted Assessor (TA) approach
The model was an efficient and streamlined approach to support discharge from hospital when individuals were identified as Medically Fit for Discharge (MFFD). This would reduce length of stay and ensure each would have Enablement or rehabilitation before a determination of their long term needs, thus improving outcomes and individual experience.

The TA approach was to support acute hospital staff completing Fact Finding Assessments (FFAs) while TICAT supported pathway decision-making where required. These had been implemented prior to Covid-19. Delayed Transfers of Care (DToC) performance was within the top 20 nationally on occasion before the metric was suspended due to Covid-19. However these was further developed through the IDT Hub (summarised below)

Integrated Discharge Hub (IDT Hub) development in line with Covid Discharge Guidance

The IDT was developed in March 2020 in line with the Covid-19 Discharge Guidance. TICAT staff joined system partners within a single virtual and actual Hub to enhance the D2A and Trusted Assessor approaches in order to facilitate discharges on the day they were MFFD. The IDT Hub was shown to be effective in completion of FFAs within 24 hours; improving Pathway 1 decisions against baseline ratios; reducing average length of stay after being MFFD.

Discharge Alliance Work programme
The Discharge Alliance group is a sub-group of the Urgent Care programme, evolved from implementing the IDT Hub. The ‘Alliance’ recognises the collective responsibility and contributions across statutory and independent sector organisations to deliver the ever-developing projects:

Workstream 1 - Early implementation of the Hospital Transformation Programme – LEAD (Chris Preston)
Workstream 2 - MSK transformation – LEAD (Kerry Robinson)
Workstream 3 - Alternatives to hospital admission – LEAD (Wasique Chaudhry)
Workstream 4 - Outpatient transformation – LEAD (Julie Davies)
Workstream 5 – Workforce – LEAD (Jonathan Rowe)
Workstream 6 – Integrated Procurement – LEAD (Victoria Rankin)

System Discharge Alliance Group Workstream updates

Workstream	Title of Project	Lead	Linked Big Ticket	Rag Rating Red - Outstanding Amber - In progress Green - Completed/Noted
1	Systems Discharge Alliance	New chair identified Lorraine Goude	1,3	3 weekly meetings in place Interim chair in place, new chair identified
2	Reporting patient concerns pathway	Heather Easton	1,3	Completed and workstream activities being monitored
3	Reporting patient concerns sub group	Heather Easton	1,3	A subgroup is in place to review reporting concerns
4	Pathway Zero refresh	Patricia Blackstock/ Michael Bennett	1,3	Ongoing meeting with Sath and partners to relaunch the process-last meeting held 30.7.21
5	UEC Performance Dashboard & Data Pack	Helen Lingham /Sean Parrish	1,4	SATH monthly Pathway profile and LOS on MFFD reports are key reporting and monitoring metrics. Pathway reporting on National Pathway 0,1,2 3 to be included using SATH
6	NHS Benchmarking submission	Emma Pyrah	1,3	Benchmarking information and date being collated. Deadline for submission 23.7.21
7	Monitoring High Impact Change Metrics and linking to workstream progress	Chair	1,3	To be tabled as agenda item for discussion at discharge alliance meetings
8	Quarterly meeting in place to review action plan from Audit by Ian Sturgess	Heather Easton	1,3	Review completed 29.7.21-update in presentation
9	Community MADE action plan	Sarah Robinson	1,3	Update in presentation
10	IDT Staffing and location	Richard Allman-Evitts	1	Updated in presentation
11	Complex Discharge process T&FG	Patricia Blackstock/ Michael Bennett	1,3	Updated in presentation Analysis of pathway profile and LoS on MFFD being carried including Trend analysis Action Plan developed and being updated for further reporting to UCDG Updated included Improving discharge performance within MFFD/ Criteria to Reside is met

Nine High Impact Change Metrics

The Nine High Impact Changes are reviewed within the Discharge Alliance. The Action plan integrates a number of schemes across the system which reports into the Urgent Care Delivery Group and Board.

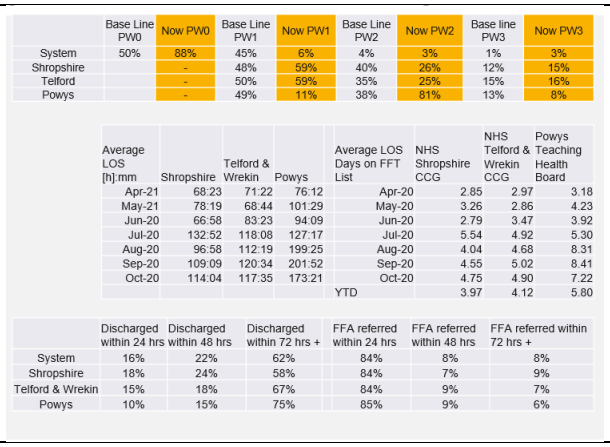
Shropshire, Telford and Wrekin
9 High Impact Changes
Draft Action Plan Oct 2021

Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

No	Impact	Where are we now?	Where do we want to be?
1	Early discharge planning.	Criteria to Reside processes in place in place Integrated Discharge Hub developed in line with national direction to support immediate discharges Flow Fortnight Events held to improve processes including EDD Stranded Patient Review processes in place Discharge Facilitators in place	EDDs and associated actions to achieve them in place MDTs fully in place including community and voluntary sector to support discharge planning
2	Monitoring and responding to the system demand and capacity	Acute and Community Demand and capacity modelling developed, in place and maintained place for covid-19 planning, capacity tracking, winter planning and continuing through the year Weekly reporting dashboard and demand and capacity modelling/ planning in place	Demand and Capacity processes remain in place
3	Multi-disciplinary/multi-agency - working.	MDTs in place: IDT; ICT; HSCRRT, Care Home MDT Integrated Discharge Hub developed …to support co-ordinated immediate discharges and planning based on joint assessment processes and protocols and on shared and agreed responsibilities Developed improved working with SATH therapists to enable integrated discharge approach	Further Improvement with MDT's ie relationships between organisations and voluntary sector.
4	Home First- Promoting and maximising the potential so that Enablement in people's homes takes place where possible.	Current ratio of c60:30:10 essentially maintained through the development of the IDT Monitoring performance in line with national indicator of 50:45:4:1% Developed improved working with SATH therapists to enable a more integrated discharge team Development of Pathway Zero and link to Social Care where needed	Increase ration of Pathway 1 Capacity to support Home First eg therapy capacity for early mobilisation
5	Flexible working patterns across 7 days	Systems and processes in place to develop target discharge numbers over 7 days including 7 day IDTs, Council Teams over 7 days; SATH weekend Discharge Teams Rapid Response over 7 days and OOH providers in place Reviewing staffing and processes to maximise Sunday discharges	7 day IDT calls Discharges across 7 days Split weekend data/activity explicitly Reflect on 7 day working outcomes
6	Trusted assessment - using trusted assessment processes to complete assessments …and accelerate discharges in a safe and timely way.	IDT Hub completing FFAs by liaising with ward staff utilising Trusted Assessor approaches SATH utilising therapists in completing FFAs FFAs increased numbers from development of IDT and staffing profile IDT Hub including Councils and SCHT to ensure effective communication and support FFA completion and decision-making	Further enhance Trusted Assessor approach to increase same day discharges
7	Engagement and Choice – early engagement ….and delivery of the Choice policy ….when no line meet Criteria to Reside	System wide Choice policy in place and reviewed. Council policies in place Developed and implemented Pathway Zero; further prioritised as part of immediate discharge	Reinforced Choice policy at step down from hospital immediately
8	Enhancing health in care homes.	Care Home MDT in place and implemented in T&W for admission avoidance and early discharge from hospital. Care Home support in Shropshire being developed in line with Care Home MDT. Teams provide training and support within care homes ??GP practices aligned to care homes?? EHCH plans in place and rolled out. Emergency Passport, Red Bag Scheme, Advanced Care Planning (ACP), support and training in care home	Further work required-links to quality/commissioning activity
9	Housing and related Services	Housing support for early discharge in place and prioritised as part of discharge process Identified workers and accommodation on place Limited housing options available particularly for those with physical disabilities	

Some key BCF programme, functions and approaches to improving outcomes are highlighted below, delivering and monitoring of safe discharge:

BCF Programme / function	Approach to improving outcomes
TICAT staff based within the IDT Community Matrons within TICAT	Integrated pathway with acute hospital through the IDT to accelerate pathway decision-

	making and early discharge- based in a single base Funding nurses to be within TICAT ensures clinical assessments and reviews to support decision-making and risk assessments
TICAT includes admission avoidance	The TICAT team is part of the integrated admission avoidance function- diverting potential admissions and reducing pressures on the acute hospital
All pathways for Enablement	TWC accepts just about all referrals as Enablement so no long term decisions are made in hospital. This also helps to accelerate discharge
Support to Pathway Zero	TWC led development of a local Pathway Zero approach in 2018 (pre-dating Covid -19 Discharge Guidance) and now supports the developed approach with acute hospital lead with alignment to ILC and First Point of Contact
Discharge Alliance monitoring of High Impact Change Metrics	See below
Performance monitoring through the system Discharge Alliance	
Care Home MDT supports care home returns	The Care Home MDT supports direct interventions within and training and development of staff within care homes. It also in-reaches to the acute hospital to accelerate early return to permanent residence and supports post-discharge care planning and Advanced Care Planning The Care Home MDT approach is being replicated by Shropshire colleagues
Quality monitoring of discharges	System partners developed a 'Quality Concern' reporting process to highlight discharge issues which when reported, are reviewed by the acute hospital
Integrated/ MDT Enablement reviews across all pathways	Weekly MDTs with the providers, Enablement therapists, Matrons and case workers following a defined process to maximise Enablement outcomes within shortest timescales.
OT reviews post Enablement	Council OTs support reviews post Enablement as part of 91 day review; single handed care

	Base Line PW0	Now PW0	Base Line PW1	Now PW1	Base Line PW2	Now PW2	Base line PW3	Now PW3
System	50%	88%	45%	6%	4%	3%	1%	3%
Shropshire		-	48%	59%	40%	26%	12%	15%
Telford		-	50%	59%	35%	25%	15%	16%
Powys		-	49%	11%	38%	81%	13%	8%

Average LOS [h]:mm	Shropshire	Telford & Wrekin	Powys
Apr-21	68:23	71:22	76:12
May-21	78:19	68:44	101:29
Jun-20	66:58	83:23	94:09
Jul-20	132:52	118:08	127:17
Aug-20	96:58	112:19	199:25
Sep-20	109:09	120:34	201:52
Oct-20	114:04	117:35	173:21

Average LOS Days on FFT List	NHS Shropshire CCG	NHS Telford & Wrekin CCG	Powys Teaching Health Board
Apr-20	2.85	2.97	3.18
May-20	3.26	2.86	4.23
Jun-20	2.79	3.47	3.92
Jul-20	5.54	4.92	5.30
Aug-20	4.04	4.68	8.31
Sep-20	4.55	5.02	8.41
Oct-20	4.75	4.90	7.22
YTD	3.97	4.12	5.80

	Discharged within 24 hrs	Discharged within 48 hrs	Discharged within 72 hrs +	FFA referred within 24 hrs	FFA referred within 48 hrs	FFA referred within 72 hrs +
System	16%	22%	62%	84%	8%	8%
Shropshire	18%	24%	58%	84%	7%	9%
Telford & Wrekin	15%	18%	67%	84%	9%	7%
Powys	10%	15%	75%	85%	9%	6%

	reviews to maximise independence and Care Lifting and Handling training to support carers in their roles

BCF Metrics

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		549.5	548.0

The identified Plan is a challenging target. This is a new metric and the plan is based on current predicted data trends. Trends have been affected by covid, reduced flu during 20/21 and 21/22 which is expected to increase this year; increased acute hospital and ambulance demand with mitigations by the integrated admission avoidance team (HSCRRT). The proposal is to reduce slightly, which is believed to be a Stretch target.

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	8.6%	9.2%
	Proportion of inpatients resident for 21 days or more	3.8%	4.0%

The identified Plan is a challenging target. Delayed Transfer of Care targets were set for each quarter, with longer delays in Q4. Reviewing the Length of Stay (LoS) data, this shows a similar trend.

In addition, monthly System monitoring of LOS on the Medical Fit for Discharge (MFFD) list shows a monthly increase in LOS on MFFD over the last six months from a baseline of 2.4 days. This increase is adding further challenge to achieve the identified target.

Average LOS Days on FFT List	NHS Shropshire CCG	NHS Telford & Wrekin CCG	Powys Teaching Health Board
Apr-20	2.85	2.97	3.18
May-20	3.26	2.86	4.23
Jun-20	2.79	3.47	3.92
Jul-20	5.54	4.92	5.30
Aug-20	4.04	4.68	8.31
Sep-20	4.55	5.02	8.41
Oct-20	4.75	4.90	7.22
YTD	3.97	4.12	5.80

The action plan agreed by the Discharge Alliance to improve performance is in place to increase domiciliary care capacity that has reduced due to impacts of covid and market dynamic highlighted locally and nationally. The action plan includes ICS agreement for additional HDP schemes to improve this performance.

8.3 Discharge to normal place of residence

	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.4%

The identified Plan is a challenging target. This is a new metric. The 19/20 outturn was 93.2% (93.3% ave to Month 5); 20/21 was 91.2% (90.3% ave to Month 5). 21/22 data ave to Month 5 shows 92.1%.The impact of covid including highlighted increases in EMI presentations, predicted increase in flu and decline in the metric during Q4 last year indicates likely challenges to achieve target. Monthly monitoring by Pathway is in place (below)

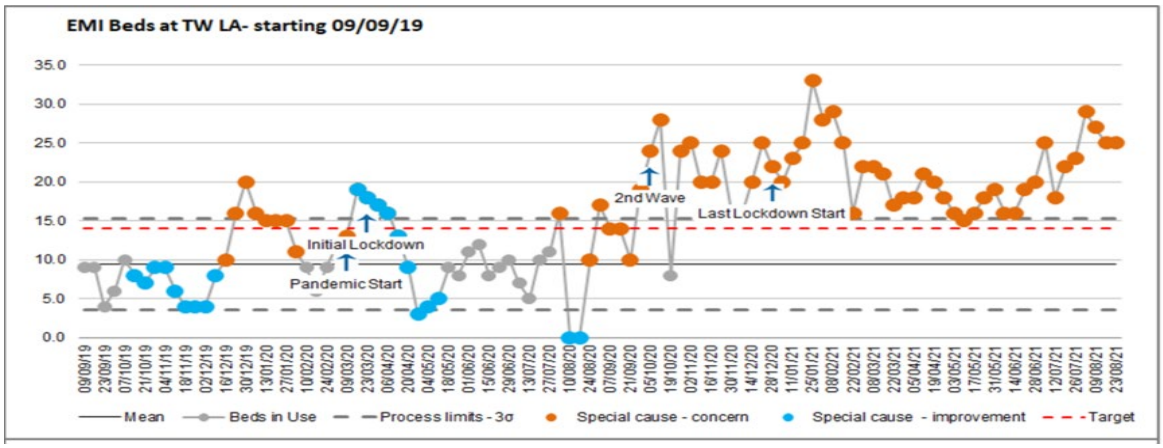
	Base Line PW0	Now PW0	Base Line PW1	Now PW1	Base Line PW2	Now PW2	Base line PW3	Now PW3
System	50%	88%	45%	6%	4%	3%	1%	3%
Shropshire		-	48%	59%	40%	26%	12%	15%
Telford		-	50%	59%	35%	25%	15%	16%
Powys		-	49%	11%	38%	81%	13%	8%

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	404	473	391	492
	Numerator	125	147	124	160
	Denominator	30,921	31,087	31,739	32,515

This is a challenging target. There has been recognition locally and across systems of a reduction in 2020/21 due to some reluctance to agree placements into residential settings due to covid. There was a prediction that there would be increases this year. Locally, there have been increasing in numbers of complex care presentations this year, particularly EMI/ Dementia.

Monthly monitoring shows increases in this metric are higher that previous years with increases by nine people rather than the expected two or three.



8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	71.4%	76.4%
	Numerator	80	162	172
	Denominator	100	227	225

The identified Plan is a challenging target. Actuals have increased from 65.4% in 2019/20; 71.4% in 2019/20 and 76.4 in 20/21. The national rate for 20/21 has reduced from 82% the previous year to 79.1%.

There are different approaches to identifying Enablement potential. TWC have focussed on almost all of people over 65 are discharged from hospital for Intermediate Care (Enablement) as Pathway 2 and Pathway 3 (Discharge to Assess) discharges. Data for 20/21 indicates that 16.9% are deceased before the 91 days. This is consistent with the previous year.

There has been a significant increase during covid of individuals needing EMI beds for Enablement (highlighted above) including needing One–to-One care on discharge and throughout their Enablement episode.

Disabled Facilities Grant (DFG) and wider services

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

The DFG Capital Grants awarded supported vulnerable people to remain independent, safe and healthy. This is a person-centred approach to understanding and assessing needs and strengths of individuals and families; supporting each individual to live a fulfilling life, while preventing needs escalating, admissions or re-admissions to hospital and reducing pressure on services.

The Grant fund was administered by the Housing department in the Councils Housing, Employment and Infrastructure Area who work in conjunction with housing providers, social care and OT teams. Key interventions related to DFG are made through:

- Preventative interventions within the locality teams
- Trusted Assessments and early help/ preventative assessments
- Occupational Therapy assessment (aids, minor and major adaptations)
- Commissioned services from Wrekin Housing Trust (housing provider) and other providers to deliver adaptations
- Home Improvement Agency within the Council supporting adaptations including falls prevention support

In June 2016 a Housing Assistance Policy was adopted to show how DFGs and other related grants would be delivered to residents within the Borough. This also added an additional support through Wellbeing Assistance which provides up to £10,000 for those on passporting benefits that require work on their home which if not completed would mean they would be admitted into hospital or care or prevented from being in hospital or care.

In June 2017 TWC lifted the means test criteria from this grant for any client requiring a stairlift, enabling more clients to be supported and referrals are through occupational therapists or other health professionals.

The range of Grants is currently:

- Discretionary Disabled Supplementary Top Up Grant - adding to the current £30,000 to a maximum of £10,000
- Disabled Facilities Grant Investigation Grant - assisting applicants who need to carry out investigations prior to any adaptation work being able to be carried out, up to £10,000
- Wellbeing Assistance up to £10,000 for repairs to help

    - Enable a discharge from hospital when an applicant cannot be discharged because of an issue connected to their home
    - Prevent admittance into hospital or residential care because of an issue connected to their home
    - Prevent additional care being provided at home because of an issue connected to their home.

TWC continues to monitor the uptake of all the Housing Assistance policy and referral numbers for adaptations. Where financially possible, TWC will continue with the Wellbeing Grant with the benefit restrictions being lifted. This enables the installation of equipment, such as stair lifts and hoists, to be completed more quickly and support replacement of faulty equipment, discharge from hospital or a care setting and reduce the likelihood of admission to residential homes and hospital

Key stakeholders are involved in development of DFG expenditure through monthly review and planning meetings: Council Housing Solutions, Housing Design and Occupational Therapists, RSLs, private landlords and independent sector representatives. The meetings focus on timescales for completion of adaptations; planning and design issues; use of technologies to support independence and future planning

TWC are in the advanced planning stage of commissioning a review of DFG as part of supporting residents to remain living independently with a view to establishing a business case to increase investment to deliver long term cost savings through independent living and reduced reliance on health and social care services. While recognising the range of support, including access to DFG and grant related support, assistive technology, community alarms, aids and adaptations, TWC want to confident of maximise the offer of independent living particularly via DFG and grant related support both for existing residents and also to meet forecast future demand.

The main aims of the review will be to:

- Enable local vulnerable people to live as independently as possible, without the need for traditional care and support
- Provide an analysis of the support we are currently providing to enable independent living across all vulnerable groups particularly via DFG and related grant support
- Make recommendations for improvement or broadening of the offer where necessary including any supplementary provisions including step up/step down accommodation
- Map the internal process for identifying need/determining grant and delivery
- Recommend any necessary process changes to ensure it is as efficient and effective as possible.

- Showcase aspects of work we are doing well to extend independent living and the impact DFG/grant is having
- Understand the financial benefit/impact of supporting independent living to support business planning, investment decisions and external funding bids by the Council and its partners
- Support the development of a range of Council policies in relation to supporting independent living
- Make a significant contribution to the elements of the Council's Social Care Cost Improvement Plan (SCCIP) relating to supporting independence

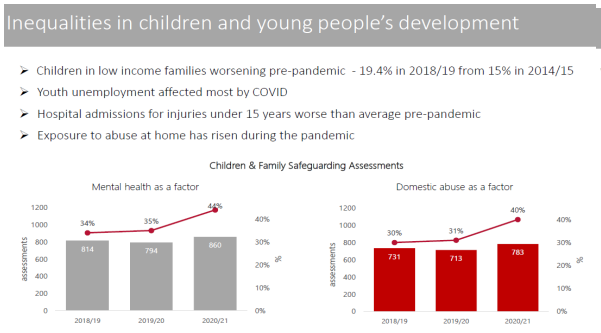
Equality and health inequalities.

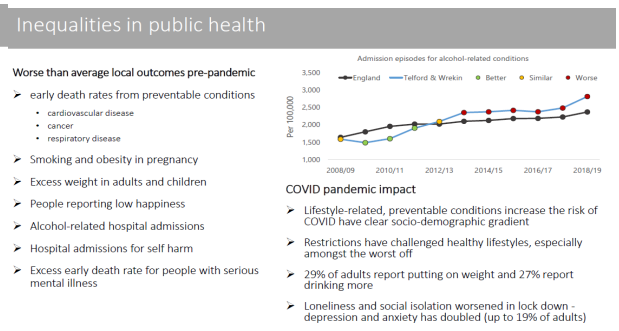
Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

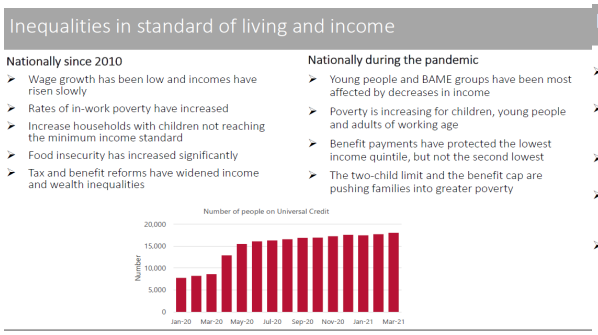
- **Changes from previous BCF plan.**
- **How these inequalities are being addressed through the BCF plan and services funded through this.**
- **Inequality of outcomes related to the BCF national metrics.**

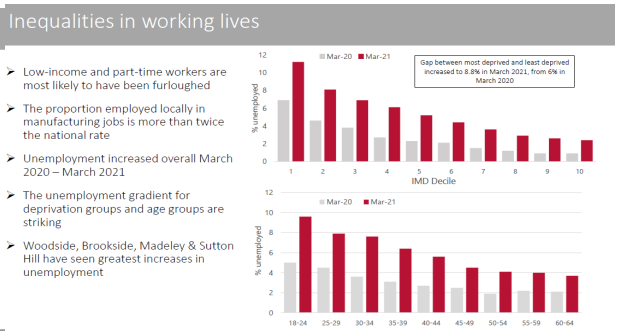
The impact of the Covid-19 Pandemic was seen to have impacted detrimentally in some communities in terms of health inequalities. The impact of Covid-19 on health inequalities was reviewed locally and issues highlighted across: (examples included)

- Children and Young Peoples development
- In Early Years; In Education and working lives
- Standard of living an income
- Places and communities including housing and homelessness
- Public Health including smoking, obesity, self-harm, well-being (loneliness and isolation), excess deaths for people with serious mental health









As well as the restoration of services inclusively, the strategic approach to inequalities was also further developed. The key priorities to addressing health inequalities, including the Equalities Act protected characteristics, is set out within the Telford and Wrekin Inequalities Plan 2021-2023, in line with the Marmot reviews. (Introduction and Health and Well-Being Strategic Context below). This was approved by the TWIPP in September 2021. This is an update on the previous Plan and Review of the Impact of Covid-19 on health inequalities.

Introduction

In 2021 there is compelling evidence of the need to reduce health inequalities. Build Back Fairer: the COVID-19 Marmot Review built on previous national reviews of health inequalities emphasising that the social, environmental and economic inequality in our communities that damages health and wellbeing had got worse in the 20 years before the pandemic.

All organisations and communities have faced an unparalleled challenge in responding to COVID-19. However certain communities and groups with longstanding health inequalities have been disproportionally affected. There are avoidable, and unfair differences in health between different groups of people, such as people from deprived areas and those from Black, Asian and minority ethnic (BAME) backgrounds.

The Black Lives Matter backdrop and the Commission on Race and Ethnic Disparities findings necessitate urgent action across many areas, including tackling health inequalities.

The Equality Act 2010 protected characteristics are clear context for health inequalities faced by some people, such as those with learning and physical disabilities.

The Health and Care Bill expects reducing health inequalities to be a mainstream activity in health and social care partnership integration.

Certain local health inequalities are already well known and can be tackled quickly. But we also need an approach to systematically identify inequalities which are currently less clear and then implement actions to narrow the gap.

This inequalities plan for Telford & Wrekin is the start of an ambitious way forward for tackling inequalities. The framework is based on the broad Marmot themes, recognising that the wider determinants of health impact on our local inequalities. A targeted, community-centered, intelligence-led partnership approach will be critical to our success.

Health & Wellbeing Strategy Context

Our Priorities

- Telford & Wrekin Integrated Place Partnership (TWIPP) priorities:
  - Building community capacity and resilience
  - Prevention and healthy lifestyles
  - Integrated response to health inequalities
  - Integrated advice, information and access to support
  - Integrated care and support pathways
- Drive progress on tackling health inequalities
- Improve emotional and mental wellbeing
- Ensure people's health is protected as much as possible from infectious diseases and other threats

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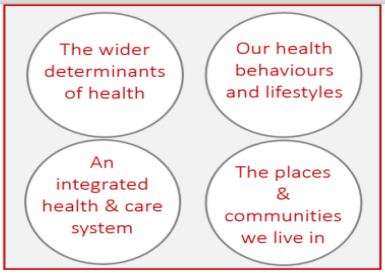
Delivering the Council Plan priorities - Protect, Care and Invest



population health framework

Our Outcomes

- Improve overall healthy life expectancy in men and women by at least one year by 2023
- Halt the increasing inequalities gap in healthy life expectancy, and continue to narrow the gap
- Narrow the inequalities gap in life expectancy for people with serious mental health problems

The drivers to systematically narrow the equalities gap are

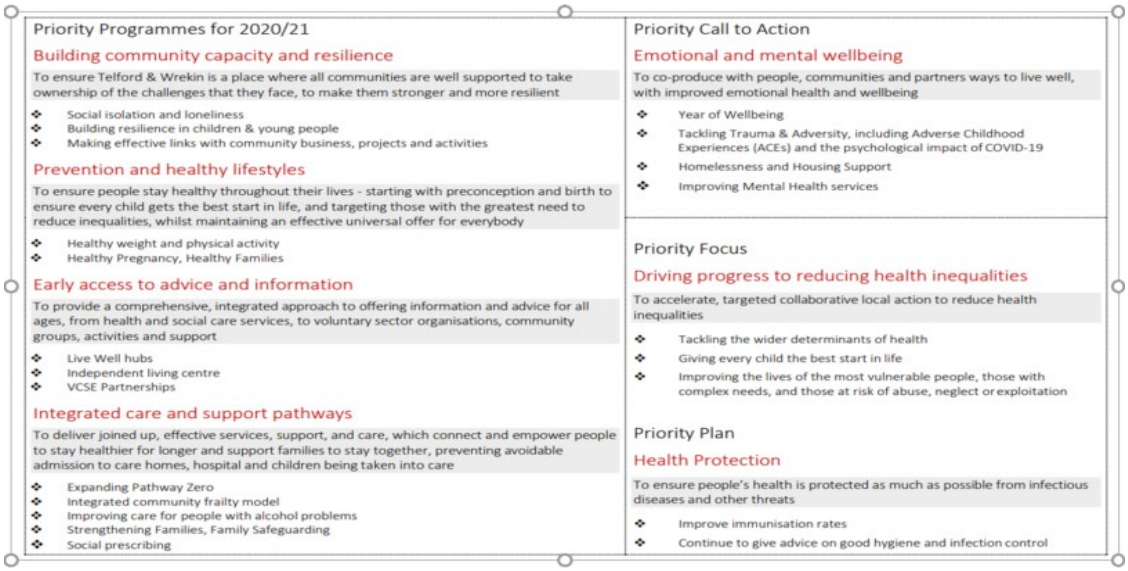
- Being Intelligence Led including population health management to drive local actions; understanding the factors that cause poor outcomes in different population groups including the Equality Act protected characteristics
- Community Centred Co-Production- using community –led approaches to help build connected and empowered communities
- Equitable Targeting of groups who are most at risk or underserved – reducing Inter-personal, Intra-personal, Community and access to service or transport barriers
- Place- based system-wide collaboration and systematic action at scale

The Themes of the Equalities Plan Framework have identified rationales, strategies and plans, priority interventions and Outcomes (summarised below from the Plan)

Best Start in Life	➢ implement a new smoke-free pregnancy pathway (as part of the NHS Tobacco Dependency Programme) ➢ expand initiatives to narrow the gap in school readiness and educational attainment for the most vulnerable children ➢ develop the enhanced parenting support for offer for those families most in need ➢ further develop bespoke, targeted support for young people who are NEET ➢ enhance emotional and mental health support for children and young people, especially those at most risk
Economic opportunity work, income, welfare, poverty, debt	➢ increase the number of people receiving welfare assistance (given Universal Credit cut from Oct 2021) – inc. older person's focus ➢ enhance community-based debt support e.g. through CAB – increasing the number of people who benefit from debt advice ➢ reduce unemployment rates in young people and those from BAME backgrounds ➢ improve employability support for people with learning disabilities
Community and Place	➢ further develop tailored wrap-around housing support for our most vulnerable residents / those facing homelessness ➢ enhance targeted interventions to reduce fuel poverty ➢ expand violence prevention initiatives such as mentoring in schools and targeted youth provision
Public Health and Prevention	➢ further develop the targeted approach of the Council's Healthy Lifestyles offer: • tier 2 weight management service for BAME community and people with a Learning Disability • whole-school approach to tackle excess weight in our most deprived communities • food poverty action – working with food banks • smoking support for people with mental health problems and those in routine and manual roles through workplaces ➢ NHS England – Health Inequalities and Prevention requirements e.g. smoking, weight management and alcohol
Health & Social Care Integration	➢ expand community and peer support for people with mental illness, learning disabilities and autism e.g.: • extend calm cafes • improve access to mental health services • reduce social isolation • improve the uptake of preventative health care • enhance the assisted technology offer
COVID-19 Impact	➢ continue to evolve the offer of COVID testing for both asymptomatic/symptomatic testing (LFT/rapid & PCR testing) in areas and groups where testing rates are lowest, through community venues and community champions ➢ develop a sustainable delivery model to improve uptake of COVID immunisation in those most at risk, including a comprehensive programme immunisation pop up clinics at accessible workplace and community venues ➢ NHS to restore services inclusively – e.g. improve early diagnosis of cancer and screening programme uptake in those most at risk

The Telford and Wrekin Inequalities Plan reports through TWIPP to the ICS Population Operational Board.

The previous Inequalities Priorities Programme (20/21) is below:



A specific thematic review of the BCF contribution to tackling inequalities took place in July 2021. This identified that specific inequalities were addressed through the BCF plan and services funded:

- Older People Strategy development with wide stakeholder engagement including protected characteristics
- ILC enhancing the access and information to those with sensory and dual impairment; improved accessibility through the town centre location; community led approaches as accessible as a community resource to utilise during the day, evenings and weekends
- Person-centred planning

- Maximising potential for admission avoidance – separation from families and communities
- Funding group to increase access to non-statutory community services for three protected characteristics
- Reviewing admission rates and reasons for individuals with presentations of Dementia in order to target approaches to improve outcomes
- Community MDT and risk stratification.

Conformation that components of the Better Care Fund that are earmarked for a purpose are used for that purpose

Annual planning, monthly reporting, development of Schedules within the Section 75 Agreement set out the expenditure across schemes and programmes. Below set out the summary for 20/21.

What the BCF funds and delivers

BCF Budget lines 2020/21		Comments
Intermediate Care	**£7,522,187**	
Rehabilitation and Enablement		Shropshire Community Trust therapists TICAT function support admission avoidance, discharge from hospital and Integrated Discharge Hub (IDT)
Domiciliary Care		Budgeted 47,000 hours. Currently forecast over 53,000 hours driven by FFA and admission avoidance increases CCG funding of Supreme Bridging service to support rapid discharge from hospital
Rehabilitation and Enablement Beds		Commissioned 43 block beds and 7 spot beds in 2020/21. GP Enablement medical support Utilised additional 40 covid funded; 20 designated settings and 16 winter beds
Shropshire Community Healthcare Trust		Aligned to SCT services including Rapid Response, Single Point of Referral, community and specialist nursing teams
Shrewsbury and Telford Hospital Trust		Aligned to SATH rehabilitation, supported discharge of stroke patients eg ESD, SATH neuro-rehab clinics and therapists
Community Resilience	**£996,311**	
Preventative Services		CCG Grants contribution to Age UK and Stroke 6 and 12 month reviews
Carers		Carers Contact Centre, specific Carers support roles, Emergency Support, Carers respite and Admiral Nursing
LA Grants		Grants (Commissioned services) includes Age UK and Information and Advice Contract (WIP)
Neighbourhood Care	**£4,386,498**	
Rehabilitation and Enablement		OT provision to deliver preventative interventions, Carer Moving and Handling, post Reablement reviews and DFG assessments
Assistive Technologies		Provision of technology enabled care to support sensory and physical impairment and AT Lead post. Funds Pill boxes; Community alarm provision and contract and Community Equipment Stores contract. Identified additional technology enabled care for 2 Carers in a Car
Preventative Services		Funding of Access Team (Family Connect); triages and directs referrals including to HSCRRT, Localities and OT Funds some Locality workers and Support Workers links to Supporting People
Shropshire Community Healthcare Trust		Aligned to community and specialist nursing teams and therapists
Other Care	**£11,445,021**	
iBCF and Winter Pressures Grant		Includes funding for additional SWs, OTs, Matron, Independent Assessor and Brokers Also funds domiciliary care bed price increases to ensure robust provision.
Maintaining Eligibility for LTC Clients		Supporting client care. Costs to the Council for this identified group is £3.1m
Programme Management		CCG monies aligned to specific PMO monitoring, finance, performance analysis and reporting, Quality Monitoring
Care Act Implementation		Range of required provisions including Information and Advice, Advocacy contracts, implementation of Safeguarding Board, training SWs in the legal process, specialist mobility assessments
Disabled Facilities Grant		Aligned to specific regulations in home adaptations. Increased utilisation and some budget pressures this year.
Grand Total:	**24,350,017**	

TWIPP – 22.04.2021

Similar work has been carried out this year with values attributed for the budget lines/ schemes including:

- Implementation of Care Act duties
- Funding dedicated to carer-specific support
- Reablement

The report is presented at TWIPP and part of the detailed submission and monitoring to HWBB.