HM Government

NHS England

BCF narrative plan template

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

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

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

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

Cover

Health and Wellbeing Board(s).

The Telford & Wrekin Health and Well-Being Board (HWBB) has formal oversight over the Better Care Fund. The HWBB has formally agreed for the Chair of the HWBB to have delegated authority to approve the submission on behalf of the Board.

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

The Better Care Fund (BCF) Plan has been jointly developed and agreed between NHS Shropshire, Telford and Wrekin Integrated Discharge System and Board (ICS/ICB) partners and Local Authority through the BCF Board, aligned work programmes and governance arrangements

Bodies involved include:

- Telford & Wrekin Council
- Telford & Wrekin Integrated Place Partnership (TWIPP, which has representation from the ICS),
- Shropshire and Telford Hospitals Trust (SaTH),
- Shropshire Community Health NHS Trust (SCHT)
- Independent Sector providers
- Shropshire Partners in Care - representative body for independent sector providers
- Voluntary and Community Sector providers
- Midlands Partnership Foundation Trust (MPFT)
- Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH)
- Healthwatch Telford and Wrekin
- Patients and Experts by Experience

How have you gone about involving these stakeholders?

The Plan demonstrates a clear integration with the place based board (TWIPP), the wider system Shropshire Telford and Wrekin ICS Urgent and Emergency Care Improvement Plan and the ICS' Local Care Transformation Programme

The BCF plan was initially developed and agreed within the BCF Board as part of annual planning. Representation on the BCF Board includes the Council, ICB, SATH and SCHT.

Development of the Plan and key metrics were considered with multi-stakeholder system meetings (representatives from organisations indicated above) including the System Discharge Alliance, Urgent Care Operational Group and Urgent Care Board, Local Care Transformation Programme and TWIPP.

The proposed Plan was subsequently presented to TWIPP for agreement on 15 June 2023. TWIPP has representation from the Council (including Public Health), the ICS, SATH, SCHT, MPFT, Primary Care Networks, the independent and VCS sector; Healthwatch, Shropshire Partners in Care.

Planning Requirements, Templates and Narrative Plan were shared through a weekly BCF planning group through April -June 2023.

There has been strategic and operational involvement from Healthwatch, Shropshire Partners in Care (SPIC), the voluntary and independent sector includes membership and representation in HWBB, TWIPP, the System Discharge Alliance, Ageing Well Partnership 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 Network.

The ICS has a Memorandum of Understand with the VCSE across Shropshire, Telford & Wrekin. The Memorandum of Understanding (MOU) sets out why the Shropshire, Telford and Wrekin (STW) Integrated Care System (ICS) values the role of the Voluntary, Community and Social Enterprise (VCSE) sector in improving health, social care and wellbeing in this area, and explains why we wish to work in partnership on shared ambitions. In signing the MOU each party has committed to building on the strength of existing relationships and working within a set of agreed principles.

TWIPP receives regular formal reporting as part of the BCF governance relationship. Formal approval of the BCF Programme is through th1-2 e Health and Well-Being Board (HWBB).

Governance

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

The BCF programme has been developed through a number of meetings, groups and system processes. Clear processes have been developed to share local commissioning strategies in order to identify commonalities and address strategic issues across the Place and wider health and social care economy eg Local Care Transformation Programme and Urgent and Emergency Care programmes

The BCF Board is made up of senior representatives from the Council, ICB, SATH and SCHT. The latest Terms of Reference 2020/21 excerpt and Governance chart included) (These are due for update by the end of Q2)

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

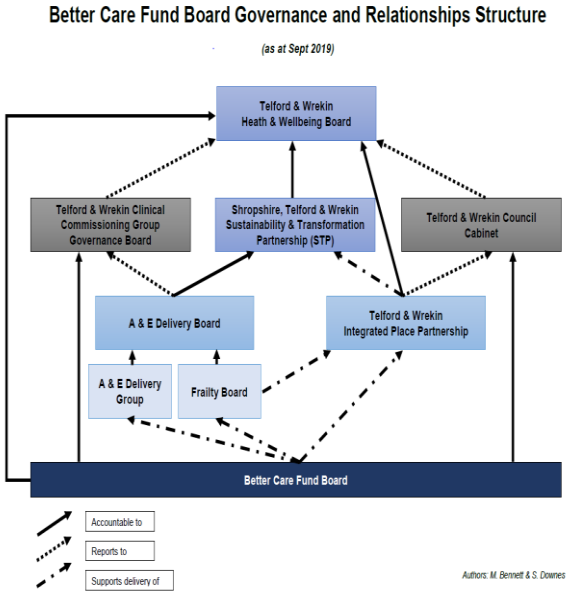
The membership of Board will be:

15

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

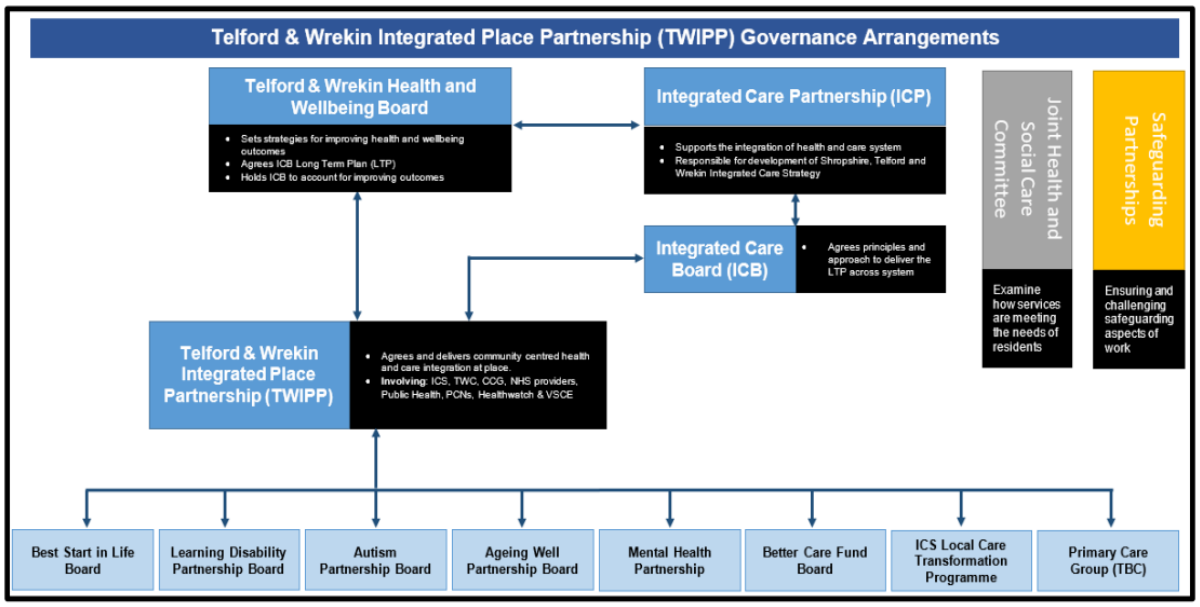
Telford and Wrekin Council
Director – Governance, Procurement and Commissioning
Director - Health & Wellbeing
Service Delivery Manager – Finance
Service Delivery Manager – Governance, Procurement and Commissioning
Service Delivery Manager – Enablement

Shropshire Community NHS Trust
Telford Locality Manager



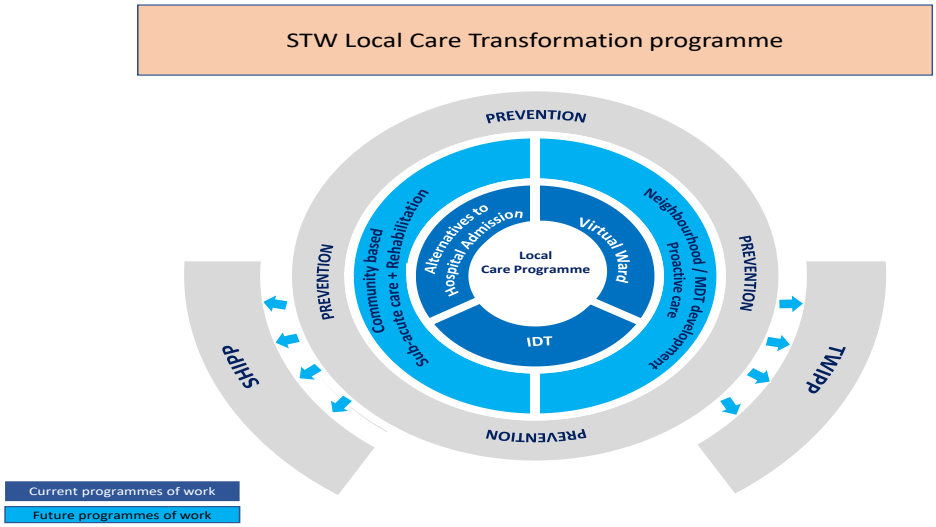
BCF Board formally reports to the Health and Well-Being Board (HWBB) via to TWIPP. This include through a combined Programme and performance reporting Dashboard and regular full programme updates

TWIPP provides formal updates of the BCF programme to HWBB. In, addition, regular periodic formal BCF updates are presented to HWBB including the BCF Plan for formal approval and end of year update.



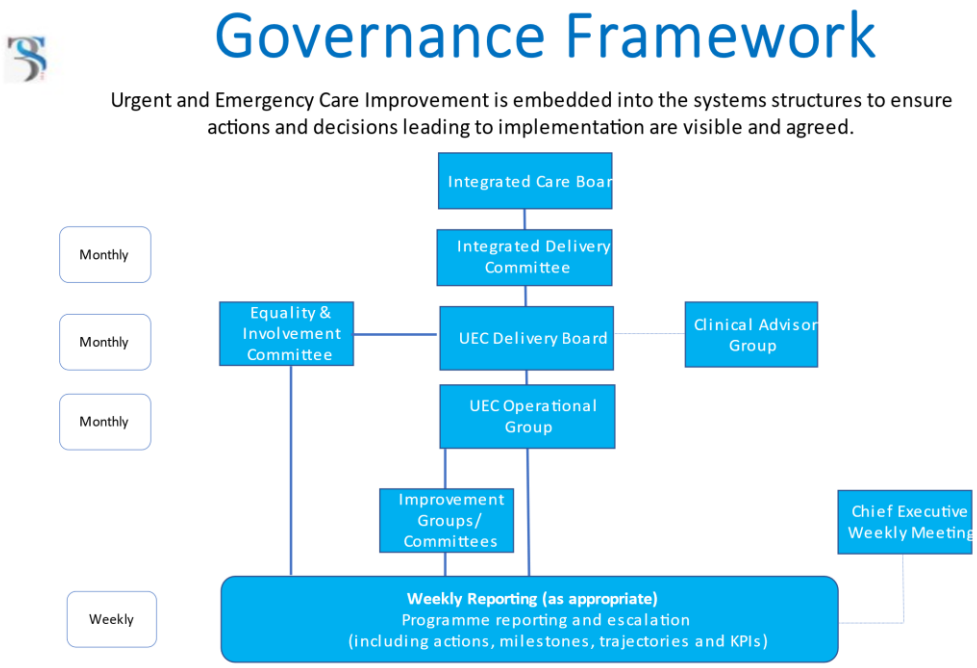
TWIPP is the Place Based Board with an agreed plan and ongoing work will create an integrated health and care system, working as a multi-organisational partnership both in terms of planning and commissioning services across the Place. Like the ICS, TWIPP seeks to integrate care system partners across Local Care Transformation and Urgent Emergency Care in order to 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.

The Local Care Transformation programme (below) illustrated the connectivity of the Place and Local Care programmes including admission avoidance, Virtual Ward and Neighbourhood MDT working



The Urgent Care programme is the key delivery mechanism for delivering targets related to discharge. The Urgent Care Group and System Discharge Alliance support the strategic planning and operational delivery. Governance for this programme is below. Connectivity between TWIPP, Local Care and Urgent Care is formally reported through the ICB Board as

well as operationally through joint working. Successful delivery is reliant on the integrated and aligned strategic planning and operation delivery, which is in place.



Executive summary

This should include:

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

The Better Care Fund (BCF) Plan continues to be jointly developed and agreed between Shropshire, Telford and Wrekin Integrated Care System (STW ICS/ ICS) and Local Authority through the BCF Board, TWIPP and and partner organisations across statutory and the independent and voluntary sector.

The BCF programme seeks to maintain and further the strength-based, person-centred approaches of the previous programmes. Personalised approaches are a fundamental principle that needs to be embraced within integrated working.

There has been effective local developments and The Plan continued to bring together joined up and integrated planning, delivery and commissioning with the Place based Boards, Local Care and Urgent and Emergency Care system plans through agreed Governance arrangements. The development of the Integrated Care Board has further provided a system-wide focus on collaboration and integration through the Joint Forward Plan.

The BCF programme for 2022/23 continued to evolve. The Programme workstreams and schemes funded by the BCF have maintained integrated team working, approaches and planning. It also further embedded within and alongside Place-based, Local Care Transformation and Urgent and Emergency Care work streams. Specific and shared priorities of the system can be clearly through:

The Health and Wellbeing Board strategy has been refreshed in June 2023 with its key approaches focus on:

- Population health
- Tackling inequalities ies and improvement in population
- Strong focus on prevention
- Person-centred care and support

Preventative approaches have been further established including Healthy Lifestyles Hubs, Social Prescribing, Care and Community Navigators to support and signpost, acccessible information through Live Well Telford, accessible Information and Advice from the commissioned First Point of Contact, Well-Being Independence Partnership first point of contact for information and early help including Trusted Assessors for equipment

The Independent Living Centre has been further developed delivering access to Assistive ad digital Technologies including community alarms, predictive technologies, Early Help appointments, OT assessments for aids and adaptations, a community Hub for Voluntary Community Sector groups to meet, assessments for Pathway Zero and pathway 1 referrals

Assistive technology development has been further developed. Working with a domiciliary care proving overnight care, a digital device allows the cared for to notify the care provider during the night when they require assistance such as personal care. Without the device and associated service, the individuals would likely need residential care or full overnight care.

The Health and Social Care Rapid Response Team (HCSRRT) is now fully established an alternative to hospital, supporting at the right time, at the right place in the right way. The Virtual ward has also been establishing itself

A Falls prevention pilot was developed and delivered as a winter scheme to reduce harms from long lying while waiting for an ambulance. The Pilot utilised the local Non-Elective Patient Transport Service providing an alternative response to West Midlands Ambulance Service for non-injurious falls. After the NEPTS assessment they could refer directly to HSCRRT for interventions.

In addition, Fit4Fall, a specialist independent sector provider, delivered postural stability programmes within local communities to maximise opportunities for improved mobility and reduce risk of falls.

The Integrated Discharge Team (IDT) has been further embedded; more closely aligned with the acute hospital flow processes; implementation of MADE events so they are now embedded as Business as Usual. Social Care more closely aligned to wards so can support early discharge planning through ward / Board round and MDT attendance.

High Impact Change metrics were aligned to the review of the 100 Day Challenge Best Practice initiatives to develop an action plan; improve flow initiatives. Developing services over 7 days and reviewing delayed discharge as 'Harm' were key outputs.

BCF programmes are monitored and reported within a performance dashboard to the BCF Board on a monthly basis. Programme performance is RAG rated at year end position below

BCF programmes 2022/23		
Maximise potential for admission avoidance including Hospital at Home / Virtual wards		•Resources within and supporting Health and Social Care Rapid Response Team (HSCRRT) and Virtual ward •Pathway development includes HSCRRT •Monitoring demand for domiciliary care for VW
Enhance integrated working of Community Teams – integrating TICAT, IDT, HSCRRT, Frailty Team, Care Home MDT, Virtual wards into streamlined functions to maximise discharge		•TICAT aligned to the Urgent Care programme supporting discharge from hospital, admission avoidance and Virtual Ward and fully engaged in services developments •Intermediate care model developed •Joined up approach to Pathway Zero linking acute leads to ILC and independent sector First Point provider
Maximise Proactive Prevention approaches to reduce/ delay use of statutory services		•TWIPP programme in place •Resources aligned to Proactive Prevention includes Housing and tenancy support for vulnerable groups and older people; Grant funding for Care Navigators, Day Centres and 6 Month post Stroke reviews; •ILC offer expanded to support early support for Pathway Zero and Pathway 1 as well as providing advice, early help, WIP/ CVS assessments, Assisted Technology, Virtual House, Sensory assessments, Early Help Hubs, Trusted Assessors for equipment and minor adaptations and OT assessments; •Live Well Telford and Well-Being Information Partnership information and advice.
Develop the Older People strategy		•Stakeholder workshops held and Steering Group with wide statutory and non-statutory stakeholder representation •Position Statement published with public consultation planned
Integrate HICMs to urgent care delivery ie Hospital Improvement/ Flow workstream		•HICMs integrated into the System Discharge Alliance work programme •HICMs reviewed within the 100 Day Challenge programme of work •SDA action plan in place and reporting to Urgent Care Delivery Group.
Develop options for delivery of a sustainable Intermediate care function (including beds, Enablement interventions; key outcomes)		•Intermediate Care Business case develop in July 2023 •Further reviews of BCF expenditure carried out with potential Business case completion post further review •Local Care Transformation review to include Intermediate Care development ing
Re-commission domiciliary care provision to maximise resources and meet increased demand		•Re-commissioned domiciliary care provision. •Capacity considered as part of STW demand and capacity modelling

The BCF Board has supported the BCF programme for 2023/25:

- Development and delivery of the Integrated Discharge Model and D2A approach
- Support acceleration of delayed discharge HICMs through further integrated working
- Support the maximisation of admission avoidance and Virtual ward
- Support Proactive Prevention Care programmes to maximise independence at home

- Enhance voluntary sector involvement in supporting independence and alternatives to statutory care
- Aligning capacity to meet demand
- Maintain and sustain provider market capacity

National Condition 1: Overall BCF plan and approach to integration

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

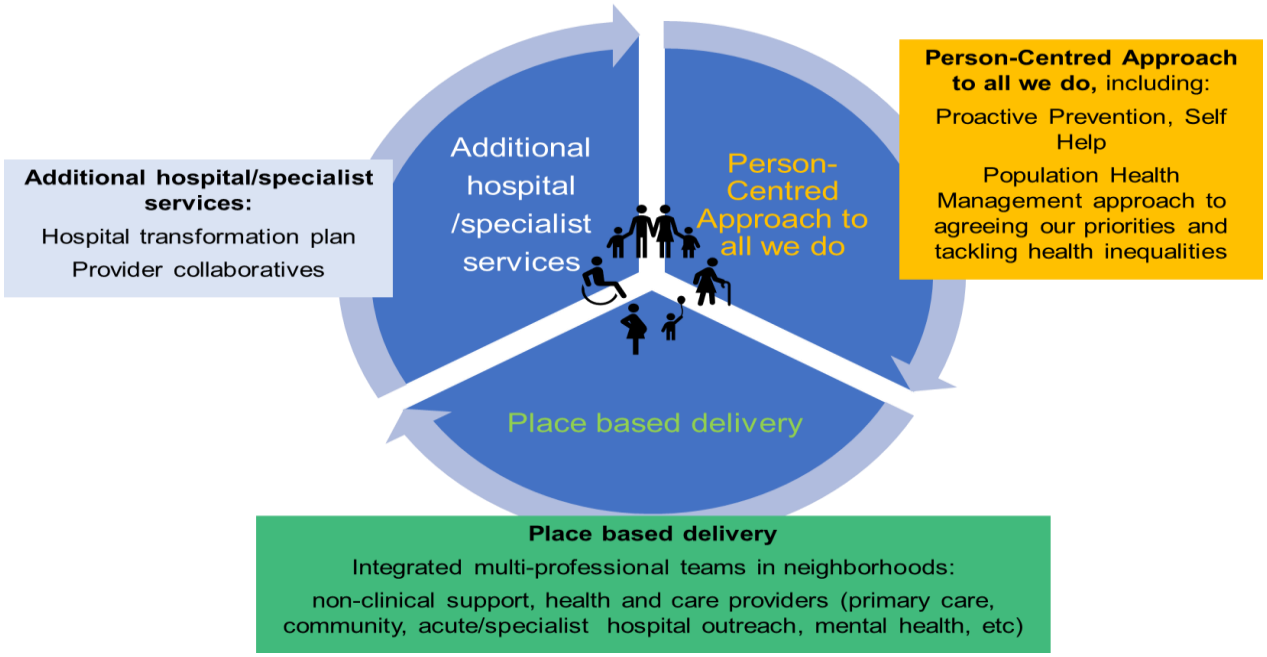
- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will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

The BCF programme is delivered through the governance of the BCF Board, strategically planning and operationally in partnership to deliver agreed programmes and outcomes. Key delivery mechanisms include a:

- Joined up approach to commissioning and delivery
- Integrated planning and operational delivery
- Strength-based, person-centred approaches across all services and access points from prevention, early help, community and acute care
- Personalised approaches as a fundamental principle
- Co-production within service planning and delivery

Equally, integration is central to the strategic and operational delivery within STW in order to transform services. This is set out with the STW Joint Forward Plan 2023-2028 (below) and sets out how the health and care system will work together to deliver agreed priorities through three key elements:

- Taking a to all Person-centred approach we do, including proactive prevention, self-help and population health to tackling health inequalities.
- Improving place-based delivery, having integrated multi-professional teams providing a joined-up team 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 (HTP).



The joined up approach of the BCF and system priorities can be clearly seen through the inter-connectivity of the BCF programme and schemes are aligned across:

- Place Based programme through the TWIPP strategic plan 2022-25
- STW Local Care Transformation Programme 2023-25
- Urgent and Emergency Care Priority Plan 2023-25

The TWIPP Strategic Plan 2022-25 set out the Place-based Delivery partnerships; System priorities and Enablers to support the Areas of Focus-clearly aligned to the System Plan.

Place based delivery partnerships	• Best Start in Life Board • Learning Disability Partnership • Autism Partnership • Ageing Well Partnership	• Mental Health Partnership • ICS Local Care Transformation Programme Board • Better Care Fund Board	• Primary Care Group (TBC)
System Priorities	• Prevention • Transforming Clinical Pathways	• Hospital Transformation Programme (HTP) • Local Care Transformation Programme	• Workforce • Value for money
Our Enablers	• Workforce • Population and Business Intelligence • Digital and Technology Enabled Care	• Housing, Estates and Planning • Finance • Commissioning	• Quality Assurance • Communication and Engagement

The Overview of the Population Health Priorities, Inequalities Priorities and Health and Care Priorities across Shropshire, Telford and Wrekin and the ICS within the STW Joint Forward Plan 2023-2028 below further highlights the strategic commitment to integrated working.

Telford & Wrekin Health & Wellbeing Board proposed Priorities	Telford & Wrekin Integrated Place Partnership (TWIPP) Priorities	Shropshire, Telford & Wrekin ICS Priorities	Shropshire Health & Wellbeing Board Priorities	Shropshire Integrated Place Partnership (ShIPP) Priorities
Population Health Priorities				
Best Start in life • Start for Life Family Hubs	Best start in life	Best Start in life	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' strategy
Healthy weight	Healthy weight	Healthy weight	Healthy Weight and physical activity	Prevention/healthy lifestyles/healthy weight
Mental health and wellbeing	Mental Health, Learning Disability & Autism	Mental wellbeing and mental health	Mental Health	Mental Health
Prevent, protect and detect early	Reducing preventable diseases through early diagnosis, screening, immunisation, and improving reach of services	Preventable conditions – heart disease and cancer	-	-
Alcohol, drugs and domestic abuse	-	Reducing impact of drugs, alcohol and domestic abuse	-	-
Inequalities Priorities				
Inclusive resilient communities Housing and Homelessness	-	Wider determinants: • Homelessness • Housing • Cost of living	Working with and building strong and vibrant communities	Community capacity & building resilience within the VCSE

Economic opportunity				
Prevent, protect and detect early Closing the gap Starting well - Living well – Ageing well	Core 20plus5 and reducing barriers to access	Inequity of access to preventative care	Reduce Inequalities Improving population Health	Tackling health inequalities
Closing the gap – deprivation – equity – equality - inclusion	-	Deprivation and rural exclusion	• Reduce Inequalities • Improving population Health	Tackling health inequalities
-	Reducing barriers to access	Digital exclusion	-	-
Health and Care Priorities				
-	Proactive prevention Local Prevention and early intervention services	Proactive approach to support & independence	-	-
Integrated neighbourhood health and care • Primary care • Closing the gap	Local Care transformation (includes neighbourhood working)	Person-centred integrated within communities	Joined up working	Local Care and Personalisation (incl. involvement) Integration & Better Care Fund (BCF)
-	Older adults and dementia	Best start to end of life (life course)	-	-
Best Start in life: Start for Life Family Hubs, social emotional & mental health, SEND	Best Start in Life SEND & transition to adulthood	Children and young people's physical & mental health and focus on SEND	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' strategy
-	-	Mental, physical and social needs supported holistically	-	-
-	Accessible information, advice and guidance	People empowered to live well in their communities	-	-
-	Primary Care access and integration, place-based development in line with the Fuller report	Primary care access (General Practice, Pharmacy, Dentists and Opticians)	-	Supporting Primary Care Networks
-	-	Urgent and emergency care access	-	-
-	-	Clinical priorities e.g. MSK, respiratory, diabetes	-	-

Commissioning collaboratively across health and social care as a system enables benefits to be realised including improved outcomes and experiences for people, reduced duplication, best use of resources and improved access to services. Joint commissioning arrangements further supports Integration; focussing on the on the collective expertise and the NHS and

Local Authority to support strategic planning and commissioning of services and building on the strengths of people and communities as a cornerstone of commissioning arrangements.

Joint commissioning will seek jointly to design and invest in pathways which are person-centred and hold organisations jointly accountable for the overall experience of individuals and families. Commissioners will also engage people with lived experience, communities, and professionals in order to set out the overall priorities for an area and designing pathways which reflect local needs and opportunities.

The core of the Joint Commissioning model is people and communities, with public services working together to support people to build the foundations for a healthy and fulfilling life. The model below, within the STW Joint Forward Plan demonstrates this people and community centred approach that is echoed throughout all the Integrated Care System's work.

Joint Commissioners will develop performance management frameworks which consider quality of individual services and the extent to which people experience integrated, high-quality care. Joint Commissioners will use the financial and workforce resources available across organisations to support local populations in the most effective means possible. Joint Commissioners will reflect and potentially identify areas of joint working in more detail during 2023-24 with the aim of aligning and/ or integrating identified services in the way in which they can be (re-)commission via the BCF and deliver via Place by year 2 (2024/25).

The Better Care Fund (BCF) enables this joint working and a focus on local priorities at place-based level.

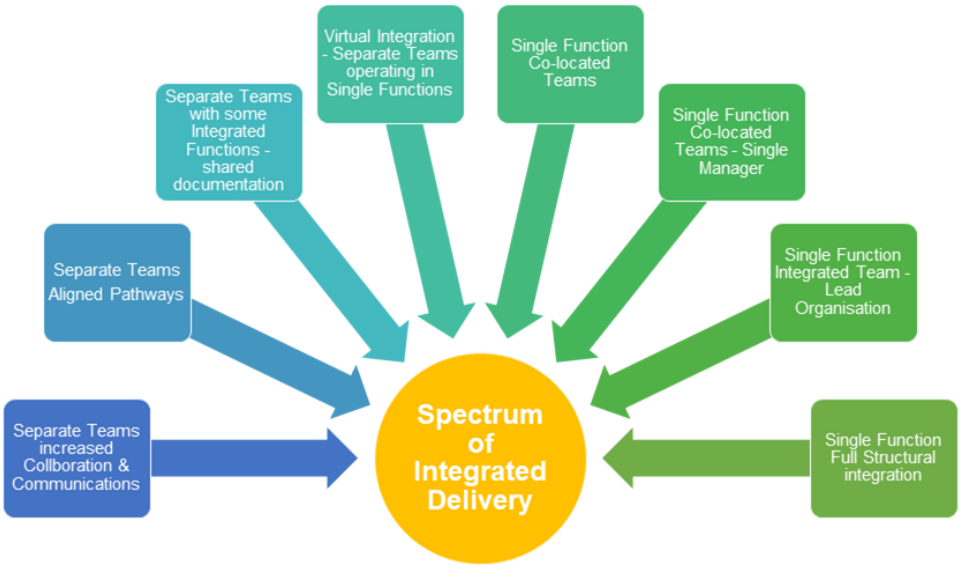
As well as the BCF schemes, identified programmes for 2023/24 will support Place-based; Local Care Transformation and Urgent and Emergency Care priorities:

Programme	Place	Local Care	Urgent Care
Development and delivery of the Integrated Discharge Model and D2A approach			x

Support acceleration of delayed discharge HICMs through further integrated working			x
Support the maximisation of admission avoidance and Virtual ward		x	x
Support Proactive Prevention Care programmes to maximise independence at home	x	x	x
Enhance voluntary sector involvement in supporting independence and alternatives to statutory care	x	x	x
Aligning capacity to meet demand	x	x	x
Maintain and sustain provider market capacity		x	x

Integration is equally seen as essential at a system level. The STW Joint Forward Plan 2023-28 highlighted that integration is central to transformation planning and development as it is the to the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy and independent lives and can improve outcomes for the population. This is key to receiving care and support 'the right care, in the right place, at the right time'

Integration can be seen as a spectrum, ranging from increasing collaboration and communications between separate teams/organisations, through to a single organisation with a single function and full structural integration. The maturity integration spectrum below highlights this range where programmes can be reviewed to maximise the potential for integration.



National Condition 2

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

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

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

Enabling people to stay well and independent at home for longer has been a principle tenet of the BCF throughout its life. TWIPP takes the strategic lead, as the Place-based approach in:

- Reducing health inequalities
- Promoting healthier lifestyles through a number of initiatives including Social Prescribing
- offering a range of early help in terms of information, advice, advocacy and support, through Live Well Telford , Well-being Information Partnership
- Independent Living Centre
- Virtual House for aids and adaptations ss independent sector providers and with statutory services
- Preventative services
- Supporting independent sector providers to offer local community based support

Preventative Services include:

- Live Well Telford
- Healthy Lifestyles Hubs
- Social Prescribers offering range of support for long term conditions by linking into local communities
- Care and Community Navigators to support and signpost to support groups within local communities
- Accessible information Advice through Live Well Telford
- Accessible Information Advice and Advocacy from the Well-Being Independence partnership first point of contact for information and early help including Trusted Assessors for equipment
- Access to Assistive Technologies including community alarms, predictive technologies
- Early Help appointments and OT assessments for aids and adaptations within the Independent Living Centre- a town centre location for ease of access.

- Voluntary Community Sector offering range of community support in local communities access directly or through voluntary organisations or statutory services
- Housing related support for vulnerable groups including homeless and tenancy support
- Falls prevention
- Housing related support and older people within tenancies including Trusted Assessors for equipment and minor adaptations
- Digital Hub for virtual calls for assessment or support
- OT assessments for equipment and adaptions at home
- Carer Moving and Handling assessments
- Ageing Well strategy- a Place and Local Care approach to enable older people to live well and independently for as long as possible

The Independent Living Centre promotes self help for aids, adaptations and assistive and digital technologies as a drop or by appointment. The Virtual House is an interactive tour showing examples of Occupational Therapy, Assistive Technology and Sensory aids, equipment and solutions in situ within a normal house that may be helpful for daily activities around the home. The Virtual House still received nearly 270 visits a month since launch in August 2020.

In addition, specific technologies to support independent living is also available to health and care staff to access directly for assessed needs:

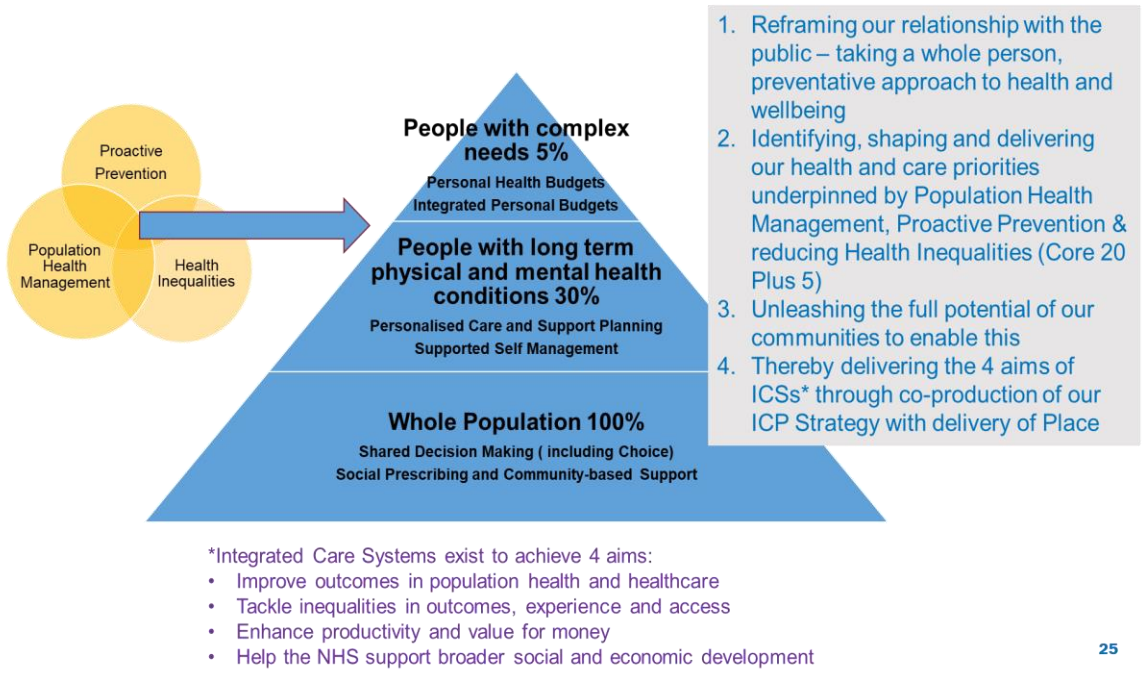
- Memo Minder
- Door sensor
- Motion sensor
- Motion sensor light
- Rosebud Reminder Clock

By 2025, all homes in the UK will have their landlines switched to a digital line. It is a particular concern for individuals who have a Community Alarm to call for help in urgent situations, such as a fall or episode of ill-health. Currently individuals in receipt of a Community Alarm have an analogue system. Once their communications provider has switched them over to a digital line in to the home the analogue unit will not reliably send the alarm call through to the monitoring centre.

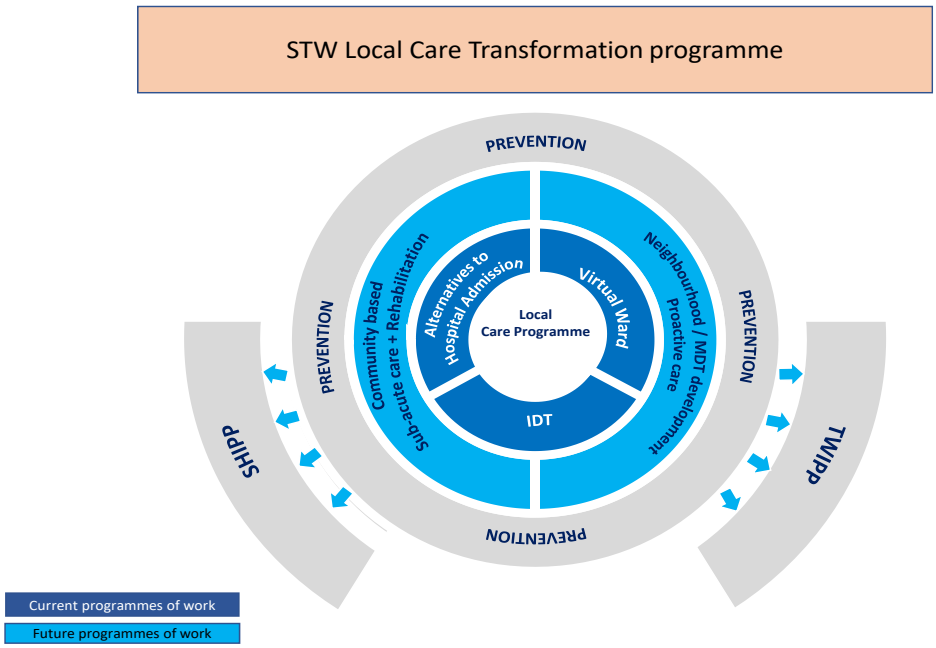
A project has been underway to procure a new provider of telecare and in June 2023 a programme to switch all of our current customers to the new digital service began. By end Sept 2023 everyone will have been switched to the digital service.

The digital equipment that has been procured will ultimately provide a platform that can grow with the needs of the individual. It has the capacity to monitor the home environment via different sensors and provide 'insights' into changes in peoples routines. It will enable support to be preventative and proactive, as well as reactive.

Person-centred care approach is a Local and STW priority. The STW Forward Plan indicated that '*We are committed to working with service users, carers and partners to support our citizens to live healthy, happy and fulfilled lives. This will mean supporting people to proactively look after their own health where possible, putting a greater emphasis on preventing illness and staying well, but also providing the right care when and where they need it.'*



Strength-based, person-centred approaches and personalised approaches are a fundamental principle of delivery to users of service. We have worked with the National Development Team for Inclusion (NDTI) and Making It Real Board for a number of years to develop those principles into practice, staff training, supervision, Peer Reviews. Services are commissioned to adopt those principles.



Approaches and interventions to enable people to stay well at home for longer at a Local Care level include:

- Principles and approaches to Proactive Care
- Strength-based, person-centred and personalised approaches
- Local Care Transformation programmes
    - Admission Avoidance
    - Virtual Ward

The Local Care programme is a key transformational programme for the ICS, bridging Place-based workstreams and Urgent and Emergency Care priorities. Local Care programmes aim to develop preventative integrated service, model of care and approaches that support people in their normal place of residents- maintaining people at home for longer.

The Local Care Transformation programme supports Proactive Care which builds on strength based approaches and personalisation. The targeted approach supports population risk management through risk stratification and case management. The programme is collaborative – engaging all partners to be engaging in planning meetings.

The approach to Proactive Care is being revised to Benchmark against the draft Operating Framework and current delivery approaches. The Intention is to build on and develop a Proactive Care approach that has:

- A common vision that is centred around a person's strengths and community assets, self-care and early intervention and advice (preventing escalation of needs).
- Common language and clear communication messages.
- A shared culture with a shared set of values, standards, and beliefs.
- Consistent ways of working and consistent decision making.
- Multi-agency intelligence from a variety of sources to support and inform decision making.

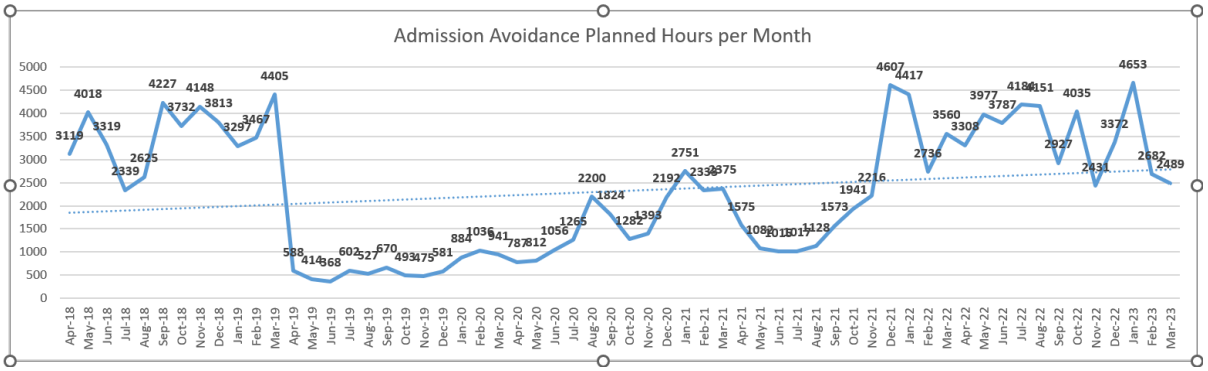
Maintaining people at home is a fundamental principle and wanted by the vast majority even when very ill or conditions deteriorate. Admission Avoidance supports people to stay well, safe and independent at home for longer and be supported at the right place and the right time in the right place.

The Admission Avoidance team, Health and Social Care Rapid Response (HSCRRT) is a well-established, co-located and integrated team. It integrates and co-locates Community nurses, therapists, Social Workers, paramedics, non-medical prescribers and Call Handlers. Referrals come from a range of agencies including GPs, West Midlands Ambulance, 111, Family Connect, community NHS and Social Care teams, care homes and the independent and voluntary sector.

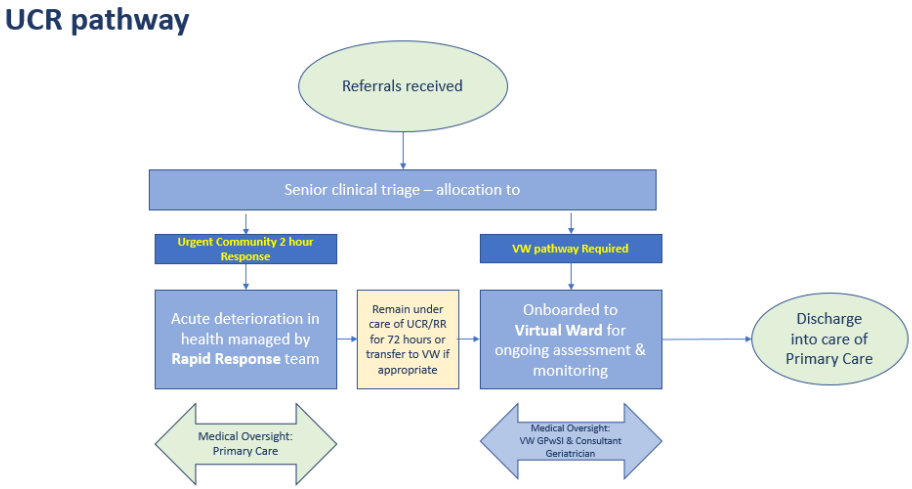
The team respond within 2 hours of referral and have processes in place to directly access to procure beds where needed to avoid and admission and access to domiciliary care out of hours and Planned overnight Care (Two Carers in a Car). The team works closely with West Midlands Ambulance Services, primary care. acute and community hospital who can be maintained at home including when admitted to ED, AMU, CDU, DSU where they do not need admission.

Interventions for up to 72 hours will determine the need for further interventions including Virtual Ward or Intermediate Care interventions in order to regain and maximise independence. Up to 95% of referrals remain at home for interventions

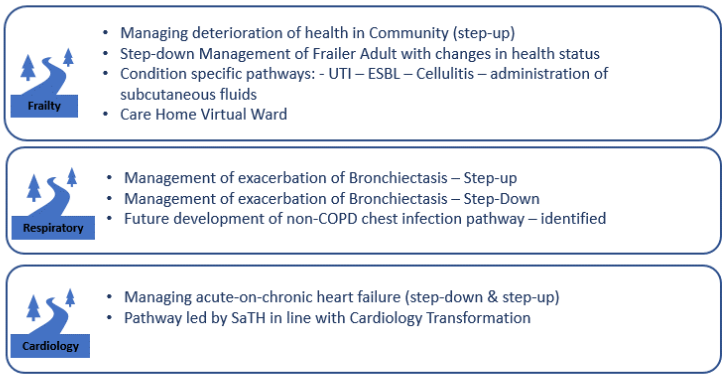
Care alternatives for admission avoidance include bed based and domiciliary care based Intermediate Care which may include Night Sitting or Planned Overnight Care. Bed based alternatives have continued to average four beds at a given time. Domiciliary care demand has increased as an alternative to hospital as overall referrals for admission avoidance have increased.



The Local Care Transformation development of the Virtual ward within STW has been developed in line with national guidance. The pathway is set out below



Pathways



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

Digital monitoring is provided through Docobo, that enables self-reporting of physical observations. This is monitored by clinicians.

Individuals can remain within the Virtual ward for up to 14 days. Additional work is being carried out to consider the relationship between Admission Avoidance, Virtual Ward and Intermediate Care

National Condition 2 (cont)

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

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

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

Summary section (capacity - demand)

Hospital Discharge	Annual Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Social support (including VCS) (pathway 0)	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement at home (pathway 1)	-777	30	-67	-67	-67	-67	-67	-67	-77	-77	-87	-87	-77
Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting (pathway 2)	-442	-31	-31	-31	-31	-31	-31	-31	-41	-41	-51	-51	-41
Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	0	0	0	0

Community	Annual Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	-600	-50	-50	-50	-50	-50	-50	-50	-50	-50	-50	-50	-50
Reablement at home	-48	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4
Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting	-44	-4	-4	-4	-4	-4	-4	-4	-4	-4	-2	-2	-4
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0	0

Demand and capacity modelling for 2022/23 was based on predicted demand, with a reasonable degree of accuracy and funded capacity in place to meet the demand. There was equivalence between demand and capacity.

Specific actions were taken to ensure capacity during last year: commissioning of agency domiciliary (up to 40% of all domiciliary care) while actions to sustain the local market were implemented; commissioned bed- based care out of the borough to ensure capacity. Patients were routinely discharged on the appropriate pathway. Additional nursing and HCA capacity was commissioned to support assessment and Intermediate care interventions for

individuals placed out of the borough where there were delays in commencing formal therapy in order to reduce length of stay in beds.

For 2023/24, the Demand and Capacity modelling (summary above) is based on a number of assumptions. Demand assumptions include:

- Discharges from all acute hospitals averaged across all four quarters. This has been cross-referenced with unvailidated acute hospital discharge numbers for comparison and shared with the STW Demand and Capacity Group who reports to the Urgent Care Board
- Projections of increased activity currently averaging 25% against 2022/23 for same period
- UCR (Admission Avoidance) activity relates to referrals where domiciliary or bed based alternatives were provides rather than all UCR referrals to the team.
- 'Rehabilitation at home' and Reablement in a bed; relate to referrals from the Community hospital for interventions

Capacity assumptions include:

- Based on currently agreed BCF funded capacity only
- Average length of stay of 28 days for simplicity of calculation. Current length of stay in 40 days with a programme of work to reduce this
- Total funded capacity of beds and domiciliary care is utilised across all demand

UCR demand for bed based interventions has remains consistent for the last years despite increased overall demand for the provision. Domiciliary care capacity continues to increase in number of hours required, use of Double up care, 1:1 care and overnight care as Night Sitting or Planned Overnight Care. These are alternatives to increasing bed utilisation.

Standard Operating Procedures review utilisation of care to reduce the risk of over-prescription including a provider review at first contact, 72- hour review, weekly MDT and review at 14 days.

There is a significant gap between predicted demand and currently funded capacity as indicated in the summary above. Specific actions to reduce the capacity gap are included within the Urgent Care Priory Plan and BCF programmes for 2023/24 and 2024/25 including:

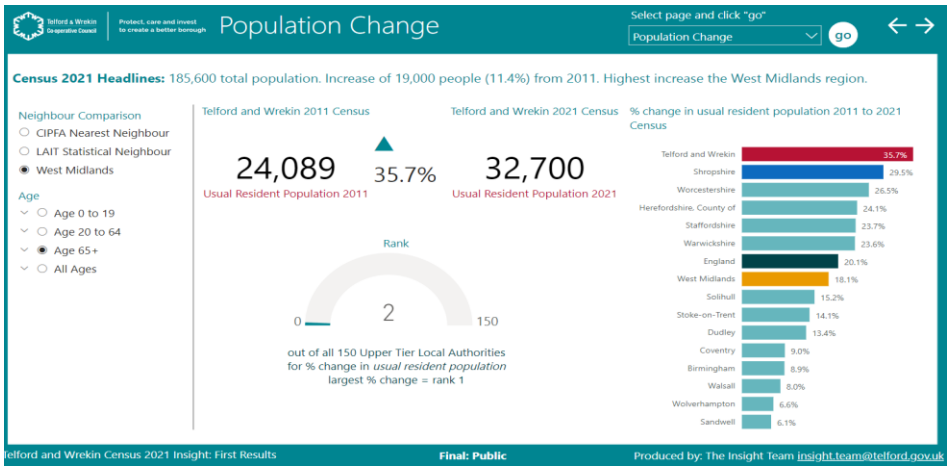
- Development and delivery of the Integrated Discharge Model and D2A approach to reduce length of stay and promote Pathway Zero and 1 discharges- reviewing complex discharge pathways and processes and develop a new model of care focussing on Home First- reducing demand for beds and reducing the domiciliary care requirements
- Accelerated discharge programme to reduce length of stay and reduce de-compensation
- Utilisation of Virtual ward to maximise interventions to reduce need for care
- Aligning capacity to meet demand
- Maintain and sustain provider market capacity
- Review of all BCF related expenditure

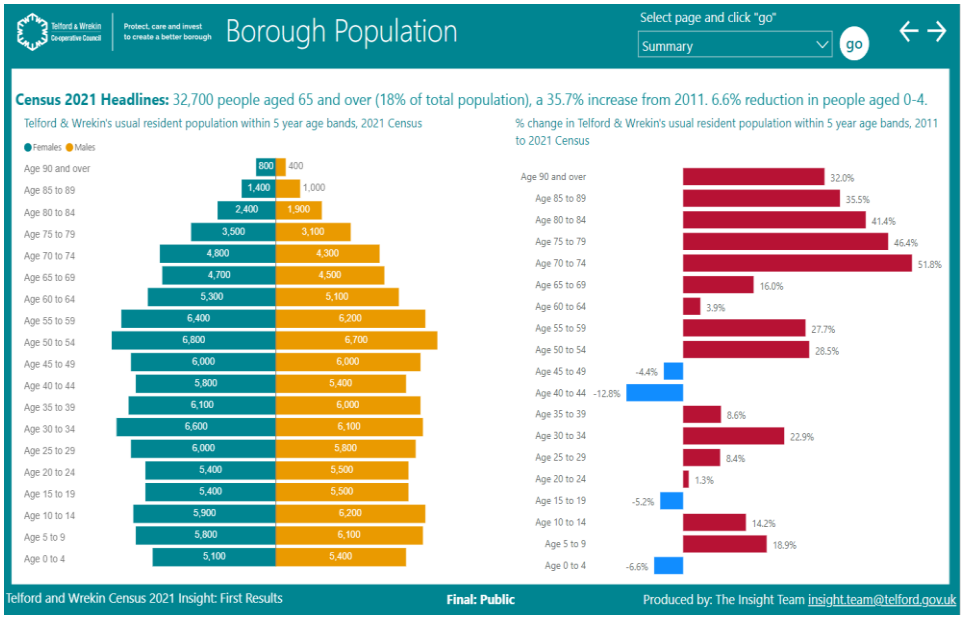
Referrals for complex discharges has increased by 126% over the last 6 years. There has been increased demand and subsequent growth in capacity and cost to meet it.

	2016	2017	2018	2019	2020	2021	2022	2023
TOTAL	1161	1311	1527	1728	2200	2650	2493	1206
AVERAGE	97	109	127	144	183	221	208	241
% CHANGE		13%	16%	14%	27%	20%	-6%	25%

Data is January – December figures. 2023 is to month 5

The increased demand is further highlighted from the changing population as highlighted in the census. Telford and Wrekin Council has seen a 355 increase in 65+ population- the highest increase in the regions- further illustrared within the 5 year age bands.





National Condition 2 (cont)

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

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

Existing programmes of work, services, pilot programmes and BCF programmes for 2023-25 contribute to the reducing in unplanned admissions:

- Admission Avoidance through HSRCCT
- Care Home MDT supporting training and proactive care interventions
- Domiciliary Care provisions in hours and Out of Hours for admission avoidance
- Planned Overnight Care (Two Carers in a Car)
- Virtual ward

A Falls prevention pilot was developed and delivered to reduce harms from long lying while waiting for an ambulance. The Pilot utilising the local Non-Elective Patient Transport Service providing an alternative response to West Midlands Ambulance Service. After their assessment they could refer directly to HSCRRT for interventions.

In addition, Fit4Fall, a specialist independent sector provider, delivered postural stability programmes within local communities to maximise opportunities for improved mobility and reduce risk of falls.

A Business case in in development. Falls prevention and falls harm reduction has significant potential for reducing demand for acute hospital services and improved outcomes.

A sensory based falls technology pilot is being implemented to reduce calls and reduce the level of 1: 1 care that is provided to maintain safety. A Telford care home will have the technology for 12 months. The systems will profile behaviours and habits and will therefore be a preventative measure as well as detection as they will be able to see when people's habits change which may indicate a deterioration in health leading to hospital admission or medical intervention.

BCF programmes within 23-25 will also seek to achieve metric ambitions and be monitored within the BCF dashboard programme update and monitoring metrics:

- Development and delivery of the Integrated Discharge Model and D2A approach
- Support the maximisation of admission avoidance and Virtual ward
- Support Proactive Prevention Care programmes to maximise independence at home
- Enhance voluntary sector involvement in supporting independence and alternatives to statutory care
- Aligning capacity to meet demand
- Maintain and sustain provider market capacity

National Condition 3

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

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

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

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

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

. The main approach and interventions to improving discharge; STW system flow and ensuring that people get the right care in the right place (and at the right time) is driving the culture and processes to support Home First. This has been a focus of national guidance across urgent care and High Impact Change Metrics.
Overwhelmingly, people want to be cared for at home or return home to recuperate after hospital care. a few days of bed based care increases the risk of de-compensation in older people – loss of muscle mass; reduced ability to mobilise; increased risk of falls; increased risk of needing bed based Reablement or higher levels of care; poorer long term outcomes. It is contrary to person-centred planned and personalised care. There are person-focussed an economic reasons to deliver Home First. Strengths based and personalised care remains central to care delivery.
Key drivers are supporting Home First and ensuring that people get the right care in the right place include:
Admission Avoidance (also highlighted above)
Early Flow (through the hospital)
Virtual ward (also highlighted above)
Support the maximisation of admission avoidance and Virtual ward
Urgent and Emergency Care priority plan
Development and delivery of the Integrated Discharge Model and D2A approach
Support acceleration of delayed discharge HICMs through further integrated working
System Discharge Alliance
Aligning capacity to meet demand
Maintain and sustain provider market capacity
Admission avoidance and the Virtual ward programme are highlighted above. Admission

avoidance maintains care at home where at all possible; the Virtual ward will support both admission avoidance and early discharge from hospital. Earlier discharge reduces length of stay; focuses on discharge home and more likely to remain independent at home. Interventions for up to 72 hours determine the need for further interventions including Virtual Ward or Intermediate Care interventions in order to regain and maximise independence. Up to 95% of referrals remain at home for interventions.

The acute hospital UEC work programme has a number of workstreams aligned to Early Flow including Criteria Led Discharge, ward processes and development of the Frailty pathway to support discharge. These are aligned with Transfers of Care High Impact Change Metrics and detailed within workstreams below:

Ward processes to improve discharge planning

Therapies

Improving Discharge Flow

The Local Care Transformation development of the Virtual ward within STW has been developed in line with national guidance (above) Phase 2 within 2023/24 will increase capacity, increase of pathways and support more people home as well as alternative to admissions after Admission Avoidance interventions where appropriate.

A BCF work programme will focus on supporting the development of admission avoidance and Virtual ward Phase 2 development. This includes:

Supporting the maximisation of capacity as alternatives to acute bed utilisation

Supporting development of the Frailty pathway

Commissioning domiciliary care capacity for Virtual ward if identified

STW ICS has developed its short to medium-term intentions for urgent and emergency care (UEC). With alignment to national priorities and addressing local population needs, the strategy sets out the improvements for 2022-2025. With UEC Board oversight, reporting to the ICB Board, developed the strategy that incorporated the areas to meet the recovery challenge of activity returning to pre-Covid 19 levels:

Increasing capacity

Growing the workforce

Improving discharge

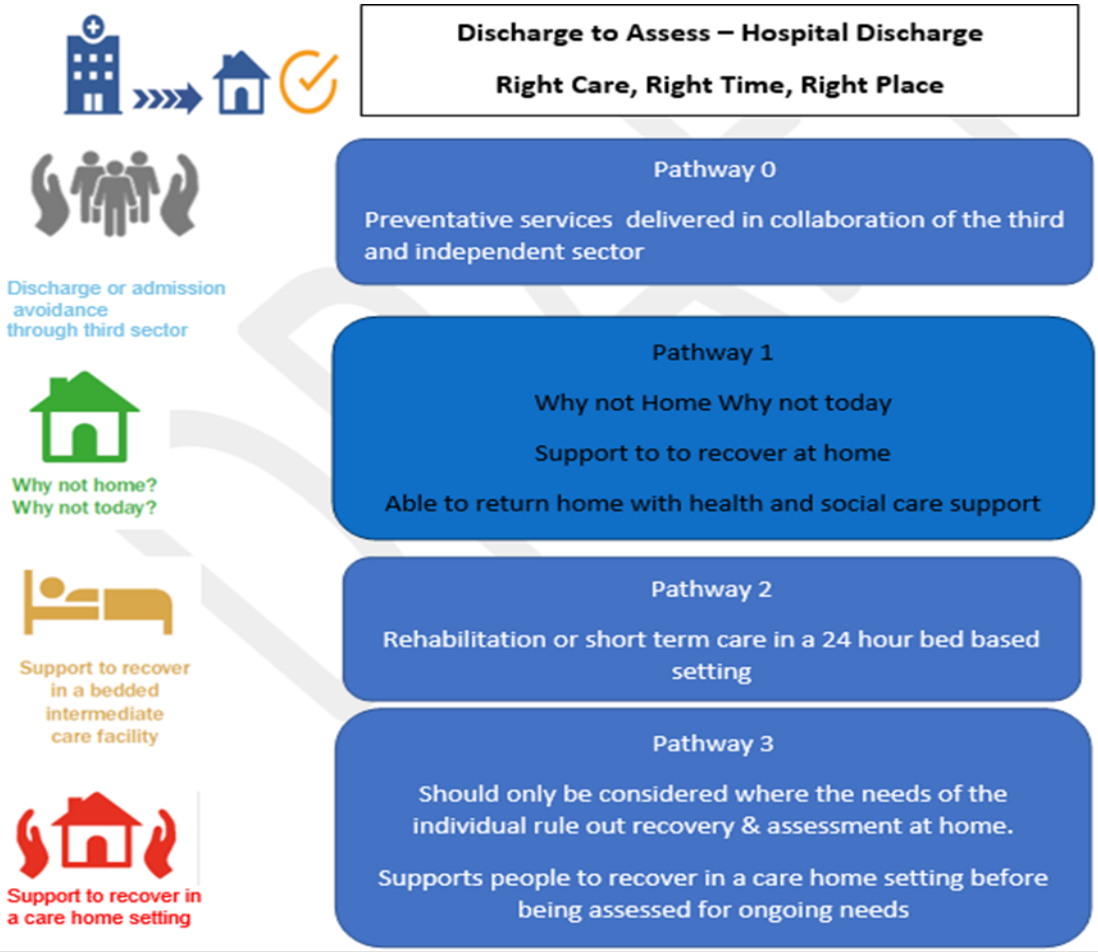
Expanding care outside hospital Making it easier to access the right care STW UEC Improvement Plan follows the 3S methodology Stabilise Standardise Sustain (below)

Urgent and Emergency Care 23/24

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

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

A key action is to further improve the discharge model in order to reduce overall length of stay; reduce to number with No Criteria to Reside/ Medically Fit for Discharge and reduce the time from being NCRT/ MFFD to discharge. UEC workstreams include '*Enhanced Integrated Discharge Team (D2A)'* and *'Improved Discharge Model (7/7)'*



The Discharge to Assess (D2A) approach (above) have been in place for a number of years

to ensure that peoples long term needs were determined within a community setting rather that within the acute hospital. There focus was supporting discharge home rather than into a care bed and reducing the time from being Discharge Ready to discharge. Covid 19 required a change in the delivery of discharge processes; accelerating the D2A approach and hospital discharges timescales when Discharge Ready/ NCRT.

The Inter-Disciplinary Hub and Team (IDT) was developed bought together non-BCF and BCF funded resources with the acute hospital team supporting discharge, Community Health Trust staff and Social Care staff from the Local Authority into a co-located team. This has supported further development of the IDT during the intervening period:

Identification of Care Managers to have an identified case worker for discharge

Patient Journey Facilitators to track discharge related actions

Develop of a Transfer of Care document

Social Work staff aligned to wards to support early discharge planning by joining ward/ Board rounds and MDTs

Developing and Embedding multi-stakeholder MADE events

Targeted In-reach to proactively 'pull' out patients

Weekly review of 14+ day and 21+ day patients

BCF funded resources and processes to support discharge and Intermediate Care interventions:

Telford Integrated Community Assessment Team (TICAT); dedicated SW team working within the acute hospital and case management during Intermediate Care

Community Health Trust therapists providing Intermediate Care interventions across all Pathway

Commissioned Block and spot purchased beds within the independent sector for Pathway 2 and Pathway 3 discharges and Admission Avoidance beds

Commissioned Block and spot purchased domiciliary care for hospital discharge and admission avoidance Brokerage capacity to source care

Standard Operating Procedure for case management indicating day specific actions and reviews/ MDTs to proactively manage flow

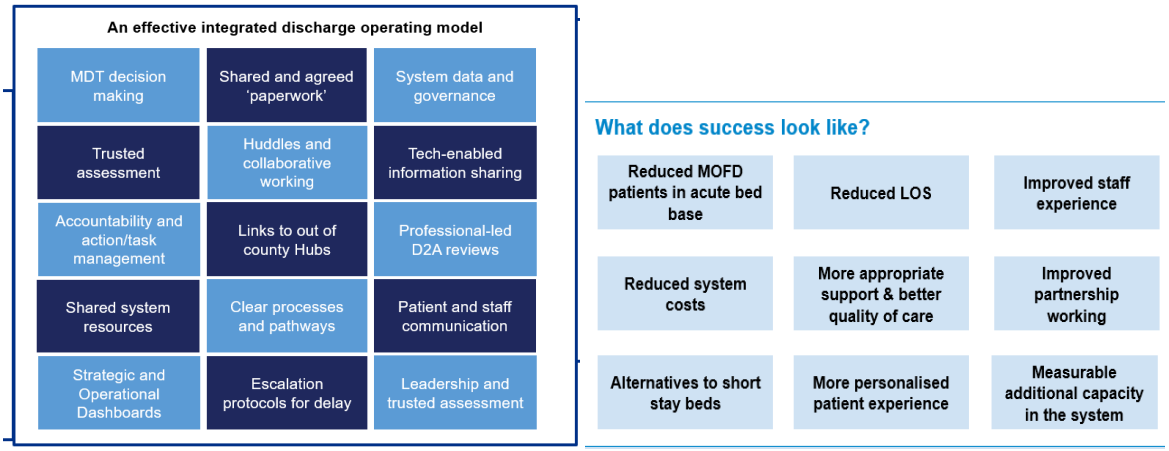
Operational processes and principles across Pathways

	Pathway Zero	Pathway 1	Pathway 2	Pathway 3
Definitions	Discharge without additional personal care needs Discharge with existing levels of care to home or care settings	Home based clinically-led Intermediate Care including personal care and therapy interventions prior to Care Act Assessment	Bed based clinically- led Intermediate Care within a care setting e.g. community hospital providing personal care and therapy interventions prior to Care Act Assessment	Bed based clinically-led Intermediate Care for Discharge to Assess within a care setting e.g. community hospital or other 24 hour care setting providing personal care and therapy interventions prior to Care Act Assessment
LA statutory duties within hospital and actions to deliver	• SW involvement within MDTs and assessments on wards • Digital Case worker involved in MDTs and assessments on wards* • Agreement of Pathway Zero as no need for Intermediate Care intervention	• SW involvement within MDTs and assessments on wards • Digital Case worker involved in MDTs and assessments on wards* • Agreement of pathway • Case management on discharge	• SW involvement within MDTs and assessments on wards • Agreement of pathway • Discharge into NHS funded Block/ Spot purchase /Winter Intermediate Care bed when funding available • Case management on discharge	• SW involvement within MDTs and assessments on wards • Agreement of pathway • Discharge into NHS funded Block/ Spot purchase/ Winter Intermediate Care bed when funding available • Case management on discharge
Brokerage support function	None	• Brokerage to source domiciliary / personal care for Intermediate Care	• Brokerage to source Intermediate Care bed	• Brokerage to source Intermediate Care bed
Local Authority statutory duties within community and actions to support	• Ensure SATH signposting to community resources for further follow up and support including: o Information, Advice, Advocacy o Independent Living Centre (ILC) for follow up review and assistive technology o Age UK for linking to local communities and volunteer support o Local community groups for community based support o Provision of digital platform	• Signposting to community resources for further follow up and support including: o Information, Advice, Advocacy) o Independent Living Centre (ILC) for follow up review and assistive technology o Age UK for linking to local communities and volunteer support o Local community groups for community based support • Care Act assessment when therapy optimised • Council Occupational Therapy support for Enablement support post Intermediate Care	• Care Act assessment when therapy optimised • Signposting to community services in line with Pathway 1 if discharged home • Council Occupational Therapy support for further Enablement support	• Care Act assessment when therapy optimised • Council Occupational Therapy support for Enablement support

Referrals for complex discharges has increased by 126% over the last 6 years. There is increased demand and subsequent growth in capacity and cost to meet it.

	2016	2017	2018	2019	2020	2021	2022	2023
TOTAL	1161	1311	1527	1728	2200	2650	2493	1206
AVERAGE	97	109	127	144	183	221	208	241
% CHANGE		13%	16%	14%	27%	20%	-6%	25%

There has been improvements in relationships, decision-making and performance of the IDT. However, the Pathway profile has deteriorated from 55: 45 split of domiciliary care to bed based referrals to closer to 50:50. Some periods have has a higher % of bed based referrals. Development and delivery Integrated Discharge Model is now in progress bring together co-located teams into a single integrated function across the STW: building on previous developments to utilise the totality of resources more effectively; create capacity for admissions and improve outcomes.



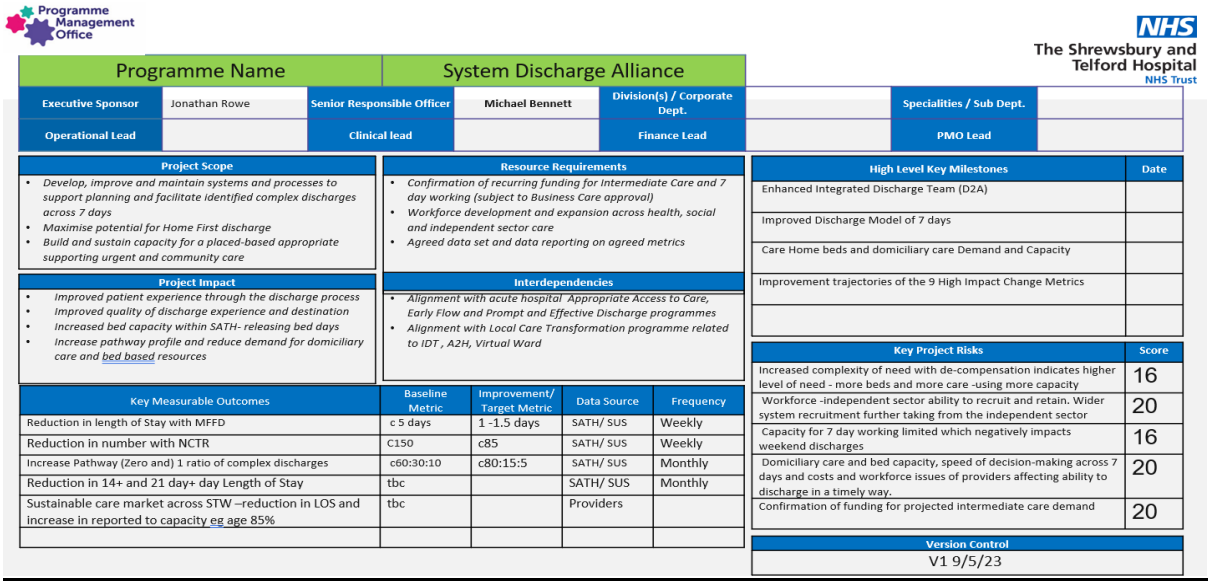
Planning for an Integrated Discharge team will support acceleration of delayed discharge HICMs through further integrated working. The acute hospital UEC work programme includes number of workstreams aligned to HICMs:

Ward processes to improve discharge planning including EDD and Criteria led Discharge

Therapies earlier assessments and interventions, which is intended to reduce de-compensation – supporting Home First – shortening length of stay and potentially reducing demand for care resources

Improving Discharge Flow through existing workforce potentially working differently to improve flow

The System Discharge Alliance (SDA) (PID below) has representation from all STW statutory partners and key independent sector stakeholders to develop plans and support actions to improve discharge outcomes. This group will have the governance lead for the Integrated Discharge Model and HICMs.



Programme Name	System Discharge Alliance						
Executive Sponsor	Jonathan Rowe	Senior Responsible Officer	Michael Bennett	Division(s) / Corporate Dept.		Specialities / Sub Dept.	
Operational Lead		Clinical lead		Finance Lead		PMO Lead	

Project Scope

- *Develop, improve and maintain systems and processes to support planning and facilitate identified complex discharges across 7 days*
- *Maximise potential for Home First discharge*
- *Build and sustain capacity for a placed-based appropriate supporting urgent and community care*

Project Impact

- *Improved patient experience through the discharge process*
- *Improved quality of discharge experience and destination*
- *Increased bed capacity within SATH- releasing bed days*
- *Increase pathway profile and reduce demand for domiciliary care and bed based resources*

Resource Requirements

- *Confirmation of recurring funding for Intermediate Care and 7 day working (subject to Business Care approval)*
- *Workforce development and expansion across health, social and independent sector care*
- *Agreed data set and data reporting on agreed metrics*

Interdependencies

- *Alignment with acute hospital Appropriate Access to Care, Early Flow and Prompt and Effective Discharge programmes*
- *Alignment with Local Care Transformation programme related to IDT , A2H, Virtual Ward*

High Level Key Milestones	Date
Enhanced Integrated Discharge Team (D2A)	
Improved Discharge Model of 7 days	
Care Home beds and domiciliary care Demand and Capacity	
Improvement trajectories of the 9 High Impact Change Metrics	

Key Measurable Outcomes	Baseline Metric	Improvement/ Target Metric	Data Source	Frequency
Reduction in length of Stay with MFFD	c 5 days	1 -1.5 days	SATH/ SUS	Weekly
Reduction in number with NCTR	C150	c85	SATH/ SUS	Weekly
Increase Pathway (Zero and) 1 ratio of complex discharges	c60:30:10	c80:15:5	SATH/ SUS	Monthly
Reduction in 14+ and 21 day+ day Length of Stay	tbc		SATH/ SUS	Monthly
Sustainable care market across STW –reduction in LOS and increase in reported to capacity eg age 85%	tbc		Providers	

Key Project Risks	Score
Increased complexity of need with de-compensation indicates higher level of need - more beds and more care -using more capacity	16
Workforce -independent sector ability to recruit and retain. Wider system recruitment further taking from the independent sector	20
Capacity for 7 day working limited which negatively impacts weekend discharges	16
Domiciliary care and bed capacity, speed of decision-making across 7 days and costs and workforce issues of providers affecting ability to discharge in a timely way.	20
Confirmation of funding for projected intermediate care demand	20

Version Control
V1 9/5/23

STW as a whole is seeking to reduce the need for standard residential care with the introduction of an extra 200 Extra care units alone in The Council in 2024.25 and a further 1200 in 25/26. Domiciliary care capacity has increased by 50% since January 23 and there continues to be new providers joining our DPS each month. This capacity is supporting more Pathway 1 and helping keep people at home until complex care is required. We have cited this change in need our Market Position Statement and our Specialist Accommodation Strategy. Providers are aware of this reducing and changing need. One residential home has now closed removing 41 beds from the market however, the home regularly carried a 20% void. Similar levels of voids are present in other residential homes.

Maintaining and sustaining provider market capacity is essential to respond to need in the right way at the right time. Last year saw a significant reduction in domiciliary care capacity leading to commissioning on agency care provision at high cost. The market gradually recovered over nine months.

The Council have commissioned three zoned enablement providers and 10 long term community zoned providers and 38 further providers on the current DPS. Competition is currently healthy for those packages that zoned providers are unable to accept**.** The Framework used for these providers comes to an end in October and the plan to align re-tendering with Shropshire Council so that there is a system approach while recognising that both Places have very different provider markets

A 72 hour Bridging service to facilitate same day discharge is in place. In order to increase same day discharges, this function will be rolled out to all three zoned Enablement providers. There is active planning to ensure that these providers will be Trusted Reviewers so are able to reduce care accordingly in real time in discussion with the Social Workers based on changing need.

There is limited capacity of Residential and Nursing Dementia designation of beds and Nursing beds in the borough. However, a new dual registered home had recently opened giving us 70 beds for mixed complex use. In addition, the Council are discussing a potential conversation of a 40 bedded residential home to a Nursing home with dementia care and another 70 bed nursing home is planning to convert a floor of 12 beds into a Nursing with dementia unit. This will all bring extra capacity.

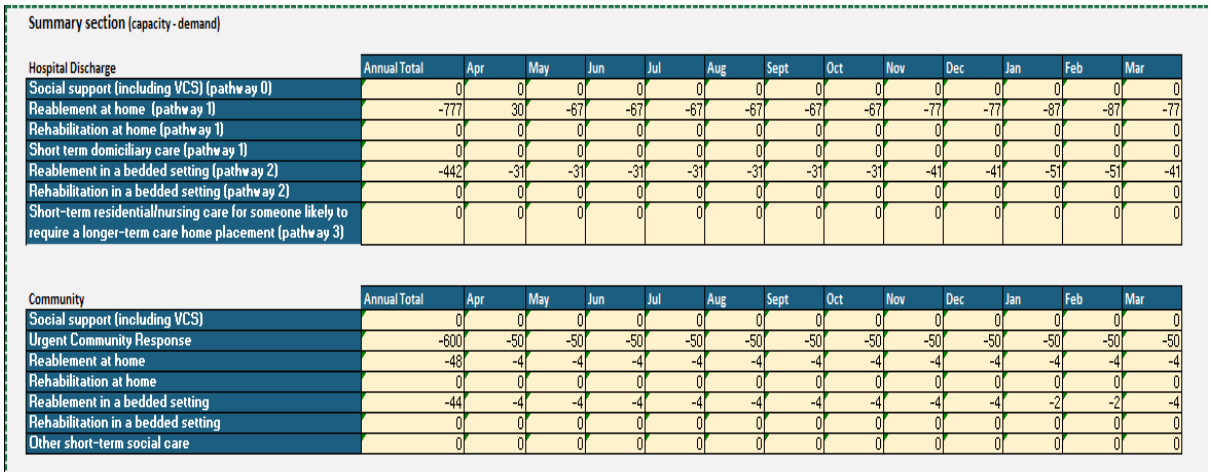
With people staying at home longer with the right support, they should not need this high end care until they are more advanced in their care needs resulting in shorter lengths of stay.

Commissioners are working with care providers to help them explore how they can have staff trained to support those who have extra 1to1needs within their own staff group to avoid external agencies delivering a minding service with little interaction.
All of the care homes in the borough are starting to access funding to implement the digital social care record and Sensory Based Falls technology to reduce hospital admissions has bis being Piloted in a Telford care home potentially, leading to reduced 1:1 care.
Market management key actions to support sufficient market capacity includes:
Potential commissioning of Extra Care and specialist accommodation to provide alternative to permanent placements
Explore potential for Step Down within Extra Care for Intermediate Care and/ admission avoidance
Further promotion for residential homes transition into residential with dementia care or nursing with dementia care
Ensure digital technology is being optimised in all settings and link this with Virtual ward and Docobo
Commence price levelling with in borough providers to manage costs while ensuring sustainable providers
Take opportunities to commission with NHS colleagues and Shropshire Council colleagues
Work with the ICS
Workforce team to develop Trusted Reviewer training that can be delivered to community long term providers to improve flow from PW1 to long term.

National Condition 3 (cont)

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

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.



Summary section (capacity - demand)

Hospital Discharge	Annual Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Social support (including VCS) (pathway 0)	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement at home (pathway 1)	-777	30	-67	-67	-67	-67	-67	-67	-77	-77	-87	-87	-77
Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting (pathway 2)	-442	-31	-31	-31	-31	-31	-31	-31	-41	-41	-51	-51	-41
Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	0	0	0	0

Community	Annual Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	-600	-50	-50	-50	-50	-50	-50	-50	-50	-50	-50	-50	-50
Reablement at home	-48	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4
Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting	-44	-4	-4	-4	-4	-4	-4	-4	-4	-4	-2	-2	-4
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0	0

Demand and capacity modelling for 2022/23 was based on predicted demand, with a reasonable degree of accuracy and funded capacity in place to meet the demand. There was equivalence between demand and capacity.

Specific actions were taken to ensure capacity during last year: commissioning of agency domiciliary (up to 40% of all domiciliary care) while actions to sustain the local market were implemented; commissioned bed- based care out of the borough to ensure capacity. Patients were routinely discharged on the appropriate pathway. Additional nursing and HCA capacity was commissioned to support assessment and Intermediate care interventions for individuals placed out of the borough where there were delays in commencing formal therapy in order to reduce length of stay in beds.

For 2023/24, the Demand and Capacity modelling (summary above) is based on a number of assumptions. Demand assumptions include:

- Discharges from all acute hospitals averaged across all four quarters. This has been cross-referenced with unvailidated acute hospital discharge numbers for comparison

and shared with the STW Demand and Capacity Group who reports to the Urgent Care Board
- Projections of increased activity currently averaging 25% against 2022/23 for same period
- UCR activity relates to referrals where domiciliary or bed based alternatives were provides rather than all UCR referrals to the team.
- 'Rehabilitation at home' and Reablement in a bed; relate to referrals from the Community hospital for interventions

Capacity assumptions include:

- Based on currently agreed BCF funded capacity only
- Average length of stay of 28 days for simplicity of calculation. Current length of stay in 40 days with a programme of work to reduce this
- Total funded capacity of beds and domiciliary care is utilised across all demand

There is a significant gap between predicted demand and currently funded capacity as indicated in the summary above. Specific actions to reduce the capacity gap are included within the Urgent Care Priory Plan and BCF programmes for 2023/24 and 2024/25 including:

- Development and delivery of the Integrated Discharge Model and D2A approach to reduce length of stay and promote Pathway Zero and 1 discharges- reviewing complex discharge pathways and processes and develop a new model of care focussing on Home First- reducing demand for beds and reducing the domiciliary care requirements
- Accelerated discharge programme to reduce length of stay and reduce de-compensation
- Utilisation of Virtual ward to maximise interventions to reduce need for care
- Aligning capacity to meet demand
- Maintain and sustain provider market capacity
- Review of all BCF related expenditure

National Condition 3 (cont)

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

- Discharge to usual place of residence

- Development and delivery of the Integrated Discharge Model and D2A approach to reduce length of stay and promote Pathway Zero and 1 discharges- reviewing complex discharge pathways and processes and develop a new model of care focussing on Home First- reducing demand for beds and reducing the domiciliary care requirements
- Accelerated discharge programme to reduce length of stay and reduce de-compensation
- Utilisation of Virtual ward to maximise interventions to reduce need for care
- Aligning capacity to meet demand
- Maintain and sustain provider market capacity
- Review of all BCF related expenditure

Referrals for complex discharge have an average length of stay of c14 days before being Medically Fit for Disharge. The current average is c4-5 days on post MFFD. The acute hospital UEC work programme has a number of workstreams that are instrumental in shortening length of stay and supporting discharge to an individuals usual place of residence :

- Ward processes to improve discharge planning including length of stay harm reduction and Virtual ward step down.
- Therapies and supporting de-compensation
- Improving Discharge Flow

Delivery of the current D2A approach further seeks to support discharge to an individuals normal place of residence though the Home First principles, the IDT collaborative approach and TICAT approach:

- Social Care staff aligned to identified wards
- Attending wards regularly prior to Transfer of Care document to support early identification of needs and initial discharge planning
- Encourage and model Strength -based conversations
- Attendance at ward huddles, ward/ board rounds, MDTs and discharge planning meetings
- Identification of Care Managers to have an identified case worker for discharge
- Co-ordination with Brokerage Team to commence planning of discharge pathway
- Ensure early and consistent information to families on discharge planning
- Highlight signposting to for community support for Pathway Zero to the Well-being Information Partnership and Independence Living Centre

BCF funded resources and processes to support discharge and Intermediate Care interventions:

- Telford Integrated Community Assessment Team (TICAT); dedicated SW team working within the acute hospital and case management during Intermediate Care
- Community Health Trust therapists providing Intermediate Care interventions across all Pathway
- Commissioned Block and spot purchased beds within the independent sector for Pathway 2 and Pathway 3 discharges and Admission Avoidance beds
- Commissioned Block and spot purchased domiciliary care for hospital discharge and admission avoidance
- Brokerage capacity to source care
- Standard Operating Procedure for case management indicating day specific actions and reviews/ MDTs to proactively manage flow

Market management to support discharge an individuals usual place of residence ensure sufficient capacity includes

- Potential commissioning of Extra Care and specialist accommodation to provide alternative to permanent placements
- Explore potential for Step Down within Extra Care for Intermediate Care and/ admission avoidance
- Further promotion for residential homes transition into residential with dementia care or nursing with dementia care
- Ensure digital technology is being optimised in all settings and link this with Virtual ward and Docobo
- Commence price levelling with in borough providers to manage costs while ensuring sustainable providers
- Take opportunities to commission with NHS colleagues and Shropshire Council colleagues
- Work with the ICS Workforce team to develop Trusted Reviewer training that can be delivered to community long term providers to improve flow from PW1 to long term.

National Condition 3 (cont)

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

Managing Transfers of Care High Impact Change Metrics (HICMs) is an important part of the Urgent and Emergency Care (UEC) priory plan in order to reduce delays discharge planning and discharge. HICMs continue to have been monitored through the System Discharge Alliance, sub-group of the Urgent Care Delivery Group. There is a high correlation between other UEC work programmes and, therefore, planning and reporting is closely aligned.

Last year, the HICMs was aligned to 100 Day Challenge requirements and a retailed review was completed and further updated. Specific Gaps were highlighted for further development (below) that are within agreed and planned programmes and actions to be included within the System Discharge Alliance programme of work

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

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

The acute hospital UEC work programme (below) has a number of workstreams aligned to HICMs:

- Ward processes to improve discharge planning (workstream 4) including length of stay harm reduction and Virtual ward step down.
- Therapies (workstream 12) and supporting de-compensation
- Improving Discharge Flow (workstream 14)

These are reported to the System Discharge Alliance and Urgent and Emergency Care Delivery Group.

Overview of Progress (in month, key achievements and opportunities) :	Workstream 2: Improving use of discharge facilities	New discharge lounge area at PRH opened in May 2023 to increase capacity by 8 chairs. Home form hospital tags have been created and project has been launched at RSH and PRH - positive results have been seen and embedding of process is going well. Colectively working with EMED to review transport demand and capacity considering the increase of patients in the discharge lounge earlier in the day.
	Workstream 4: Ward processes to improve discharge planning	Work progressing to develop the plan for Ward processes to be rolled out to Surgical wards - to commence mid May 2023 - this has stalled and is now planned to commence end June 2023 Criteria Led Discharge roll out planned to commence in May 2023 - has commenced in Medicine but not surgery. weekly performance meetings being put in place with wards, matron and operational manager utilising ward dashboard - these are to commence in May 2023.
	Workstream 5: ED redirection and Initial assessment	•ED Redirection tool is no longer live as agreed with ICB 5th May 2023 •SDEC streaming app is being trialled in RSH ED wc 5th June for 5 days •Initial assessment trajectory is under development. Feedback from the recent ECIST visit 23rd March is being incorporated into trajectory and is also an area of focus within the ECTP workstream 1 and 5 - actions include - embedding a consistent process for initial assessment, ensuring tests/observations outside of required initial assessment process are not included within initial assessment, continue recruitment campaign particularly around paediatric trained staff, review demand v capacity through the day/week to ensure that they match appropriately. •Development of Children and Young Persons services within ED PRH was approved at Divisional Committee and is going through the Trust wide Business Case Group for approval. This development will support with improving initial assessment time for CYPD •Joint working with UTC provider to focus on initial assessment processes for patients that attend with minor illness
	Workstream 9: Reducing ambulance handover delays	Ambulance receiving area opened and fully functioning at RSH. Ambulance receiving area openedon 1st April andis now fully functioning at PRH Further work required to ensure flow through ED occurs in a timely way to ensure ARA space is utilised effectively - current systems do not enable us to measure effectively the LoS in a specific part of ED - however Careflow will enable this to be measured easily (due to implement in October 2023) A focus on pinning out is being undertaken by the team with a clear SOP and clarity around roles and responsibilities - process mapping exercise being completed in June 2023 to redesign the process in order to improve perofrmnace in this area.
	Workstream 12: Therapies	this is two workstreams:- 12a - focus on the process for completing the TOC to reduce the amount of qualified therapy time spent undertaking this where there are not complex therapy needs for the patient. process mapping completed and schedule of rollout on wards has commenced. will be completed by end September 2023 across all wards. 12b - integrated therapies - meeting held on 4th May to agree next steps - a full workshop is required to move this forward
	Workstream 14: Improving Discharge Flow	The discharge management tool has been furtehr developed over the
	Workstream 14a: Virtual Ward Step Down	In order to ensure the effective utilisation of the Virtual ward capacity - there is a focoused piece of work by SaTH being undertaken with the clinical teams to increase awareness of the service and increase the confidence of the clinical teams within the acute hospital to refer and discharge into the virtual ward.
	Workstream 15: Acute Frailty Pathway	To explore the feasibility to create a dedicated assessment environment for patients who attend the emergency department and are identified as frail and complex but could potentially not be admitted into the deep bed base if additional wrap around services can support a safe discharge. A workstream brief has been created and workstream meetings have commenced.

Specific areas have been highlighted that will further develop each HICM (summarised below) that are within agreed and planned programmes and actions to be included within the System Discharge Alliance programme of work

High Impact Change Metric	Schemes/ programmes/ actions to support improvements
Change 1: Early Discharge Planning	Ward processes to improve discharge planning workstream Improving Discharge Flow workstream Integrated Discharge Model development Virtual ward development Length of stay harm reduction
Change 2: Monitoring and responding to system demand and capacity	STW Demand and Capacity Modelling group tracking Discharge monitoring tool
Change 3: Multi-disciplinary working	Ward processes to improve discharge planning Improving Discharge Flow Integrated Discharge model development Virtual ward development
Change 4: Home First	Integrated Discharge model development
Change 5: Flexible working patterns	Development of 7 day services Business case Discharge metrics over 7 days
Change 6: Trusted assessment	Development of Trusted Assessors to support discharge Develop Trusted Assessor approach to view domiciliary care utilisation
Change 7: Engagement and choice	Review of Choice policy

Change 8: Improved discharge to care homes	Care Home MDT development Rapid Response support to care homes
Change 9: Housing and related services	Homeless Protocol

The System Discharge Alliance Delivery plan (draft below) is being further updated to include actions identified to improve performance. A further formal review of the HICM in line with the action planning Template will be carried out by December 2023.

Programme	Delivery Plan 23/24		
Project/ Workstream	**Key Milestone**	**Due Date (Month)**	**Status (RAG)**
Improved Discharge processes	Trajectories for 9 High Impact Change Metrics reviewed, development areas identified and improvements highlighted Criteria Led Discharge PID developed Ward processes to decrease LOS on NCRT work programme implemented Discharge Monitoring tool merged with IDT tool to have one version of the truth for SaTH patients	 June 2023 June 2023 June 2023	
Improve Discharge performance	Improved Integrated Discharge Team (IDT) functioning Enhanced Integrated Discharge Team (IDT) supporting Discharge to Assess Improved Discharge model Development of 7 day services Criteria led discharge in place on all wards	 July 2023	
Improve Discharge Capacity	Care Home beds and domiciliary care Demand and Capacity Support independent sector ability to recruit and retain. Wider system recruitment further taking		
Key Impact/Outcomes	**Measures**		**Status (RAG)**
Reductions in LOS in MFFD/ NCRT	Daily measures of discharges Discharge profile against NHS Operational plan goals		
Reductions in number on MFFD/ NRCT	Daily measures of discharges Discharge profile against NHS Operational plan goals		
Improve Pathway 0 and 1 profile	Pathway profile of P0:1:2:3.		
Reduction on 14+ and 21+ day LOS	To be agreed		
Sustainable care market across STW	Market capacity (beds and domiciliary care) Bed and domiciliary care availability		

National Condition 3 (cont)

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

The Local Authority is responsible for discharging Care Act duties that include the facilitation of assessments and support planning to meet need. These are indicated within the Planning Template (Tab 3a). The BCF supports the discharge of these duties through practitioners working with individuals, families, and carers. Included in these functions are:

- Care Act assessments, reviews, and support planning
- Prevention and delaying care and support needs through a strength-based practice model
- Multi-agency risk management
- Deprivation of Liberty assessments
- Community Deprivation of Liberty assessments
- Mental Capacity assessments and Best Interest decisions
- Adult safeguarding
- Hospital discharges (acute and long stay)

Commissioned services to deliver Care Act duties include

- Care Act Independent Advocacy service
- Information and Advice provision
- Carers support (within the Information and Advice provision (highlighted below)
- Market management

Supporting unpaid carers

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

There is dedicated all age carers support delivered through the commissioned Carers Contact Centre. There is significant recognition of the important contribution of carers and their commitment to their cared for that support system wide priorities, delaying the need for care, support and treatment. The range of support provided to unpaid carers seeks to meet their needs through dedicated, personalised support approaches seeking to:

- Reduce social isolation and potential loneliness when committed to caring
- Maintain health and wellbeing, by providing tailored and flexible support approaches which help make their caring roles feel as fulfilling as possible and recuing feeling of guilt, loss or anxiety
- Identify and respond to any safeguarding concerns for the cared for and carer
- Enable carers to have informed information and make informed choices about their needs and those of the cared for
- Reducing the risk of carer breakdown by offering ongoing access to support including at points of crisis; personalised, tailored and targeted approaches; access to information, advice and training
- Dedicated acute hospital discharge liaison worker
- Give confidence to maintain their caring role, and provide support to enable sustainability of their carers report

The Carers Centre is a commissioned bespoke service that provides a range of support for carers:

- Information and advice through the general Information and Advice provision (Well-Being Improvement Partnership)
    - Advice Line
    - Individual contacts
    - Wellbeing contact
    - Peer support, specialist activities
- Specialist advice workers information, advice and support
    - Learning Disability and autism
    - Mental Health
    - Substance Misuse
    - Young Carers
- Care Register monitored through the Carers Contact Centre with routine follow up of contacts to ensure support is maintained and reduction of isolation
- Peer Support through borough wide activities, targeted peer support
- Individual on-off and / or on-going Support (face to face, telephone or virtual engagement) to enable carers to have information, advice; explore options and make informed decisions.
- Carers Support Network – face to face and virtual individual and group and Peer group support, networking with NHS, community and voluntary sector services or support
- Information and Awareness raising events for carers which feedback from other organisations.
- Carers Network offering a voice for carers to support planning
- Pathways to immediately facilitate

    - Emergency Crisis Response Services for out of hours response within two hours
    - Carer Assessments and up to 25 hours of dedicated and personalised support
    - Carer Moving and Handling assessment and training
    - Link with Admiral nurses

BCF support to carers, through identified schemes and services includes:

- General advice and guidance and advocacy support
- Specific carer advice via dedicated workers
- Admiral Nurse for support with an early dementia diagnosis
- Social Prescribing
- Care Navigator support
- Alzheimer's Society
- Carers Well-being guide
- Autism West Midlands
- Emergency Crisis Response Services for out of hours response within two hours
- Carer Assessments and up to 25 hours of dedicated and personalised support
- Moving and Handling assessment and training
- Carers counselling service
- Dedicated Carers commissioning Officer

Carer Support from statutory services can be through self-referral; voluntary, statutory, community organisations or through the Well-Being Independence Partnership, if part of the overall First Point of Contract provision in TWC. Referrals made for:

- Carers assessments, crisis response, wellbeing support
- Emergency Crisis Response Services for out of hours response within two hours
- Carer Assessments and up to 25 hours of dedicated and personalised support
- Moving and Handling assessment and training
- Carers counselling
- Facilitation of one-off Direct Payment (through the local authority) to sustain the carers role.

The Carers Centre manage the independent Carer Network that feeds into the commissioning and operational services to ensure the voice and ask of carers is listened to and acted upon. Supporting carers to influence the development of services through co-production.

Working in partnership with the Local Authority the statutory duty of prevention, well being and the completion of Care Act carers assessments are supported through this dedicated partnership. Joint decision forums bring the Carers Centre and the Local Authority together for individual decision making and planning services in the future.

Disabled Facilities Grant (DFG) and wider services

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

BCF strategic approaches includes tenancy related support to vulnerable group and maximising independence through the utilisation of the DFG.

Services have been commissioned and support contracts are in place to offer Short Term Supported Accommodation, floating support and sheltered housing support targeting vulnerable groups across the borough.

- Floating support delivers tenancy support to any individual in the borough in need of help to establish or maintain independence.
- Short Term Supported Accommodation offers both accommodation and support to help some of the more vulnerable groups to develop the required skills to manage independently with the aim of moving on to independent living within an average of 2 years
- Sheltered Housing Support provides help to older individuals living in a number of sheltered housing schemes across the borough.

All support is personalised and is of a preventative and enablement nature to help individuals to establish and maintain independence, remain independent in their own home and lead fulfilling and independent lives.

Support contributes to Adult Social Care (ASC) Services helping shift the demand from ASC services by preventing, delaying and reducing unnecessary or early access to ASC service and acute settings.
Examples of key outcome areas include:

- Supporting individuals to acquire the necessary skills to live independently
- Preventing loss of accommodation
- Preventing access to social care and other acute services
- Managing finances
- Avoiding eviction, care/residential services/hospital admissions
- Supporting access to health professionals and services to manage health
- Support to access local resources and support such as GP/dentist/social and community networks; Support to explore and access assistive technology.

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

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 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 and finance. The meetings focus on timescales for completion of adaptations; planning and design issues; use of technologies to support independence and future planning

An external review was completed in April 2022 of the current Supporting Independent Living service offer; supporting business processes and cost benefits for older people and disabled people was completed across:

- Disabled Facilities Grant, grant related support and minor works.
- Equipment and aids.
- Technology enabled care/support and community alarms.

Key stakeholders (highlighted above and commissioners, registered social landlords and independent sector representatives) were involved in the review. Key findings are abridged below:

Key findings (abridged)

- The number of DFG awards has increased year on year since 2015, without there being a commensurate increase in relation to in-house staff resources. This indicates that the current system is providing a higher level of outputs over time in terms of adaptations delivered, i.e. increased efficiency even though the system is complex.
- The number and range of care enabled technology devices being used by customers has been increasing modestly over the last three years.
- There is some evidence that the number of people receiving equipment and aids has been increasing over the last 3 years.....
- The home adaptations and assistance grants programme is comprehensive and flexible and is consequently meeting the needs of a wide range of customers. The 'wellbeing' grants have been particularly effective in being used flexibility to support customers with a range of needs, e.g. in relation to hospital discharge through to managing hoarding.
- In terms of DFG performance compared with other local authorities, the Council delivered more DFGs than the England average in the last financial year; 236 in Telford against the national average of 190.
- There is strong evidence that the current Supporting Independent Living services have a positive impact for the older and disabled people who receive them.
- The current Supporting Independent Living service offer is substantial in its scope and breadth; however it is provided in a 'piecemeal' way, i.e. the different current service 'components' are not a combined or holistic service offer for customers.
- The cost-benefit analysis shows annualised 'savings' from the range of Supporting Independent Living services assessed. These almost all show financial benefits to the Council from the delivery of these services (in addition to the quality of life benefits to customers).
- The cost-benefit analysis does provide sufficient evidence to indicate that the provision of Supporting Independent Living services, particularly DFG funded adaptations, deliver financial benefits to the Council.

The recommendations for supporting and organising the Supported Independent Living offer have been reviewed and taken forward, supporting the strategy approach to independent living, including:

- Telford & Wrekin's Supporting Independent Living current service offering a more coordinated and 'one stop' promoting independence service offer so any potential customer needing one element of the current service offer is automatically considered for access to the other Supporting Independent Living services based on need.

- Telford & Wrekin's Supporting Independent Living service offer is increasingly being extended in scope to be aligned with other existing services that are focussed on sustaining people in their homes including:
    - Home adaptations funded through DFGs
    - Equipment and minor adaptations
    - Wellbeing Grant assistance
    - Telecare and care enabled technology
    - Warm homes activities/grants (fuel poverty measures)
    - Handyperson service (technical and advisory)

- To meet potential unmet need for a Supporting Independent Living service, the provision is being extended to a greater number of older people, working age adults and children, subject to the cost benefit analysis demonstrating the financial benefits of doing so.

- An enhanced Supporting Independent Living service is being promoted to the public more deliberately as a 'living well at home' programme – a range of supports and assistance that people can draw on as and when needed including Technology Enabled Care services and equipment offering digital solutions to prevent admission and to support low level care on discharge with ongoing wellbeing and independence as well as family peace of mind.

- The Independent Living Centre in Telford town centre is the in-person 'shop front' that enables the public to access all or any of the portfolio of Supporting Independent Living services.

- Opportunities are being identified with ICB and NHS partners in relation to the benefits from enhancing supporting Independent Living housing with health related activity including social prescribing, falls prevention and admission avoidance.

- There is a clearer public point of access to all Supporting Independent Living services via the Wellbeing Independence Partnership (WIP). This includes improved navigation in relation to DFGs, minor adaptations, equipment and aids, assistive technology, the Independent Living Centre and the virtual house.

Additional information (not assured)

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

No

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

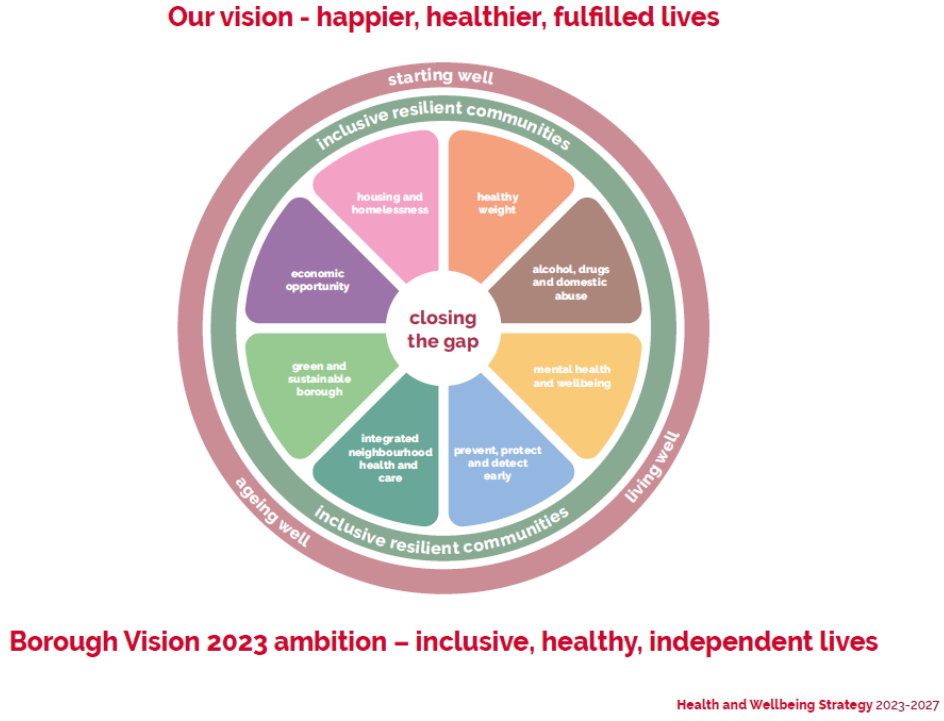
Not applicable

Equality and health inequalities

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

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

The Telford & Wrekin HWBB is refreshing its strategy priorities and the updated strategy will be approved in June 2023. The priorities (below) are based on engagement and insight with our residents and intelligence from the JSNA on local health and wellbeing outcomes and inequalities gaps. As well as key local health and wellbeing challenges, the priorities recognise the wider determinants of health, including housing and homelessness, economic opportunity - poverty, employment and the cost of living, and the impact of living in our communities. Our life course approach provides the opportunity to identify key improvements needed to improve outcomes for residents at all stages in their lives.

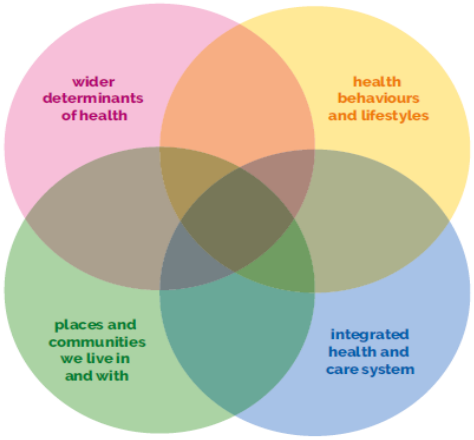


This strategy aims to deliver the health and wellbeing priorities and commitments in both the Council Plan and the Borough Vision 20323 and contribute to the ICS strategy. The Borough Vision 2032 to build a more inclusive borough**,** strongly aligns to the inequalities agenda, and includes the ambition – everyone is able to live a healthy and independent life.

Our approaches

Population health

We can improve health and wellbeing at a population level by impacting on the way people live in their communities, the wider determinants of health – jobs, income and education, healthy lifestyles and through an integrated health and care system.



Closing the gap - tackling inequalities

We can reduce inequalities by using an approach that is co-produced with communities and is underpinned by intelligence such as equity profiles for the uptake of services and outcomes, so services and support can be targeted toward those most in need and delivered in the most effective way.

- Community insight
- Engagement with service
- users, parents and carers
- TWIPP co-production charter
- Telford & Wrekin Integrated Place Partnership
- Strategic Commissioning
- Shropshire, Telford & Wrekin Integrated Care Partnership STW ICP

- Joint Strategic Needs Assessment
- Population Health Management
- Equitable targeting
- Equality, diversity & inclusion

Our approaches

Strong focus on prevention

Advice and support on prevention is essential at all levels, universally for everybody to stay healthy and support self care, but with a more targeted and proactive preventative approach for those who need more support.

Person centred care and support

Keeps people and their individual needs at the heart of everything, offering tailored and personal support, in the right place and at the right time, so people feel empowered and in control of their health.
https://makingitreal.org.uk

Prevent, protect and detect early

Why it's important

- Many conditions which are important causes of reduced life expectancy and the inequalities gap in life expectancy in our more deprived communities, can be prevented and treated earlier – for example certain cancers and heart disease.
- Healthy Lifestyles services offered by the council in the community focus on prevention support for people with excess weight and those who smoke, this offer is particularly targeted at those who need it most to reduce inequalities.
- NHS prevention programmes are varied and offered universally to everybody depending on age, such as cancer screening and cardiovascular risk checks and are also targeted at those people at risk, such as stop smoking support for people with serious mental illness and pregnant women.
- Reducing inequalities in those taking up prevention programmes and an extra focus on people living in the most deprived communities is the NHS priority inequalities programme known as the core20plus5.

Local picture

- The top three causes of the gap in life expectancy between the least deprived and most deprived communities are:
  - circulatory diseases (27% of the gap for males and 24% of the female gap).
  - cancers (16% of the gap for males and 15% of the female gap).
  - respiratory diseases (9% of the gap for males and 12% of the female gap).
- Bowel cancer screening coverage in 60-74 year olds is lower than the national average at 69%, with an inequalities gap between GP practices of 18%.
- Just over half 53.6% of people in Telford and Wrekin have their cancers diagnosed early and the national commitment is to increase this to 75% by 2028.

Working in partnership is critical to improving health and wellbeing, and collaborative work is going on across many different organisations through a variety of partnerships. The key strategic partnerships supporting the Health & Wellbeing Board and the implementation of this strategy are TWIPP and the Community Safety Partnership. The HWBB also work as partners in the STW ICS. There is also other partnership work supporting the wider determinants of health.

Integrated neighbourhood health and care:

Overview

Why it's important

- The Shropshire Telford & Wrekin Integrated Care System and new Partnership (ICP) are overseeing the development of new ways of working with the NHS, local councils and other partners.
- The ICS ambitions include ensuring a person-centred approach to care so people are at the heart of everything and joined up services are delivered in both the acute and community health and care settings to give everyone the best start in life, creating healthier communities and helping people to age well.

Delivering the priority

The ICS strategy and Joint Forward Plan set out the delivery commitments, the ICS will be working in different ways to deliver health and care integration.

People First

- People are at the heart of everything we do.
- Ensure community-centred co-production (with staff, partners, patients, carers, VCS and residents) underpins the development of services.

Prevention and inequalities

- Act sooner to help people with preventable conditions.
- Enable people to stay well and independent for longer by providing a greater emphasis on proactive prevention and self-care.
- Tackle the wider determinants of health - homes, jobs, education.
- Offer accessible, high quality health and care services, which are equitably targeted towards people in the greatest need.

Subsidiarity

- Things should be done, services and decisions made at the level that is most relevant, effective and efficient.
- These actions at every level work together to contribute to the overall ambition of the ICS.

Joint working

- Both in the way we commission and the way we deliver services, from shared funding, and collaboration to health and care teams designed around people and their lives.

Empowerment

- Enabling people to navigate our system when they need help. We will need every organisation to think harder about access, inclusion, cultural safety and health literacy in the services they provide.

Innovation, evidence and research

- Should be at the heart of our approach to the challenges we face and the opportunities to deliver.
- Maximise innovation and digital opportunities.

Integrated neighbourhood health and care:

Primary care focus

Why it's important

- The national Fuller report, 'Next steps for integrating primary care' recommends the development and integration of primary care into local neighbourhood communities, to help address the current challenges and improve the care and experiences received by patients.
- The NHS expect primary care to evolve with its core strengths protected, placing it at the heart of ICS, offering people streamlined access to care and advice, more proactive, personalised care and support from a multidisciplinary team based around neighbourhoods.
- Primary care cannot achieve the ambition alone and the ICS needs to take a system-led approach to drive improvements and to develop Integrated Neighbourhood Teams connected with Primary Care Networks (PCNs).

What engagement tell us

- The lack of access to GPs was a particularly strong theme we heard from our communities through both the 2020 residents survey and 2022 residents insight survey and focus groups. There is concern regarding the expansion of Telford and development of housing exacerbating an already difficult position with primary care as more people move into the borough.
- The residents responses to the consultation for the ageing well strategy revealed that access to GPs is one of the top health and wellbeing issues for older people.

Local picture

- GPs are providing more appointments now than they did before the pandemic with seven out of 10 patients being seen face to face. Despite this demand continues to outstrip supply.
- Latest data suggest that 55% of Telford and Wrekin patients have an appointment same day/next day with 90% seen within two weeks.
- It is clear from direct patient feedback and the latest GP Patient Survey that some patients continue to experience difficulties in both getting through to their practice on the telephone and accessing a timely appointment.
- Additional roles such as social prescribers, community pharmacists, paramedics and care-co-ordinators have been recruited by the PCNs to increase the breadth of the multi-disciplinary team available to meet patient needs.

Delivering the priority

The ICS Joint Forward Plan is committing to develop actions to implement improvements to primary care across the following areas:

- enabling PCNs to develop integrated neighbourhood teams;
- co-design and put in place infrastructure and support for integrated neighbourhood teams;
- supporting a primary care forum and representation;
- supporting the development of Primary Care Networks and leadership;
- primary care workforce planning embedded in system workforce plans;
- developing a system-wide estates plan for primary care;
- a development plan to support the sustainability of primary care.