Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 16 May 2018

Committee:
Health and Wellbeing Board

Date: **Thursday, 24 May 2018**
Time: **9.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Wellbeing Board

VOTING
Shropshire Council Members
Lee Chapman – PFH Health and Adult Social Care (Co-Chair)
Nicholas Bardsley – PFH Children's Services and Education
Lezley Picton – PFH Culture & Leisure

Prof Rod Thomson - Director of Public Health
Andy Begley - Director of Adult Services
Karen Bradshaw - Director of Children Services

Shropshire CCG
Dr Simon Freeman – Accountable Officer
Dr Julian Povey – Clinical Chair (Co-Chair)
Dr Julie Davies – Director of Performance & Delivery

Jane Randall-Smith – Shropshire Healthwatch
Rachel Wintle – VCSA

NON-VOTING (Co-opted)
Neil Carr - Chief Executive, South Staffordshire & Shropshire Foundation Trust

Simon Wright - Chief Executive, Shrewsbury & Telford Hospital Trust

Jan Ditheridge - Chief Executive Shropshire Community Health Trust

Dr Tony Marriott - Chair GP Federation

David Coull – Chairman, Shropshire Partners in Care (Chief Executive Coverage Care Services)

Mandy Thorn - Business Board Chair (Managing Director Marches Care)

Bev Tabernacle – Director of Nursing, Robert Jones & Agnes Hunt Hospital.

Your Committee Officer is: **Michelle Dulson** Committee Officer
Tel: 01743 257719 Email: michelle.dulson@shropshire.gov.uk

AGENDA

1 Election of Co-Chairs

To elect two Co-Chairs of the Health and Wellbeing Board for the ensuing year.

2 Apologies for Absence and Substitutions

To receive apologies for absence and any substitutions notified to the clerk before the meeting.

3 Disclosable Pecuniary Interests

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

4 Minutes (Pages 1 - 6)

To confirm as a correct record the minutes of the meeting held on 8 March 2018.

Contact: Michelle Dulson Tel 01743 257719.

5 Public Question Time

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14.

6 System Update (Pages 7 - 46)

Regular update report to the Health and Wellbeing Board is attached:

i. The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin

ii. Future Fit – a presentation will be made.

Contact: Director of the STP Programme, Phil Evans.

7 **Report from the HWB Joint Commissioning Group** (Pages 47 - 70)

Regular update reports will be made to the Board on:

i. Better Care Fund Update & Performance.

Contact: Tanya Miles.

8 **Maternity Transformation Plans** (Pages 71 - 126)

Report attached.

Contact: Fiona Ellis, Shropshire CCG.

9 **Public Health Annual Report** (Pages 127 - 192)

Report attached.

Contact: Rod Thomson, Director of Public Health, Tel: 01743 258918.

10 **Children's Trust** (Pages 193 - 200)

Report on the work of the Children's Trust is attached.

Contact: Director of Children's Services, Karen Bradshaw Tel 01743 254201.

11 **Mental Health Partnership Board** (Pages 201 - 332)

Report attached about the work of the Mental Health Partnership Board.

Contact: Director of Adult Services, Andy Begley, Tel 01743 258911.

12 **Shropshire Care Closer to Home** (Pages 333 - 336)

A report 'for information' is attached.

Contact: Lisa Wicks, Shropshire CCG.

13 Pharmaceutical Needs Assessment (Pages 337 - 338)

A report ‘for information’ is attached.

Contact: Director of Public Health, Rod Thomson, Tel 01743 258918 / Emma Sandbach, Public Health Officer, Tel 01743 253967.

14 Communications and Engagement Group (Pages 339 - 350)

A report ‘for information’ is attached.

Contact: Val Cross, Health and Wellbeing Officer, Tel 01743 253994

15 Exemplar development - Carers Strategy (Pages 351 - 354)

A report ‘for information’ is attached.

Contact: Val Cross, Health and Wellbeing Officer, Tel 01743 253994

16 Health and Wellbeing Board Work Programme (Pages 355 - 358)

The Health and Wellbeing Board Work Programme is attached for information.

Contact Lorraine Laverton, Business Manager, Shropshire Health and Wellbeing Board, Tel 01743 243991.

Shropshire Council

Committee and Date

Health and Wellbeing Board

24 May 2018

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 8 MARCH 2018
9.30 - 10.50 AM

Responsible Officer: Karen Nixon
Email: karen.nixon@shropshire.gov.uk Tel: 01743 257720

Present

Councillor Lee Chapman (Co-Chair)	PFH Health and Adult Social Care
Professor Rod Thomson	Director of Public Health
Lezley Picton	PFH Culture and Leisure
Andy Begley	Director of Adult Services
Karen Bradshaw	Director of Children Services
Jane Randall-Smith	Healthwatch Shropshire

Also observing:
John Bickerton, David Coull, Val Cross, Gerald Dakin, Phil Evans, Madge Shineton, Tanya Miles, Ivan Powell, Cathy Riley.

57 **Apologies for Absence and Substitutions**

The following apologies were reported to the meeting by the Chair

Di Beasley	NHS Telford & Wrekin CCG
Nick Bradsley	PFH Childrens Services and Education
Dr Julie Davies	Director of Performance and Delivery, Shropshire CCG
Dr Simon Freeman	Accountable Officer, Shropshire CCG
Sarah Hollinshead-Bland	Service Manager, Adult Safeguarding, Shropshire Council
Neil Nisbet	SaTH
Dr Julian Povey	Clinical Chair, Shropshire CCG
Bev Tabernacle	RJ&AH Hospital
Mandy Thorn	Business Board Chair

The following substitutions were also notified:

Sam Tilley, Director of Corporate Affairs; substituted for Dr Simon Freeman, Accountable Officer, Shropshire CCG.

Lisa Wicks, Head of Out of Hospital Commissioning & Redesign Shropshire Clinical Commissioning Group, substituted for Dr Julie Davies, Director of Performance and Delivery, Shropshire CCG.

58 Disclosable Pecuniary Interests

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

59 Minutes

At Minute 48, it was agreed that the resolution should have also stressed that the ratification of the Partnership Agreement was subject to the approval by the CCG; at the time, more work was required on this. Subject to this, it was duly

RESOLVED: That the minutes of the meeting held on 12th January 2018, be approved and signed by the Chairman as a correct record.

60 Public Question Time

There was one public question from John Bickerton, local resident from Oswestry about the Better Care Fund in relation to the Grant Thornton progress report (March 2018) and its implications. This question was circulated round the table at the meeting (copy attached to the signed minutes).

In response, the Chair advised that he could not address this at the meeting; he needed time to check out the Grant Thornton report and therefore he undertook to respond directly to Mr Bickerton after the meeting, which was duly agreed.

61 System Update

61.i <u>The Sustainability and Transformation Plan for Shropshire, Telford & Wrekin</u>
In introducing the STP Programme update, (copy attached to the signed minutes) Phil Evans, Director of the STP Programme, advised that the next report would not be so detailed in future; it would be in a different format and split into 3 sections as follows

- Commission Section
- Acute Section
- Enablers Section

This new monthly update would inform all, including NHS stakeholders.

It was agreed that Claire Old, newly appointed Urgent Care Director be invited to a future Health and Wellbeing Board to give an update on A&E and urgent care in Shropshire.

It was noted that in respect of prevention, the Healthy Lives work continued and dovetailed well into the planning system. This covered Diabetes and CBT and the Board was assured that a whole system was implicit within ongoing work.

In response to questions from the Chair the Board was assured that the Joint Strategic Needs Assessment was due a refresh soon and that there were no issues in respect of the Strategic Estates Group and engagement. Phil Evans assured that this document was a snapshot in time and that things had moved on.

The Director of Health informed that at a recent meeting of the Joint Health Overview and Scrutiny Committee the Chief Executive of the Hospital Trust had given an update on the sustainability and safety of clinical services provided by Shrewsbury and Telford Hospitals NHS Trust which had been very informative. To this end he suggested that it might be beneficial for the Health and Wellbeing Board to also be sighted on this and have a similar presentation/briefing in future.

61.ii Neighbourhood Work
Noted.

61.iii Future Fit
An update on this was still awaited.

RESOLVED: That the report be noted.

ACTION: Invite Claire Old, Urgent Care Director to the next Health and Wellbeing Board meeting on 24th May 2018.

ACTION: Invite the Chief Executive of the Shrewsbury and Telford Hospitals NHS Trust be invited to brief the Health and Wellbeing Board on the sustainability and safety of clinical services in Shropshire.

62 Report from the HWB Joint Commissioning Group

62.i Better Care Fund Update & Performance

Tanya Miles, Head of Operations, Adult Services, gave a verbal update on progress to date with the Better Care Fund. The Better Care Fund final submission had been duly approved in November 2017. The Partnership Agreement was nearly complete and subject to ironing out a few issues and firming up agreements between Shropshire Council and the CCG, she was hopeful that a fuller report would be made to the next Health and Wellbeing Board.

In noting this, the chair sought reassurance that the delays would not have any impact on the voluntary organisations concerned. The Head of Operations assured that over the next two weeks those schemes would be clarified and it would then the CCG would be able to write out to them and confirm their positions, which was welcomed by the Chair.

62.ii Healthy Lives

The Health and Wellbeing Officer and Healthy Lives Co-ordinator, Val Cross, introduced a report and gave a PowerPoint presentation (copies attached to the

signed minutes) updating the Board on the role of the Healthy Lives Programme and each of its areas;

- Social prescribing
- Carers
- SFRS 'Safe and Well' visits
- Diabetes (pre-diabetes)
- Dementia
- Mental Health, Housing, Musculoskeletal system (MSK)
- Falls and Physical Activity and Cardio-Vascular Disease (CVD)

In response to a question on social prescribing, the Director of Public Health informed that the bid for funding had been unsuccessful.

63 **Transforming Care Partnership**

The Director of Adult Services introduced and amplified a report (copy attached to the signed minutes) informing the Board on progress in meeting the targeted level of bed reductions by April 2019; moving long stay patients out of long stay beds and into the community. In doing so, he explained that the Transforming Care Partnership (TCP) was a small team across both authorities and to that end they were both working towards two pooled budgets. However there were two issues of concern that he highlighted to the Board;

- Finances
  Funding moves with each person and there were issues that the money was not coming across with the individuals concerned thus far. A letter outlining concerns had been sent to the NHSE.

- Trajectory
  Activity at national level was scrutinised very closely. Currently Shropshire was +1 over the trajectory, which put us on the 'At Risk' register, however he assured that as numbers increased from original the deviation, such variations would not be so significant.
  The people the team were working with were also often susceptible and therefore this is turn sometimes made the numbers fragile. He assured the Board that by the end of Quarter 4, numbers should be back on track.
  There was an offer to provide an interim report on numbers to a future meeting of the Health and Wellbeing Board, which was welcomed by the Chair.

The Board generally welcomed this report and the work being undertaken, but were concerned about the long-term sustainability of funding for this in the future and asked if this could be looked into. The Director of Adult Services said that robust discussions were currently being held about long-term funding. The Board welcomed this and offered to support the Director in any way in future discussions if need be.

RESOLVED:

a) That the report be welcomed and noted.
b) That completion of the targeted bed reduction by March 2019 be required by the Health and Wellbeing Board.
c) That closure of the programme, post March 2019 be confirmed.
d) That an interim report on numbers be made to a future meeting of the Health and Wellbeing Board.

64 Healthwatch Shropshire

A report (copy attached to the signed minutes) was received and welcomed by the Health and Wellbeing Board on the activities and impact of Healthwatch Shropshire.

The end of March 2018 heralded the end of the first Healthwatch Shropshire contract and 1st April 2018 the beginning of a new three year contract. This was an opportunity to look back over the first five years of Healthwatch, with a focus on the last 6 months, and then to look forward to the next contract ahead.

Page 5 of the Appendix was highlighted where stakeholders were asked for any suggestions for the future Healthwatch topics (input and ideas). Generally, the Board welcomed Enter & View, Hot Topics and the successful brand that had been created to date. A topic suggestion was raised at the meeting; 'Long term funding for social care' which was duly noted by Jane Randall-Smith, Chief Officer, Shropshire Healthwatch. In doing so she also invited individuals to contact her after the meeting if they had any more suggested priorities they might want to be looked at in the future.

It was noted that the engagement of Future Fit when it were to come on stream would create a lot of work for Heath watch and that dashboards might be introduced. Finally it was noted that due to reduced funding the opening hours of Healthwatch Shropshire would be reduced down from 5 day to 4 days per week and therefore the offices would be shut on Fridays.

RESOLVED: That subject to the foregoing the report be noted

65 Children's Trust

The Director of Children's Services introduced and amplified a report (copy attached to the signed minutes) which gave an update briefing on the focus of Educational Achievement in Shropshire – 'Diminishing the Difference' – a partnership approach to promoting and supporting the health and wellbeing of children, young people and families in Shropshire.

Sadly it was noted that many schools in Shropshire might be missing out on the pupil premium because many families did not take up their entitlement to Free School Meals (FSM). It was thought this might be due to lack of knowledge or often due to a perceived stigma associated with claiming FSM. Therefore the Director of

Children's Services stressed the importance of getting the message out to those who were entitled to claim to please do so and thereby draw down as much money as possible for their schools.

RESOLVED: That the information within the report be noted and that all partners consider how they might raise awareness with families they come into contact with and encourage them to claim Free School Meals as far as possible.

66 **Mental Health Partnership Board**

A regular update briefing paper (copy attached to the signed minutes) was introduced and amplified by the Director of Adult Services; it gave assurance to the Board on the work of the Mental Health Partnership Board and highlighted areas for closer consideration.

There had not been a lot of activity recently and therefore it was suggested that this item become a 'for information' item on the Board's agenda in future and that a report only be made to the Health and Wellbeing Board by exception, which was generally agreed.

The issue of parity of esteem, valuing mental health equally with physical health for younger people was highlighted. The Board was assured that this topic was being looked at. It was proposed that this might be an item for the Health and Wellbeing Board to look at in more depth and perhaps from a more strategic point of view.

RESOLVED:

a) That the information contained in the report be noted.
b) That the Board encourage people to undertake the free training being provided by the Zero Suicide Alliance.
c) That the issue of parity of esteem be included into the development of the Strategy for Mental Health.
d) That it be noted the Health and Wellbeing Board Refresh was taking place at 10.00 am on 29th March 2018. All Board members were urged to attend or to send a substitute if they were not available.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

Shropshire, Telford & Wrekin STP

Sustainability and Transformation Plan

Footprint Name and Number:
Shropshire and Telford & Wrekin (11)

Region:
Shropshire and Telford & Wrekin

STP Directors Monthly Report
April 2018 ***<Final>***
Next Update June 2018

Integrated System Working, the transition from STP to ICS

In 2018/19, all STPs are expected to take an increasingly prominent role in planning and managing system-wide efforts to improve services.

Integrated Care Systems

- *System working will be reinforced in 2018/19 through STPs and the voluntary roll-out of Integrated Care Systems.*
- *Integrated Care Systems are those in which commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility*
- *The term 'Integrated Care System' as a collective term for both devolved health and care systems and for those areas previously designated as 'shadow accountable care systems'. An Integrated Care System is where health and care organisations voluntarily come together to provide integrated services for a defined population.*
- Integrated Care Systems are seen as key to sustainable improvements in health and care
- *Integrated Care Systems will be supported by new financial arrangements*
- *It is anticipated that additional systems will wish to join Integrated Care System development programme during 2018/19 as they demonstrate their ability to take collective responsibility for financial and operational performance and health outcomes. It is envisaged that over time Integrated Care Systems will replace STPs*
- *As systems make shifts towards more integrated care, they are expected to involve and engage with patients and the public, their democratic representatives and other community partners.*
- *Engagement plans should reflect the five principles for public engagement identified by HealthWatch and highlighted in the Next Steps on the Five Year Forward View.*

Further Information:

https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

Our vision for health and care services in Shropshire, Telford & Wrekin

https://www.england.nhs.uk/systemchange/view-stps/shropshire-and-telford-and-wrekin/

Priorities

•Focusing on neighbourhoods to prevent ill health and promoting the support that local communities offer to help people lead healthier lives and encourage them to care for themselves where appropriate.

•Multi-disciplinary neighbourhood care teams working closer together supporting local people with long-term health conditions, and those who have had a hospital stay and return home needing further care.

•Ensuring all community services are safe, accessible and provide the most appropriate care.

•Redesigning urgent and emergency care, creating two vibrant 'centres of excellence' to meet the needs of local people, including integrated working and primary care models.

•Making the best use of technology to avoid people having to travel large distances where possible – especially important to people living in the most rural communities in Shropshire and Powys.

•Involving local people in shaping their health and care services for the future.

•Supporting those who deliver health and social care in Shropshire, Telford and Wrekin, developing the right workforce, in the right place with the right skills and providing them with local opportunities for the future.

Our ambition is simple:

We want everyone in Shropshire, Telford and Wrekin to have a great start in life, supporting them to stay healthy and live longer with a better quality of life.

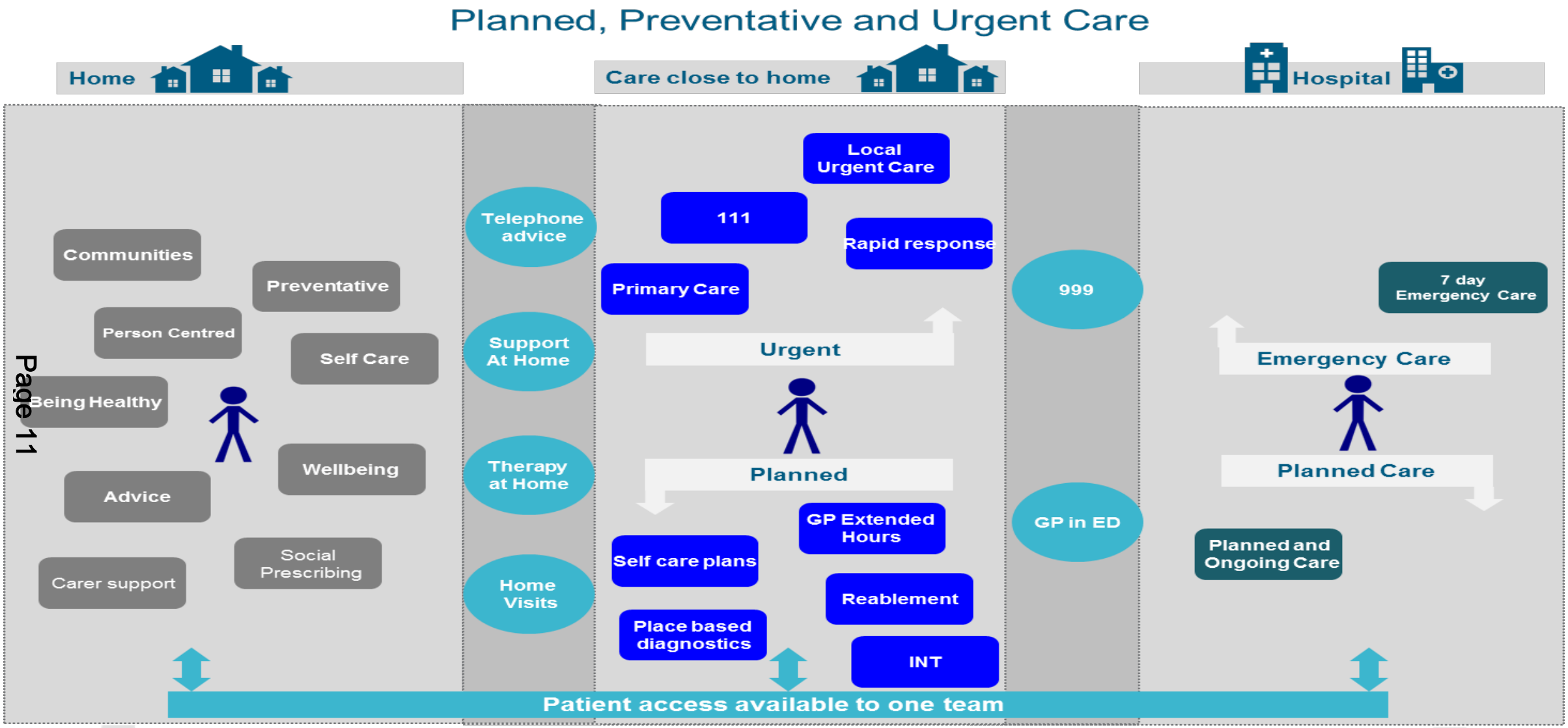
Our STP is the culmination of a wide range of local organisations, patient representatives and care professionals coming together to look at how we collectively shape our future care and services.
This strong community of stakeholders is passionate, committed and realistic about the aspirations set out in this document.

Our thinking starts with where people live, in their neighbourhoods, focusing on people staying well.
We want to introduce new services, improve co-ordination between those that exist, support people who are most at risk and adapt our workforce so that we improve access when its needed.

We want care to flow seamlessly from one service to the next so that people don't have to tell their story twice to the different people caring for them, with everyone working on a shared plan for individual care.

Prevention will be at the heart of everything we do –
from in the home to hospital care. In line with the GP Five Year Forward View priorities, we plan to invest in, reshape and strengthen primary and community services so that we can provide the support people in our communities need to be as mentally and physically well as possible.

Its all about integration



Stop Press – Further details in Next Report – June 2018

- STP System Leaders Group – The Kings Fund OD Phase 1 now concluded

- STP Clinical Strategy Group – relaunch – 1st meeting in May
  - Supporting STP Clinical Priority areas
  - Underpinning a clinically driven system
  - Increased engagement across all STP Partners including patient voice

- STP Transformation Delivery Group – The Kings Fund OD Phase 2 to commence in May / June

- Future Fit Public Consultation commences in May

Commissioner Led System Improvements Plan on a page

Out of Hospital Programme – Shropshire - Delivery of Integrated Care in the community

Exec Lead – Julie Davies Programme Lead – Lisa Wicks

Programme needs to:

- Using all available resources to commission integrated health and care services that are clinically effective and cost effective and as close as possible to where people live with the greatest needs

System Partners / Enablers need to:

1. Collaborate and co-produce
2. Agree alliance working across providers
3. Agree pathways to support admission avoidance
4. Reduce occupied bed days by impact of F1&2 and F3 & 4

The progress:

- Stakeholder workshops held
- Patient and engagement workshops held
- Task & Finish groups formed to co-produce
- Governance in place
- Admission avoidance modelling complete
- Engagement strategy in development

Key Interventions / Milestones

- Primary Care Development including risk profiling, case management, enhanced service delivery
- Development of a Hospital at Home service to support admission avoidance
- Development of a Rapid Response and Resolution team to manage patients prior to and during crisis
- Development of DAART and Community Bed Provision
- Enhancement of the Frailty Front Door/Community Pull Team

Risks to delivery

Risks

1. Culture of 'bed based' care persists, and risk aversion preventing people being managed at home
2. Needs assessment to inform future design (JSNA)
3. Workforce limitations and reluctance to develop one team approach
4. Contract negotiations and reluctance to risk share
5. Sustainability of current services

Data

The work completed by Optimity (2017) and Deloitte (2016) illustrates Shropshire's over dependency on in-patient resources secondary to historically commissioned services which have grown organically and failed to take into account key factors such as demographic changes. Optimity (2017) suggest that through shifting secondary service utilisation by a 5 year age band will reduce emergency usage of secondary services by 385 cases per 5,000 head of population within the 65+ age band equating to 4586 admission avoidances.

Out of Hospital Programme – Telford & Wrekin Neighbourhood Programme

Updated April 2018 Next update–

Exec Lead – Anna Hammond Project Lead – Ruth Emery

Programme needs to:

1. Improve access to activities that will prevent the development of poor health
2. Improve early identification of illness to stop further deterioration
3. Promote self-care/self-management
4. Demonstrably increase effective community support available
5. Strengthen Primary care
6. Reduce dependency on statutory services
7. Develop a sustainable workforce
8. Reduce social isolation

System Partners / Enablers need to:

1. Services and activities to be available closer to home
2. Prevention to be promoted throughout all work
3. Optimal use of technology
4. Introduction of new roles and ways of working
5. Well connected services and communities
6. Robust information accessible for communities and the professionals working with them
7. Empowerment for people and professionals
8. Consideration of mental health embedded

The progress:

- Community resilience and prevention
- Social prescribing within Newport and Central East Telford
- Healthy Lifestyle service
- Neighbourhood Teams
- Diabetes – improvement in patient outcomes has been achieved
- Hypertension – An increase in the number of individuals being screened has resulted in more diagnosis of hypertension and people referred for further support to manage this.
- Branches – feedback is demonstrating that a number of Section 136 are being avoided.
- Citizens Advice - outcomes achieved include an estimated £15,200 in welfare benefit gains
- Cancer Detection – 2 pilots have taken places with practices, both achieved an increase in screening for bowel cancer.
- Reduction in demand on social care

Key Interventions / Milestones

Page 15

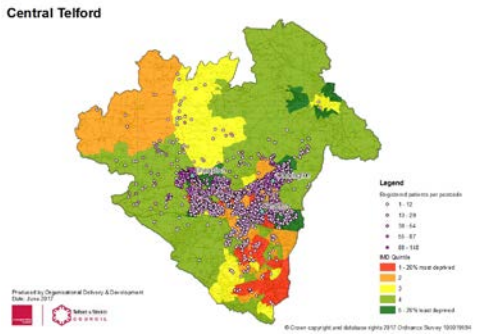
- Encouraging healthy lifestyles
- Promoting community resilience
- Direct care in the community
- Speciality review
-

Risks to delivery

Risks

Actions:
Develop enablers as detailed below
Community Information Portal which holds information on services and groups in the area
Robust and practical communication and engagement plan
Strong, well represented working groups to progress development
Strong leadership within the organisations involved
Proactive working relationships between stakeholder

What next – using data to drive change



Cancer

Exec Lead – Clinical Lead Project Lead –

Programme needs to:

- Deliver all Cancer Waiting Times (CWT) standards consistently, including the forthcoming 28 days from referral to diagnosis standards
- Monitor and scrutinise performance for individual tumour sites and challenge the system where needed
- Pilot innovative ideas to improve cancer service and patient outcomes, such as Telford and Wrekin pilots to trial vague symptoms and FIT testing

System Partners / Enablers need to:

- Make sure that processes and pathways are in place to deliver Cancer Waiting Times standards consistently
- Implement remaining parts of the NICE NG12 suspected cancer guidance – for upper GI, vague symptoms and FIT testing for lower GI
- Benchmark against optimal pathways produced by NHSE ACE programme to identify areas where improvements could be made
- Implement remaining areas of the national cancer strategy 'Achieving World Class Cancer Outcomes', such as the new CWT standards for confirmed diagnosis within 28 days of referral
- Improve 1 year survival for all cancer patients to achieve the overall target of 75%

The progress:

- Cancer Waiting Times standards generally met and performance good for SaTH as the main cancer centre
- Majority of NG12 pathways in place, with those outstanding in advanced stages of development
- Replacement of SaTH LINACs
- Representation at tertiary centre contracting meetings to make sure that our issues are addressed
- Recovery package implementation for all cancer patients - SaTH funded by Macmillan Cancer Support 2018 for 2 posts over 3 years
- The Local Health Economy established an STP local cancer group which continues to focus on objectives linked to STP:
  - Preventing cancer
  - Diagnosing more cancers early
  - Improving cancer treatment and care.

Key Interventions / Milestones

- Develop health economy wide cancer strategy based on National Cancer Taskforce priorities in the national strategy
- Use of Digital Health solution to develop new whole population models of care
- Investment from NHSE to support tertiary centres to improve performance against cancer waiting times
- Plan capacity needs to implement GP direct to test aspects of NG12 guidance
- Development of a whole health economy cancer strategy and action plan linked to STP priorities

Risks to delivery

- Diagnostic capacity needed to deliver NG12 and optimal pathways
- Poor performance at tertiary centres
- Workforce development needed to meet future demand
- Lack of funding to further develop and roll out Cancer app and digital technologies to all cancer patients (particularly for treatment and recovery stages)
- Insufficient focus and capacity locally to drive and support earlier patient presentation and diagnosis through public awareness and community engagement

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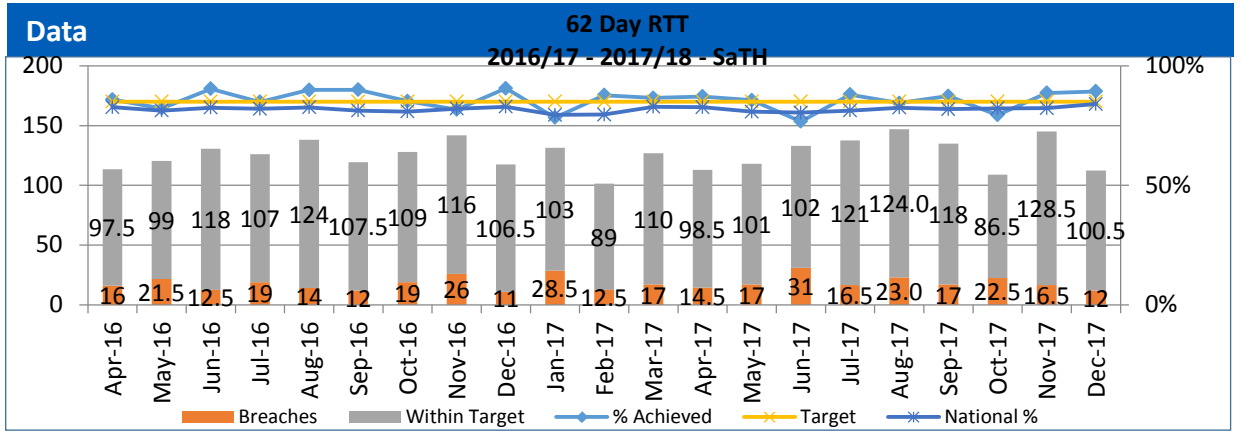
Data



End of Life

Exec Lead – Clinical Lead - Project Lead –

Programme needs to:

- Develop a whole systems direction of travel for EOL care that all partners and organisations are working towards together. This direction of travel is to shift care further upstream from the last few weeks and days of life to at least the last 12 months.
- Consider EOL /palliative care for children and young people and where this fits into the STP

System Partners / Enablers need to:

1. Shift approach to eol care further 'upstream'. This means recognising earlier when a person is in at least the last 12 months of life.
2. Reduce demand on acute trust by enhancing anticipatory care and planning ahead; reducing the amount of inappropriate and non beneficial treatments/interventions of for some patients.
3. Recognising that 'planning ahead' (Advance care planning) is a positive intervention . Including preferences and options and should be included in all care interventions/pathways.
4. Develop new models of working to support neighbourhoods- use of voluntary sector and communities to support eol care.

The progress:

- Development and agreement by all partners on the strategic direction of travel for eol care across the whole system.

Key Interventions / Milestones

- Facilitate effective personalised care planning and planning ahead and support those important to the dying person
- Ensure equal access to palliative and end of life care. Develop systems to identify when a person is in the last year if life
- Establish concept of 'living well' supporting advanced and anticipatory planning and access to services
- Ensure skilled and compassionate workforce. Identify education needs across the county
- Work in partnership to ensure that care is co-ordinated between systems.

Risks to delivery

Risks

Capacity and demand- a growing elderly population, impacts on workforce
Multimorbidity including frailty.
Rural and urban models affecting care access and support.
Social care provision inconsistent across the county, worse in rural areas.

Inconsistent understanding of the term end of life- has different meanings for different organisations and professionals.

A shift in culture for many aspects: upstream working, stopping treatments that aren't beneficial, introducing the concept of planning ahead. This will be for all organisations

Data

Data is required to quantify this for example:
Those attending AE and the nature of emergency admissions and interventions
The types and numbers of high cost LTC interventions where the patient dies within a certain time limit when other care and treatment options could have been used.

- Those attending AE and the nature of emergency admissions and interventions used.
- Those being admitted 3 times a year or more(particularly those patients with severe frailty).
- Those attending AE and the nature of emergency admissions and intervention used inappropriately;
- The types and numbers of high cost LTC interventions where the patient dies within a certain time limit when other care and treatment options could have been used.
- Those being admitted 3 times a year or more(particularly those patients with severe frailty).

Primary Care Programme – GPFV

Updated April 2018 Next update– June 2018

Exec Lead – Nicky Wilde Project Lead – Phil Morgan

Programme needs to:

The GPFV programme has five main elements:

New models of care
- Developing an approach to "working at scale" among practices
- Linking practices working at scale to wider new models of care – i.e. the Out of Hospital Model (SCCG) and Neighbourhood Working (TWCCG)

Extended Access
- Ensuring that 100% of the population has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need

Workforce
- Meeting national targets for increases in the number of GPs and other clinicians
- Retaining existing GP and other clinical staff in practices
- Developing at-scale approaches to workforce

Resilience/Workload
- Using the Resilience Fund to deliver practical, local solutions to increase resilience
- Implementing the 10 High Impact Actions

Estates and Technology Transformation Fund
- Delivering against key physical and digital projects, funded through the ETTF

In addition, CCGs are required to **invest** £3 per head, over two years, to enable Primary Care transformation.

System Partners / Enablers need to:

There are a number of enablers that would assist in the successful implementation of the GPFV programme:

Workforce
- The CCGs need to work with other health stakeholders to increase and improve the integration of workforce across different providers.
- The OOH and neighbourhood working models, and the Future Fit strategy, need to be aligned to primary care strategic planning when considering workforce mobilisation

Digital Information and Technology
- Key projects within the GPFV, particularly extended access and implementing the 10 High Impact Actions, are dependent on IT/digital solutions

Estates Investment
- Working across key STP stakeholders (local authority, public health, secondary and community providers) to utilise and develop the current and future estate

The progress:

New models of care
- Practices in both CCGs are increasingly working in groups/localities – further work is being planned with NHS England to develop at-scale working
- Primary Care is inputting into the development of both the Out of Hospital Model (SCCG) and Neighbourhood Working (TWCCG)

Extended Access
- Current provision of evening and weekend appointments covers over 90% of the population
- Local pilots are being developed to ensure that the 100% target is met by October 1st

Workforce
- An STP Workforce Plan has been submitted with projects designed to address the recruitment and retention targets
- The CCGs are working with the STP workforce group to explore the possibility of developing banks for GPs and other clinicians.

Resilience/Workload
- Successful bids to the Resilience Fund have helped to increase resilience
- The CCGs are working with the national Time for Care team around the 10 High Impact Actions

Estates and Technology Transformation Fund
- A programme to install VOiP, VDI and WiFi across practices has been agreed
- Funding for 2018/19 projects (Skype and Telehealth) has been agreed
- Good progress has been made on a number of estates projects to address growing population GMS needs and to link with hospital service transformation

Interventions and process change milestones

- Increased levels of working at scale between practices
- 100% of the population having access to GP appointments 8am to 8pm Mon-Fri and at weekends/bank holidays subject to local need
- Targets for workforce recruitment and retention across primary care met
- Successful implementation of the GPFV 10 High Impact Actions
- Successful implementation of ETTF funded IT and estates projects

Risks to delivery

Risks
1. Lack of alignment between the at-scale primary care plans and the Out of Hospital plans
2. Continued uncertainty around continuation of funding for extended access pilots and the post-October 1st scheme(s)
3. Insufficient interest from GP practices in providing the extended access service
4. Inability of CCGs/GP practices to attract new GP and non-doctor clinicians to the local area
5. Pressure on revenue budgets from ETTF-funded capital estates projects
6. A change in historical culture is required to enable transformation and collaborative change in Primary Care which will take time to embed
7. Difficulty in accessing up to date and meaningful data to identify unsustainable practices who need support with resilience funding

Data

Extended Access
- Over 90% of the registered population currently has access to GP (or other clinician) appointments 8am to 8pm Mon-Fri and at need

Workforce
- NHS England targets for Shropshire STP are for 101 GPs and 47 non-Doctor clinicians to be recruited/retained by September 2020

Resilience/Workload
- Each of the practices across the STP need to implement at least two of the 10 High Impact Actions during 2018/19

Estates and Technology Transformation Fund
- VOiP Telephony Project – 2 sites now live for VOiP and Wi-Fi

Mental Health

Exec Lead – Clinical Lead - Project Lead –

Programme needs to:

1. Deliver the implementation plan for the Mental Health Forward View, ensure delivery of the mental health access and quality standards, increase baseline spend on mental health;
2. work to eliminate out of area placements and reduce PICU spend
3. Improve access to psychological therapies and ensure at least 16.8% of the population access IAPT in 2018/19 rising to 19% in 19/20 and 25% by 20/21 a key milestone under 5YFV
4. Eradicate legacy issues in CAMHS around access, backlogs and reduce waiting lists whilst also providing specialist help to Looked After Children placed in the area and overall improve delivery and efficiency
5. Provide one stop coordinated service for Adult Autism and stepdown beds for Learning Disability patients from Tier 4

System Partners / Enablers need to:

1. Work across all systems to consider mental health needs of individuals
2. Ensure services all are trauma aware
3. Focus on prevention and early intervention
4. System has a clear understanding of reasonable adjustments for individuals with mental health or learning disabilities issues
5. Close gaps in provision of Autism services for adults as there is no commissioned pathway in Shropshire
6. Improve provision and support for out of area Looked After Children
7. Eliminate inappropriate access arrangements ,improving multi-agency working and enhance understanding amongst other agencies of role of core CAMHS team and lead overall improvement of service
8. reduce treatment time in Early Intervention In Psychosis, reduce inequity in LD services
9. Have provision of both acute and PICU MH beds locally to avoid spot purchasing out of area based on competitive tariffs

The progress:

1. Extra Funding has been extended to current Provider to enable increase of Mental Health patients receiving employment support (IPS) under 5YFV
2. Scoping is now complete for the Commissioning of a clear integrated pathway for Adult Autism Disorder Spectrum, next stage will be moving into procurement process (April 2018)
3. Equity access to LD respite agreed with Local Authority
4. Scoping underway to reduce PICU bed use out of area and improve quality, QIPP benchmarking in progress
5. Delivery issues in CAMHS being addressed via a Remedial Action Plan with clear milestones and objectives. Operational Group in place monitoring progress
6. Dementia diagnosis rate for Shropshire is presently at 69.9% against the national benchmark of 66.7%.
7. CCGs meeting entry, recovery and waiting times targets for Access to Psychological services

Key Interventions / Milestones

- Contactual talks pencilled for March 18 with aim to increase IAPT access
- Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete
- Implementation of Community Mental Health Hubs joining the Main Provider and Third Sector Organisations almost complete
- Development and delivery of new models of integrated care for MH and LD services
- Benchmark and scope likelihood of having local PICU beds to reduce OOA placements

Risks to delivery

Risks

1. Legacy issues and backlogs in CAMHS require more resource in terms of workforce to eradicate. Provider currently running extensive recruitment process, Risks of serious incidents, safeguarding issues as a result of service problems with recruitment.
2. NHSE requirement that IAPT interventions be clustered and each treatment be tariff based will likely push contract prices up based on national reference costs which means there is a financial risk to the CCG to meet the required IAPT access targets mandated under the Five Year Forward View
3. Burden on financial resources due to spot purchasing of beds for female PICU
4. Gaps in provision, adult ASD (no LD), some patients might not receive required support.

Data

Mental health MDS (MHMDS) - difficult to manipulate
IaPTUS- IAPT service only

Acute & Specialist Programmes - Musculoskeletal Services

Exec Lead – Gail Fortes Myer Clinical Lead - Programme Lead – Nina White

Programme needs to:

- Implement the national high impact MSK triage intervention
- Improve patient outcomes through improved access to conservative management
- Reduce surgical interventions to normalised rates
- Deliver a vertically integrated local care model

System Partners / Enablers need to:

Support implementation of evidence based Value Based Commissioning (VBC) policy across the full pathway from referral to treatment
Ensure the MSK triage service is the single point of access to secondary care for all routine MSK referrals
Support the implementation of the single MSK physiotherapy specification and treatment pathways for Hips, knees, shoulders , spines and ankles.
Collaborate to maximise the effective utilisation of local physiotherapy, conservative management and secondary care capacity and capability
Better interface tier T3 and T4 health services with T1 and T2 social care physical activity services and maximise the opportunities for supported self management through shared decision making
Supporting Primary Care to implement evidence based care of osteo arthritis, providing early advice, education and management prior to any onward referral

The progress:

- Specialist MSK triage assessment and treatment service (SOOS) live in North and Shrewsbury localities, expansion into the South 10 th March 2018
- Appointment of SEM consultant to lead SOOS 1 April 2018
- Working with PHE to introduce effective local physical activity interventions
- Implemented prior approval for the VBC policy, with agreed schedule for future updates
- Signed up to the Shared decision making collaborative, with patient participation Jan 2018
- Improvement reported in the NJR PROMs
- CQUIN for MSK –health questionnaire outcome measure developed and currently being piloted
- MSK Physiotherapy specification developed and with local providers for implementation
- 2017/18 QIPP FOT of £3m from reduced secondary care intervention rates

Key Interventions / Milestones

- Timely direct access to MSK therapies operating under a single specification (April 2018) and central booking (Sept 2018)
- Shropshire Patients have access to services compliant with NICE OA Quality Standards , in Primary Care from September 2018
- SOOS established as Countywide community based specialist MSK assessment and treatment service from March 2018 & providing MSK triage by April 2018
- All routine MSK direct access to be coordinated through SOOS, the specialist access route April 2018
- Aligned incentives contract in place with RJAH from 1st April 2018

Risks to delivery

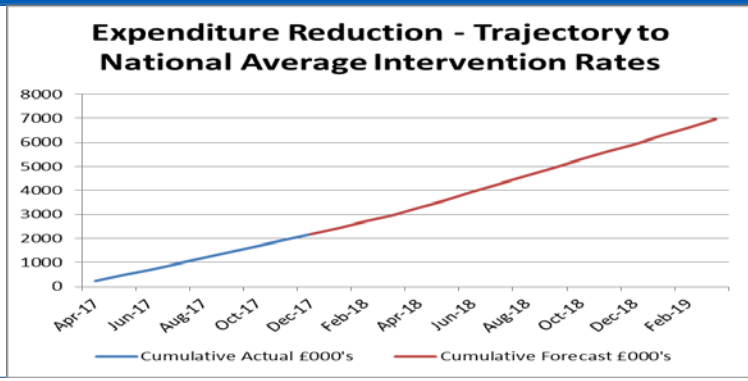
Risks

1. Lack of GP/provider engagement and support for the agreed pathways and associated compliance issues
2. Availability of conservative management
3. Patient expectation /acceptance of non surgical interventions

Actions:

1. Communication and engagement plan and targeted practice visits
2. Mapping of demand and capacity . Action plan to maximise utilisation and MSK business case to increase capacity
3. Patient and public involvement. Active engagement with and support from Health Watch and Shropshire Patient Group. Implementation of Shared decision making and partnership working with PHE .

Data



Acute & Specialist Programmes - Future Fit

Exec Lead – Phil Evans Project Lead – Andrea Webster

Programme needs to:

- Ensure safe progress towards a formal public consultation, including developing effective relationships with scrutiny bodies
- Once approval received, deliver a formal public consultation, analysis of data, final report and decision making process
- Ensure implementation of the action plans arising from the Clinical Senate Review and NHSE Assurance Panel feedback
- Co-ordinate the development and delivery of a robust IIA Mitigation Plan before the end of the consultation period
- Ensure the completion of a ambulance and patient transport impact modelling exercise prior to the end of the consultation period
- At the end of the consultation period, ensure robust analysis and full report to inform next phase of decision making

System Partners / Enablers need to:

- Support the effective delivery of the consultation with relevant clinical and managerial support to key events
- Contribute to the development of the IIA Mitigation Plan
- Ensure delivery of actions to timescale arising from external review exercises where individual stakeholder organisations are nominated as lead officers
- Develop and implement robust out of hospital/neighbourhood models which will support the required reduction in demand on acute hospital services in line with the Future Fit Activity and Capacity modelling and which also delivery effective and seamless integrated pathways between acute and community

The progress:

- NHSE assurance process undertaken
- Consultation materials developed and approved
- IIA Workstream established and held first meeting, next meeting scheduled for 5.3.18, chaired by RJAH Director of Nursing
- Ongoing monitoring of progress in implementation of the action plans from external reviews

Key Interventions / Milestones

- Approval to proceed to formal consultation by NHSE (date tbc)
- Consultation exercise completed and results analysed and report available to inform DMBC (date tbc)
- IIA Mitigation Plan and Ambulance Impact Modelling completed prior to the end of the consultation period in order to inform DMBC
- All key actions arising from external reviews of the programme completed
- Development of DMBC (date tbc)

Risks to delivery

Risks

Lack of resource to effectively deliver a public consultation, including programme management, patient and public involvement and communications, impacting on ability to receive QA from external assessor

Insufficient non-pay budget to deliver a public consultation of this scale

Significant political and campaign opposition to the proposals, impacting on programme reputation in the media

Uncommissioned activity, including travel and transport analysis, therefore impacting on planning public involvement in the process

Continuing delay in progess ing to formal consultation risks damaging the reputation of the programme and the increasing workforce challenges in SATH with recruitment and retention of ED clinicians risks decision to close PRH A&E overnight to maintain safe services has to be taken which could be viewed as predetermination ahead of completion of the consultation exercise

Actions:

Data

Pharmacia

Exec Lead – Project Lead –

Programme needs to:

- Awaiting details of this plan on a page – further update to follow

System Partners / Enablers need to:

The progress:

Key Interventions / Milestones

Risks to delivery

Risks

Data

Urgent & Emergency Care

System Improvements

Plan on a Page

Mixed format of Plan on a page and updates to reduce duplication

FRAILTY

Exec Lead – Fran Beck

Programme Lead – Emma Pyrah

SATH needs to:

1. **F1** Implement the MDT Frailty Team at RSH ED front door in line with AFN model
2. Adopt comprehensive Frailty Assessment Tool for use by MDT and wider hospital and make it a mandatory field in the electronic patient clerking system in ED
3. Avoid all avoidable admissions by MDT assessment/rapid care plan for ongoing care in community
4. If admitted ensure frail patients have a clear time limited care/treatment plan with an EDD to minimise LoS
5. **F2** Replicate at PRH
6. **Keep patients mobile** at all times to reduce de-compensation and rehabilitation needs
7. Discharge frail patients home on the agreed EDD

System needs to:

1. Implement the following schemes:-
2. F1: Shropcom to work with SATH to explore the potential for Shrewsbury DAART to function as the frailty assessment area
3. F3 Reduce admissions/re-admission from Care Homes by a) focus on high admitters; b) Care Home team (T&W)
4. F4 Reduce admissions/re-admission from Care Homes by a) focus on high admitters;) b Trusted Assessors (Shrops) to reduce Los
5. Reduce occupied bed days by impact of F1&2 and F3 & 4

The progress: 5.4.18

- Frailty MDT in RSH piloted since Sept – scheme continuing post end of non-recurrent NHSE funding at the end of March 2018.
- Evaluation report drafted and out with stakeholder partners for comment. Final report will be submitted to A&E Group 17.4.18.
- Mapping of existing services and pathways underway to inform the PRH model.
- Meeting being scheduled with SATH/Shropcom to explore the potential of DAART as the frailty assessment area
- £333K invested in new Care Home Team (T&W). 4 Trusted Assessors appointed to work with Shropshire Care Homes – start in post w/c 9.4.18
- Both CCGs to work with SPIC to focus on high admitting homes. Shropshire have commenced a deep dive to identify homes to target.
- System focus on 3 areas:-Prevention, Admission Avoidance and End of Life.
- CHAS being reviewed as part of 'Out of Hospital' service design
- Care Home Pharmacists appointed in both SC and T&W
- Practices using Frailty Index to identify/risk stratify patients – next steps will be ensuring all Care Home residents have advanced care plans/CHAS; and then all >75s

Interventions

- F1 Move Frailty Team to the front door PDSA February 2018 to ensure earlier decisions
- F2 Replicate model at PRH with Community Matron/Rapid Response
- Resolve payment for Frailty Teams from 1.4.18
- F3 Agree actions with 10 Care Homes and SPIC
  F4 Agree metrics for Care Home Team
- F5 Agree actions with Primary Care clinicians across both Shrops and T&W for practices to prepare care plans for all patients on Frailty Index

Risks to delivery

1. F1 & 2- risk that ED teams will not support the AFN model and allow Frailty MDT to make early decisions at front door before the ED Clinicians – this will waste time and opportunities for turn around on same day/avoid admissions
2. Workforce gaps to allow staffing Frailty MDTs
3. Insufficient awareness of the harm admissions can cause/understanding that de-compensation adds to delays/failure to embed rapid care/treatment/discharge to reduce LoS and discharge needs
4. Culture of 'bed based' care persists, and risk aversion to sending patients home first, or to prescribe bed based rehabilitation instead of home
5. Lack of ownership of all hospital staff to keep patients mobile – risk aversion re Falls
6. F 3 & 4 risk of insufficient engagement from Care Home managers/proprietors, and risk of hospital staff 'over-prescribing on going care needs on discharge.

Data

75+ admissions account for 25% of emergency admissions, and c75% of OBDs. Average LoS = 9.5 days

F1 & F2 will reduce admissions of Frail patients >75 by 7% (half the Frailty modelling number) **i.e.2205 f**ewer admissions (1483 SCCG 722 T&W) equivalent to 6/day. After 90 days the target will be revised and will rise to 9/day – **3,285**/year.

F1 & F2 will also result in corresponding reduction in OBDs of 20,897 (14,261 SCCG/6626 T&W), rising to 31,345

F3 & F4 will reduce admissions and LoS of Care Home residents – 2 fewer per day = 14/week = 728/year, with corresponding OBD reducing bed occupancy by 6,899. This will increase to 3 fewer admissions /day; 21/week; 1092/year after 90 days with corresponding OBDs reducing by 10,374.

Urgent & Emergency Care - Demand and capacity review

Exec Lead – Julie Davies Clinical Lead Project Lead –

SATH needs to:

1. Develop Chris Green's basic model to accurately reflect SaTHs demand and capacity
2. Agree final version of acute model and resulting actions agree project approach and action plan /timescales
3. Task and Finish Group to be set up to implement findings from acute model
4. Work with commissioners to define the acute support required to review and strengthen Discharge to assess in line with the findings of the out of hospital work

System Partners / Enablers need to:

1. System lead to visit Wye Valley to discuss implementation of SOP with Powys.
2. Gain input from Powys to the process by mid April
3. Draft report on out of hospital demand & capacity to be complete end of April
4. Workshop to receive out of hospital report early May, agree the findings, including chance to redefine and strengthen D2A
5. Agree project approach and action plan /timescales
6. Final plans to A&E Delivery Board in May

The progress:

1. Acute modelling meeting with SaTH was held 27th March
2. Review of PW1for Shropshire, Telford and Wrekin completed by end of March 2018.
3. Community Hospital capacity review completed
4. Not secured input from Powys to review
5. Draft ToR went to A&E board
6. SaTH COO has met with Powys team
7. Powys SOP being developed by SaTH COO

Interventions and process changes

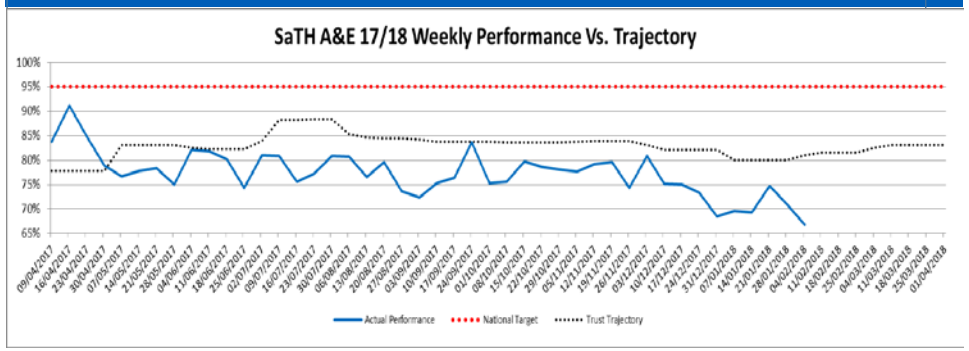
- Complete LOS reviews on all bedded environments by the end of February 2018
- Complete review of percentages of simple and complex discharges by 7th March 2018 and compare with national average
- Review findings of the Appropriateness Evaluation tool to add intelligence
- Complete Length of Stay review in the acute Trust- end March 2018
- Dennis Holmes to complete interviews with identified system leaders and staff – end March 18

Risks to delivery

Risk

1. Operational pressures prevent full engagement and involvement in review and development of an action plan and implementation.
2. Financial pressures prevent implementation of the review recommendations.

Data



3A. Project -Reduction in the Stranded Patient Metric

Project Overview				Overall Project Status
Project Title:	**Stranded Patients**	**Deadline:**		**AMBER**
Exec Lead:	**Edwin Borman**	**Project Lead:**	**Gemma McIver**	
Clinical Lead:		**Project Group:**	**Improving patient flow**	
Date of Report:	**18theApril 2018**	**% improvement in admitted performance target 4%**		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- SOP completed for check chase challenge
- Rota extended to end of July
- Planning for Peer review commenced
- Made Event planning on going
- Collation of patient stories around stranded for each group to use as an example
- Targeted support on ward 22
- Therapists attending CCC
- FFA immediate plan and long term solution scoped
- Referral to LA's for most complex flagged up in the check chase challenge - Richard worked this through at PRH

Key Issues/Risks

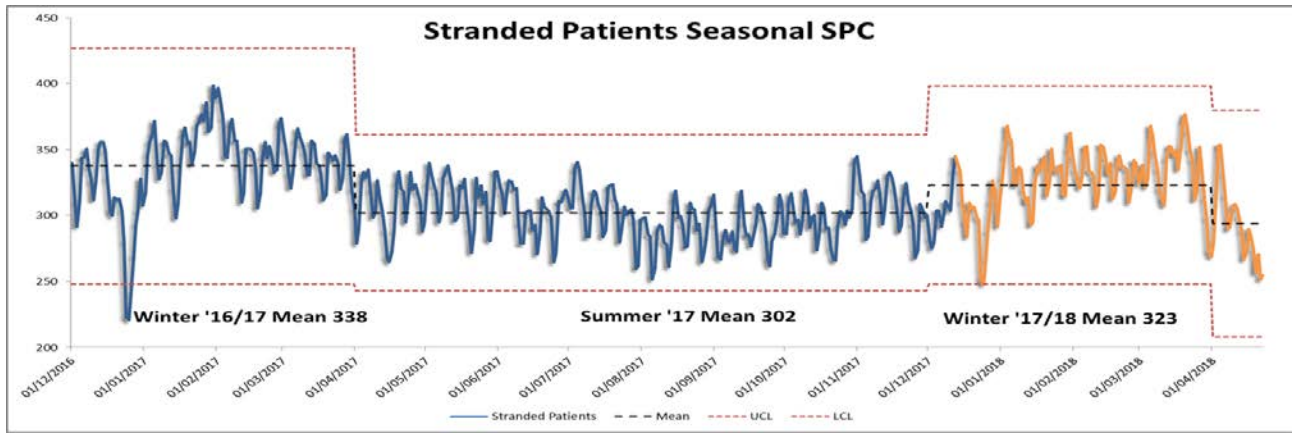
- Need senior clinical challenge, support and capacity to support sustainability of the improvements
- Forward look for PW2 beds and 3 Telford

Key Items for next week

- HRG top reasons for admission and stranded patients – bench marking on going
- PSAG use into CCC
- MADE
- Focused approach for CCC – more than one person extra MDT push for prep to bank holiday weekend?

Hospital	Base Position as at March 18	02/04/2018	09/04/2018	16/04/2018	23/04/2018	30/04/2018	07/05/2018	14/05/2018	21/05/2018	28/05/2018	04/06/2018	11/06/2018	18/06/2018	25/06/2018	02/07/2018
RSH	185	180	175	170	165	155	145	140	135	125	120	115	110	100	100
PRH	165	145	140	135	130	125	120	110	105	100	95	90	85	85	80
Total	350	325	315	305	295	280	265	250	240	225	215	205	195	185	180
Planned Reduction		(25)	**(35)**	**(45)**	**(55)**	**(70)**	**(85)**	**(100)**	**(110)**	**(125)**	**(135)**	**(145)**	**(155)**	**(165)**	**(170)**

Actual Midnight Monday				
RSH	177	175	164	157
PRH	113	125	126	124
Total	290	303	290	281



ED Systems and Processes

Project Summary

Project Overview				Overall Project Status
Project Title:	**Improving ED Processes**	**Deadline:**	**06.04.18**	**AMBER**
Exec Lead:	**Nigel Lee**	**Project Lead:**	**Rebecca Houlston**	
Clinical Lead:	**Dr Kumaran Subramanian**	**Project Group:**	**Urgent Care improvement Programme**	
Date of Report:	**25th April 2018**	**% improvement in admitted performance target**		**TBC**

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- ED flow coordinators in post – rota template to reflect reduced crossover
- Professional standards and SOP for doctors circulated for review – MC confirmed amendments required. To be discussed at meeting on 26/04/18
- Action tracker produced in line with trajectory included in Trust Operational Plan (saved on central drive for information)
- ED workforce Exec level meetings have taken place 20/04/18 and 23/04/18 due to significant fragility of staffing both departments
- Daily escalation of staffing levels provided to Medical Director
- 1 Consultant locum failed to attend as planning on 23/04/18 – awaiting confirmation of new start date and another locum consultant booked from 7th May
- ED Consultant interviews take place on 300418 – 1 shortlisted
- ED workforce and recruitment forecast plan completed
- Specialty performance report shared with NL and EB

Key Issues/Risks

- ED workforce status – impact upon ability to deliver required process changes
- Operational Team capacity to deliver required process changes
- Senior nursing sickness levels – awaiting outcome of plan
- Constant changes to medical rota to cover key shifts resulting in gaps 'within hours' is resulting in significant delays tbs.
- Financial impact of highly escalated salaries for overseas doctors and locums
- Additional physio clinics following the ED clinics no longer being in place – funding source required
- CDU paper – funding for staffing not yet confirmed
    - Medical capacity to review clinical pathways for CDU/AEC is limited
    - Inappropriate use of CDU – daily monitoring

Key items for next week

• Continue to embed CDU • All patients to be managed against professional SOP's/ professional standards • On-going recruitment drive and review of potential locums • ED Nurse Coordinator meetings being arranged – professional standards to be included at session • Continue to push internal ED actions to improve non admitted performance • RPIW Specialty Review commencing 30/04/18

Performance metrics

• April MTD non admitted performance is 86.89% against a target of 88% • April MTD admitted performance is 37.79% against a target of 53.4% • CDU at PRH average of 9 patients a day with an average of 2/10 already breached due to the unit not being open 24/7. Throughput is currently an issue due to delays in being seen

Red2Green/SAFER

3A. Project Summary

Project Overview				Overall Project Status
Project Title:	Objective 7 - Red 2 Green/SAFER	Deadline:		AMBER
Exec Lead:	Deidre Fowler	Project Lead:	Rachael Brown	
Clinical Lead:	To be agreed for each site	Project Group:	Improving patient flow	
Date of Report:	25th April 2018	% improvement in admitted performance target 4%		

3B. Progress, Issues/Risks, and Decisions

Key Items completed this week/since the last report

- Red2Green tracker form converted onto psag. In 'test' phase currently. To 'go live' beginning of May in line with EDD update. Comms and training required for staff
- Super - stranded patient reviews continue to take place on a weekly basis for both care groups across both sites. Weekly escalation meetings in place to discuss and highlight patients for further attention. Task and finish group establish to support this work.
- SAFER pin board monthly information available on people link boards. Evidence supports improvements to morning discharge numbers – ward 27 and ward 28 (from single monthly figures to double figures). Currently no ward is achieving 1 pre-lunchtime discharge daily. The impact has been less in SC wards, this could be due to the baseline from where the team were starting from, or as a result that the red2green support 4 areas and not 1 ward.
- Weekly information / feedback developed for all ward areas focusing on SAFER scoreboard, to commence April onwards.
- Theory of constraints focusing on ward 22 T&O and ward 22S&A – ongoing support for the work provided by Red2Green team
- Check, chase, challenge process in place across both sites, all care groups. Metrics agreed to uncover key delays / blocks in patient journeys. Task and finish group in place. Therapists now attending their ward areas daily.
- Red2Green team taking place in RPIW for FFA completion – 30 day period in place at PRH.
- RPIW completed for CLD, Red2Green supported. Patient journey facilitator continues to support ward for the next 30, 60, 90 day period. Discharge performance continues to improve in March / April, pre10 and pre 12., although still reliant on a consistent approach from the team to board round attendance and use of CLD.
- Launch of 70 day end pjparalysis on both sites / both care groups.
- Snapshot feedback gained from areas supported by Red2Green regarding board rounds/ ward rounds, CLD and the 4 questions.

Red2Green/SAFER

Key Issues/Risks

- FFA ownership of completion
- Discharge planning process and med fit category, changing of pathways, and ability to 'flag' complex patients earlier in the patient journey. Changed available on psag
- Internal blocks: doctor review / specialty referrals and FFA completion still highlighted as areas of concern
- Lack of red2green tracker form completion leading to insufficient and potentially misleading data on some wards. Weekend completion remains poor
- Workforce shortfalls, hinder consistency at board and ward rounds, and inhibit flow

Key Items for next week

- Continue to work with the identified wards to understand processes, key issues and effectiveness with a view to making further improvements
- Continue to support RPIW for FFA completion on ward 10 and 11. Not in test period 30, 60, 90 days.
- Continue to support RPIW for CLD on ward 32 during test period 30, 60, 90days.
- Stranded patient reviews both care groups, with weekly metrics, and escalation.
- Check, chase, challenge approach and process and outcome from meeting.
- Planning underway for a MADE event in May.
- Continuing with 70 day end pjparalysis challenge
- EDD changes to psag – training of staff

Shrewsbury and Telford Hospitals NHS Trust
Integrated Discharge Team

NHS England

NHS Improvement

Health and social care system needs to:

1. Ensure an integrated team discharge team approach continues to develop.
2. Continue to support the admission avoidance pathway provided by Rapid Response nursing and social care teams.
3. Review current team scope to further improve performance.
4. Improve flow through discharge process to maintain performance by improving the level of rigour particularly in the intermediate care bed process.
5. Haver a single narrative in the form of a system wide operational framework for intermediate care in Telford.

System needs to:

1. Increase membership and increase input to the current integrated discharge processes particularly enabling SaTH therapy directed transition planning for discharge.
2. Further develop towards an integrated discharge team using the guidance on the High Impact Change Model, Jan2018 (Slide 6)
3. Support the current demand and capacity modelling across the system.
4. Implement the aspiration target of 21 days length of stay inn the intermediate care beds to improve flow and access.
5. Further develop the system wide assistive technology offer.

The progress:

1. Review day held 5/2/18 for all system partners in discharge and intermediate care planning including; SaTH/SSSFT/SCHT/TW CCG/TWC/third sector/independent sector.
2. System wide operational refresh intermediate care framework agreed by all partners.
3. Review of intermediate care beds provision and process carried out by CCG quality Lead Nurse and improvement action plan developed as a result.
4. Visit booked to Warwickshire to view best practice model.
5. From 26/2/18 British Red Cross will be seeing all PW 1 patients before discharge on the ward and once home if required.
6. Since Jan 18 specific OT to support patients being discharged from intermediate care to prevent re-admission.
7. Well-being sessions being offered to those on GP Frailty list following MDT to prevent urgent admissions to hospital.
8. NHS Digital bid submitted to join up partner discharge planning

Interventions and process changes

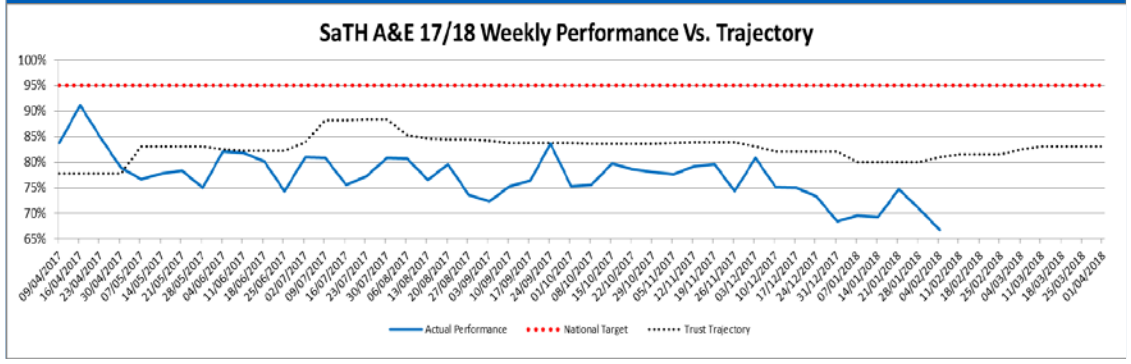
- Set criteria met nurse discharge especially at weekends
- Operational intermediate process and framework review and system wide agreement to new framework.
- Training across all partners regarding new intermediate care process.
- Red, amber, green process for all intermediate care pathways with twice weekly monitoring and MDT's. tracker post out to advert.
- Point prevalence/audit to review progress against new framework
- SaTH therapists to goal set for minimum 72 hours post discharge
- Transfer by relative/Red Cross should be default unless otherwise indicated
- Anticipatory equipment planning and prescribed meds with person day before discharge

Risks to delivery

Risk

- **Provider failure dom/bed based care. Mitigation plan in place**
- **Lack of collaboration between partners. Framework in place across all partners including training and routine consultation and collaboration.**
- **BCF sufficiency to meet demand. New governance structure to support BCF board to monitor performance.**

Data



Urgent & Emergency Care Programme – IV Therapies

Exec Lead – Steve Gregory Project Lead –

Programme needs to:

- Awaiting details of this plan on a page – further update to follow

System Partners / Enablers need to:

The progress:

Key Interventions / Milestones

Risks to delivery

Risks

Data

Urgent & Emergency Care Programme – Therapies

Exec Lead – Steve Gregory Project Lead –

Programme needs to:	System Partners / Enablers need to:	The progress:
• Awaiting details of this plan on a page – further update to follow		

Page 34

Key Interventions / Milestones

Risks to delivery	Data
Risks	

Transformation Enablers

System Improvements

Plan on a Page

Digital Enabling Programme

Updated April 2018 Next update– June 2018

Exec Lead – Clinical Lead - Programme Lead – Rob Gray

Programme needs to:

- Refresh the Local Digital Roadmap (LDR) to focus on most beneficial changes.
- Connectivity : Provide seamless access networks and efficient procurement of new connections / wifi access for staff and citizens at all locations.
- Populate Information sharing Gateway with agreements to allow sharing of information between organisations.
- Formulate an STP-wide plan for Cybersecurity: Ensure records and systems are secure.
- Licensing: future proof and cost efficient route for Microsoft and Office upgrades (towards O365 and CloudFirst)
- Support digital requirements for all other programme groups
- Improve Digital Maturity Assessment scores to support programme success.
- Develop funding bids for possible future funding availability
- Appraise options for an Integrated care record across health and social care settings.
- Identify the capability for Interoperability across the STP area.

System Partners / Enablers need to:

1. Clarify the end vision and the level of commitment required from organisations.
2. Act as One! Agree the objectives of the enabling group with in the strategic governance process at exec level
3. Standardise on clinical coding (SNOMED-CT) for all organisations.
4. Provide resource (inc funding, project management etc) to define and plan programmes and projects
5. Involve digital solutions in all workstreams. Promote the modernisation and efficiency of paperless processes to increase efficiency through a digital programme
6. Conform to cyber-security requirements – and resource specialist support
7. Provide Strategic direction for an STP solution to enabling a system wide approach to an infrastructure that enables the use of all modern technologies to improve frontline patient care.

The progress:

- Universal Capabilities: target to significantly deliver by March-18 – successful. (9/10 see data below). New programme items to be decided in refreshed LDR.
- linking with Maternity to strengthen the link with Digital and structure the changes required. Workshop scheduled to clarify the digital items in the programme.
- Information Governance – ISG signed up to by all agencies, progress report requested
- Refined membership of the clinical group and programme board using questionnaire.
- Investigating programme management software for use across the LHE.
- LDR refresh plan accepted at DEG. Workshop to be scheduled.
- LDR update also requested by GP IT Forum to guide their programmes.

Key Interventions / Milestones

- Data Sharing Agreements on Electronic register across the LHE — May 2018
- LDR refreshed and new Digital Programme defined. GP IT Forum also follows lead of LDR.
- Electronic Patient Record systems need to be procured for SaTH and RJAH to support shared access to Integrated care records.
- Network - shared procurement in place. Access for all orgs at all sites
-

Risks to delivery

Risks

Resources – (lack of funding, governance and leadership to progress strategic planning, and availability. commitment from senior management to release or increase resources)
Lack of Technology standardisation - Action :Identify interoperable platforms and recommending their use across the STP
Licencing costs are set to increase with a requirement to migrate to a supported set of office applications with revenue costs instead of capital.
Executive Strategic Direction
Lack of clear co-ordinated approval processes for schemes with a cross-organisation impact.
Complex governance arrangement (STP is not an executive group with delegated authority.)
Lack of consistent engagement from social care and mental health trust.
Uncertain leadership of the DEG. No consistent CCIO appointment process and no DEG CCIO position defined.
Actions:
Creation of 3 supporting groups

Data

ID	Universal Capability	Significantly deployed	Pass
A	Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions.	Pharmacists using more than most	Y
B	Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC).	SaTH has it available, but not yet using process to access via spine	Y
C	Patients can access their GP record.	Available 98.2% - 0.12% registered to use	Y
D	GPs can refer electronically to secondary care.	GPS refer via e-referrals to RAS/TRAQS.	Y
E	GPs receive timely electronic discharge summaries from secondary care.	Stats on discharge summaries issued within 24 hours of discharge to be collated by provider.	Y
F	Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care.	Some improvement possible, but significantly deployed	Y
G	Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly.	CPiS on Spine SCR	Y
H	Professionals across care settings made aware of end-of-life preference information.	Not by Digital. Evaluation did not prove that Digital would help	N
I	GPs and community pharmacists can utilise electronic prescriptions.		Y
J	Patients can book appointments and order repeat prescriptions from their GP practice.	!00% offer. 15.2% registered	Y

Strategic Estates Programme

Updated April 2018 Next update– June 2018

Exec Lead – Clive Wright

Programme Lead – Becky Jones

Programme needs to:

- Use data in geographic layers at a very local level as evidence of emerging community need, & how or if they are being addressed
- Identify opportunities for developing community hubs, housing solutions or projects to support economic growth, where a local need is present.
- Inform the requirements for future service provision and ultimately guide the utilisation of the public estate
- Ensure estate is accessible, efficient and safe.
- Engage the expertise and knowledge of public sector delivery leads in developing community needs-based projects stemming from opportunities created by the One Public Estate work-stream.

System Partners / Enablers need to:

- Provide an integrated and co-ordinated healthcare estate relevant to redesigned patient /service user and staff pathways under the STP
- Deliver a reduction in estate
- Reduce / plan removal of backlog maintenance
- Support Estate aligning with and utilising the One Public Estate agenda
- Utilisation aligned with Carter review
- Deliver a Reduction in annual revenue costs
- Provide flexible estate that will enhanced a dynamic healthcare economy
- Develop local solutions drawing on all the assets and resources of an area
- Build resilience of communities.

The progress:

- SHAPE database validation undertaken by all partner organisations.
- Estates Workbook & Disposal produced, now a 'living' document
- Initial Community Needs workshop 27 Feb 18 to inform future Estates projects delivered with engagement from senior reps inc. Public Health England, CCG's Providers; VCSA, Adult & Social Care, DH, Early Help, Shropshire Council, Keele Uni, Housing, Economic Growth, Community Health FT, Nature Partnership, Data Analyst/Intelligence,
- Similar repeat workshop planned for Telford localities 17Apr18*
- Project Manager & Project Group in place for Whitchurch Project, following successful OPE bid. Now moving from strategic planning to delivery
- Asset Mapping & data layering work with Shropshire Council going well, producing evidence base & assisting to inform opportunities

Key Interventions / Milestones

- Circulate workshop outcomes , feedback through STP/Council/OPE partners/Local Councillors. Market Town specific Workshops to inform next steps
- Run Telford & Wrekin Workshop, identify opportunities and then bring together all opportunities into one whole system approach
- Overarching and adopted estate strategy aligning with the estate outcomes and key STP outcomes
- Outline rationalisation plan, with better use of void space, shared/bookable space, joint utilisation, extended opening hours, energy efficient
- Evidence using Geographical Intelligence Systems applied in layers ; to include Voluntary Sector services

Risks to delivery

Risks

- Timelines for funding bids vary across different organisations; aligning for cross-organisational estate projects difficult to achieve.
- Aligning existing projects and agreement on potential future opportunities
- Engagement not fully embraced
- Rejection of future capital bids through omission of estate projects/concepts from STP Estates Strategy
-

Actions:

- Transparency and awareness of funding timelines between organisations
- Agreed approach to partnership working
- Identify and Plan for interim arrangements
- Comprehensive links across all STP workstreams/enablers to include their known and anticipated estate implications

Data

- Validation and updates of SHAPE database (Health Service Estates) by all relevant organisations; ongoing requirement to maintain accuracy
- Property and Estates (Shropshire and Telford), Freehold land, Leasehold land, Leased land;
- Transport , Shropshire and Telford Bus routes 2016, Car and Van ownership *(2011 Census);*
- Demographic (covers Telford and Shropshire) *(2016 MYE ONS)* ,
- Deprivation (2015 IMD, DCLG)
- Community Facilities (e.g. libraries/schools)
- Older People,
- Health, including long-term illness & disability; health deprivation
- Planning Themes (Planning and Land Use Monitoring
- systems, Planning Policy Team
- Economy
- Housing Affordability

Strategic Back Office

Updated April 2018 Next update– June 2018

Exec Lead – Ros Preen Programme Lead – Maggie Durrant

Programme needs to:

- Update the planning assumptions made in the 5 year STP financial plan and identifying a more robust view on the scale of savings in the following areas;

Corporate services savings in the health economy, using recent benchmarking data,
Shared recruitment processes (being developed by the Workforce Work stream
Procurement savings through model hospital and PPIB data
Estate rationalisation (developed by the STP Estates Work stream)

- Develop an over view that makes it clear what exists in plans already and whether the programme can stretch the thinking to gain more operational and financial value (e.g. target set to drive costs to the national median).

System Partners / Enablers need to:

1. Support a level of ambition proposed by the programme – ie. drive costs to the national median (where there is one or other agreed benchmark where there isn't),
2. Sponsor and support the collaboration on key priorities, initially by sponsoring the CSU's diagnostic and option appraisal process.
3. Have an 'open book' approach to data and information to enable opportunity assessment,
4. Develop the relationship with other STP stakeholders to assess the opportunity for wider public sector benefits,
5. Agree a change programme in due course.

The progress:

- The work stream has demonstrated good practice in collaborating and sharing information between NHS providers.
- Underpinning case for change still holds true.
- Individual STP work streams are working on discrete aspects of rationalisation or collaboration (estates and workforce)
- All providers are using benchmarking data to support decision making

Key Interventions / Milestones

- Initial exploration of the Model Hospital opportunities for Providers, including corporate services and ambition set – February 18
- Initial discussion with Midlands and Lancashire CSU Value Add proposal to pump prime further review and option appraisal – March 18
- Commence CSU diagnostic – April 18
- Evaluate CSU diagnostic conclusions and agree programme of change – Summer 18
- Implement change programme – Autumn 18 onwards

Risks to delivery

Risks
The scale of opportunity will not be realised due to;

1. Lack of collaboration beyond health on procurement.
2. Capacity to drive ideas forward across organisations at pace
3. Lack of willingness to collaborate on a joint agenda and give or pass on sovereignty by individual organisations.
4. A Shropshire centric preference not accessing the opportunity where it is at its greatest on a wider footprint (ie out of STP boundaries)

…….
Actions:
A review of the effectiveness of the existing county wide Procurement Group
Using the CSU diagnostic and option appraisal process to increase pace, draw conclusions and propose a change programme which will require tangible agreement.

Data

Model hospital (Carter)
Corporate services data (Model Hospital)
NHS Efficiency Map
Procurement data (PPIB)

Strategic Workforce Programme

Updated April 2018 Next update– June 2018

Exec Sponsor – Jan Ditheridge Exec Lead – Victoria Maher Programme Manager – Sara Edwards

Programme needs to:

1. Develop a system-wide **Strategic Transformation Workforce Plan.**
2. Develop and implement a system **Organisational Development Plan** to support new ways of working.
3. Develop **workforce sustainability** through the identification of learning and development, education and training needs and through supporting system programmes to implement change.

System Partners / Enablers need to:

- **Work closely to share workforce intelligence**, undertake workforce modelling and strengthen system ownership of workforce strategies.
- **Work collaboratively** to attract, recruit and retain the current and future health and care workforce.
- **Agree system-wide requirements** in order to maximise the education, development and training opportunities for our workforce.
- Lead a **system programme** that delivers transformation and sustainability.
- Lead **cultural change** through health and care that supports **integrated working** which prioritises patients resulting in improved population health and wellbeing.
- Deliver **system-wide workforce solutions** and improvements in response to the system workforce challenges.

The progress:

- Agreement between STP partners on **priority areas.**
- **System-wide Workforce Strategy** initial stages begun .
- **Mental Health Workforce Plan** March submission on schedule
- **OD plans and Workshops** with King's Fund underway.
- **Local Maternity Services (LMS) Transformation Plan** developed with workforce analysis being undertaken.
- **GP Forward View Workforce Plan** and delivery of GPFV primary care workforce projects underway.
- West Midlands agreement for **consistent /shared statutory and mandatory training** across NHS organisations.
- **2017/18 workforce investment programme** of £817,600 covering both primary care and acute services.

Key Interventions / Milestones

Complete the **workforce profile data** gathering and individual specialist workforce plans.

Leadership and OD Programme with the King's Fund ongoing. STP Partner attendance on **TCSL Programme .**

Development of **Shared Recruitment** project and **Collaborative Bank.**

Implementation of a pilot **Rotational Apprenticeship Programme.**

Delivery of **STP/LWAB funded priority areas** and development of a **shared training/learning** offer to meet system needs and promote integrated working.

Risks to delivery

Risks:

- Planning without knowledge of future finances and service redesign/configuration.
- Varying levels of stakeholder engagement driven by different approaches to Workforce and access to data.
- Ability to fund workforce development activities both in terms of finance and time.
- Risk to quality of STP submissions due to a lack of clarity around requirements .
- Timely decisions in respect of funding which affects education, development and recruitment.

Actions:

- Ensure strong workforce links with STP clinical /service priorities reporting into the Strategic Workforce Group.
- Continue to build relations through working together on identified projects/ task & finish groups.
- Identify priority development areas and align through STP PMO processes.
- Collaborating with HEE to access support and align programmes.
- Piloting areas of work to test outcomes.

Data

Shropshire Workforce Baseline: HEE are developing an STP dashboard for workforce data which will use NHS organisations workforce data submitted to NHSI as part of the operating plan submission on 8th March along with social care data from the NMDS. There is also the potential for Skills for Health to undertake some analysis on behalf of the STP.

Individual areas of workforce:

- Mental Health Workforce data included in the submission of the MH Workforce Plan in March.
- Maternity workforce data being developed as part of the LMS Plan
- Primary Care workforce data has been collated as part of the GPFV Workforce Plan
- Future plans to include Cancer Workforce.

Strategic Communication & Engagement Programme

Updated April 2018

Next update– June 2018

Exec Lead – Martin Evans

Programme Lead – Pam Schreier

Programme needs to:

- Create a comprehensive communications and engagement strategy, building on the wider vision and values OD activity, to encompass all workstreams of the developing STP, ensuring co-production with all stakeholders
- Provide communications and engagement support to STP priorities
- Develop channels for communication of STP activity
- Provide advice, support and guidance to individual workstreams, facilitating two-way communication and identifying content for communicating across the STP partners and beyond

System Partners / Enablers need to:

1. Work together to utilise each organisations' limited resource for patient involvement and communications
2. Ensure synergy across core delivery partners - such as providing additional assurance that the delivery of the plans is embedded within the sponsoring organisations' own activities, but also provide insights on how to best deliver across the wider community that the programme impacts
3. Develop and embed a cohesive vision and values for the STP footprint that each organisation and their staff recognise and understand, thereby facilitating the production of a meaningful communications and engagement strategy

The progress:

- Communications and engagement workstream meets monthly and includes representation from all partner organisations, including Healthwatch
- Communications and engagement leads aligned to each of the workstreams, to offer support and advice and gather progress articles

Key Interventions / Milestones

- Gain a clear understanding of the vision and values of the STP that have been signed up to by all partners
- Map activity across workstreams to understand timing of potential service changes
- Develop a comprehensive communications and engagement strategy
- Develop and deliver channels for communication of STP priorities
- Support service reconfiguration activity

Risks to delivery

Risks

Lack of building blocks in place to effectively resource (pay and non-pay) the activity required lead to an inability to develop and maintain external, internal communications

Lack of understanding of the proposed overall plan for the STP leads to public objections.

Limited system wide resource may lead to failure of workstreams to adhere to required processes leading to assurance test issues going forward.

Inadequate patient, citizen, stakeholder involvement in proposed service transformations, leads to public opposition and a potential failure to meet assurance tests moving forward.

Lack of coordination or necessary timings lead to service reviews and potentially consultations taking place at the same time, leading to public confusion and opposition.

Negative presence in the media undermines confidence in the programme which may lead to distraction, unnecessary excess utilisation of resources and finances.

Data

Plan is to use Comms & Engagement data to inform

1. Public perception of service changes
2. Confidence levels in strategies and plans
3. How well we are including stakeholders in our redesign and service changes
4. Measure responses from websites and surveys

Population Health & Prevention

Exec Lead –Rod Thompson

Clinical Lead - Helen Onions / Emma Sandbach

Updated April 2018 Next update– June 2018

Programme Lead – Penny Bason

The programme needs to:

1. Develop our wider workforce to 'make every contact count' (MECC+) / proactive identification of people at risk of ill health and behaviour change conversations, brief interventions
2. Prevent harm due to alcohol, obesity and CVD
3. Support culture change and new working practices that help people at the earliest opportunity
4. Support active signposting and develop a good understanding of how communities support people – linking to Social Prescribing
5. Work across organisations (including the VCSE) to prioritise support for key population groups – address inequity and inequalities
6. Support and embrace the role of the VCSE and communities to drive forward prevention activity
7. Focus on developing a good understanding of need – continual information provision for the JSNA
8. Improve communication between organisations

System Partners / Enablers need to:

1. Systematically raise awareness and deliver lifestyle advice, signposting and referral by healthcare and other professionals, e.g. through MECC +, PHE's One You, including for:
   - Stop Smoking Support
   - Weight management
   - Physical activity programmes
   - Immunisation opportunities, e.g. flu
2. Improve the prevention, detection and diagnosis of CVD, specifically diabetes and hypertension
3. Radically upgrade the role of the NHS in tackling harmful alcohol consumption, through screening, identification, brief advice and referral into treatment services
4. Deliver prevention expectations of the national Cancer Strategy
5. To ensure the systematic delivery of mental wellbeing services, including identification of mental ill health and prioritisation of emotional support
6. **Work together to make best use of resource and expertise**

The progress:

STP

Mobilisation of the National Diabetes Prevention Programme March-May
Neighbourhood working to build community capacity- focus on Healthy places, Active and Creative communities
Delivery of Social Prescribing initiatives and infrastructure
Supporting Carers through all age strategies and Dementia Companions
Delivery of Fire Safe and Well Visits (since July 17)
Develop and deliver a system prevention framework for all pathways
Developing very positive joint working across health and care
Individual Placement Support Service for those in secondary MH services

Telford & Wrekin – Healthy Telford

Borough-wide lifestyle offer
Twitter and blog – using social media to inspire behaviour change
Developing and nurturing our community health champions
Public Health Midwife, stop smoking support and maternal health advice

Shropshire – Healthy Lives

Development of an Integrated Care Navigation Programme
Delivery of Healthy Lives Programme and prevention services

Opportunities

- Smoke free hospital and brief interventions in hospital
- Connecting to workforce (and funding) to support development of staff (link to MECC plus)
- Mental health hubs, MH support in Local Maternity hubs, Early help for children and young people, link to Estates
- Healthy hubs and social care support/ advice and guidance in hospital
- Risky behaviour CQUIN - link to MECC Plus

Key Interventions / Milestones

- Improve access and use of population health and wellbeing data from across the system to support decision making
- Develop and Deliver System CVD & Diabetes Strategy
- Deliver the prevention expectations of cancer strategy
- Develop system social prescribing infrastructure
- Develop and Deliver System Obesity Strategy
- Development of a system plan to reduce harm related to alcohol
- Develop the system MECC Plus proactive approach, including training and delivery plan

Risks to delivery

1. Lack of buy in by partner organisations
   - Risk to strategy delivery
   - Risk to culture change needed
2. Investment in prevention programmes (national and local)
   - Local Authority Public Health Grant challenges
   - Lack of NHS investment in prevention
3. Medical and nursing capacity
   - NHS Trusts (SaTH, SSSFT, ShropCom, RJAH)
   - Primary Care

Outcomes – how do we know it's working? DRAFT

Public Health Outcomes Framework
- Healthy life expectancy
- Health Equity
  - Smoking rates
  - Obesity – children and adults
  - Physical activity
  - Wellbeing measures – Social Prescribing
  - Reduction in GP attendances
  - Reduction in unplanned hospital admissions
  - Cancer rates
  - Harm due to alcohol – alcohol admission rates

Connecting to other programmes

- Health and Wellbeing Boards Strategic Planning (both T&W and Shropshire)
- Better Care Fund (T&W and Shropshire)
- Rightcare
- STP Neighbourhoods and Out of Hospital Programmes – community development,
- GP 5 Year Forward View –
- Mental Health 5 Year Forward View – preventing
- Maternity Services Transformation
- Workforce – developing our
- Estates Partnership
- Musculoskeletal and Falls System Planning

System Strategic Finance Programme

Updated April 2018 Next update– June 2018

Exec Lead – Claire Skidmore Programme Lead – Paul Gilmore

Programme needs to:

- Provide clear, timely, accurate and relevant financial information and reporting to internal and external stakeholders including NHSE/NHSI, member organisations, Executive groups and individual work stream programmes and enabling work streams
- Support individual and collective work stream program managers, provider and commissioner finance teams to provide financial guidance to achieve defined outcomes and benefits including specific programme targets and timelines
- Support identify the optimum decisions with pertinent financial information.
- Increase the financial profile and raise financial understanding amongst non-financial management
- Better understand the objectives and congruence with each work stream to advise most appropriate action/outcome.
- Provide clear financial overview of each work stream, timing and planned gap to achieve overall financial control total.

System Partners / Enablers need to:

- Clearly define objectives, activity, resource, milestones within each program work stream to enable accurate assessment of financial impact and timings of each work stream quantifying target financial benefit / cost.
- Clearly define current financial position for each work stream
- Share all pertinent current financial information.
- Organisations needs to appoint and advise of financial resource (personnel) for each project.
- Greater financial transparency; Organisation needs to share financial information sufficient to be able to identify potential double counts for QIPP/CIPS and identify any performance / activity / demand / income / expenditure gaps.
- Identify additional cost savings to recover adverse in year FOT performance
- Include a suitable provision (target over-performance) to cover performance slippage and help protect control total target attainment

The progress:

- Identifying current financial gaps in STP outturn group performance
- Started to work with LMS projects to understand project objectives, milestones and financial impact with timings (process needs to be completed for all work streams)
- Supporting Estates work stream improving financial transparency and congruence with the members' strategic capital investment plan Establishing a credible portfolio of executive reporting tools for financial transparency to aid control and improve relevant response
- Developing a risk register that includes valuations of risk, pre and post mitigation potential
- Building strong links with CCG and provider finance teams to aid transparency and consistency to help provide a congruent financial footing for effective decision making

Key Interventions / Milestones

Understand and report control gap
Support work streams, providing financial management, help define and achieve financial and quality goals

Work with the Integrated Care System and work streams to:
1. attain / retain identified financial and quality benefits
2. Identify additional opportunities to recover the reported control deficit

3. Establish a work plan provision for a robust trading position (aim for over delivery)

Develop and deliver channels for communication of STP priorities

Identify capital requirements and ensure full disclosure (link with estates strategy

Risks to delivery

- **Risks**
- '17/18 FOT negative variance from control totals; achieving underlying financial performance targets. Additional plans required to recover this forecast deficit.
- Future CIP, QIPP and STP double counts between commissioners / providers
- Co-operation and necessary disclosure between all member organisations.
- Triangulation and accuracy of contract activity and income assumptions between CCG and provider.
- Availability and timing of capital for strategic change e.g. Future Fit requirements.
- Resource; STP finance support available throughout project life .
- Extended double running; timings of inter-connected and enabling work streams essential to ensure efficient transformation and full financial benefit attainment.

Data

1. System Data in relation to finances will be shared via the following routes
   - Strategic Leadership Group
   - Organisational Board Meetings
   - System Finance Group

All data in relation to system finance will need to be consolidated and checked for accuracy

STP PMO Resource

STP PMO Support

- STP PMO are a flexible system resource allocated across a number of Transformation Enabling & Delivery programmes
- Their key role is to support existing system staff: Programme Management, including project set up, engagement, reporting, risk mitigation, benefits realisation.
- STP PMO can provide standard templates and methodologies where those don't already exist and support the system as required.
- They hold a system wide view and can help identify interdependencies and risks across system programmes of work
- STP PMO are NOT leaders for programme delivery, they support coordination and facilitation to drive change. The leaders come from within the system itself.
- The PMO will hold the System Project register

Current Support Provided

- The next slide shows the STP Team Resource and allocated area of work
- Where STP Partners have existing resource, the ethos is to work in a matrix approach to avoid duplication and to ensure added value
- Collaborative working will be facilitated through SharePoint shared files and virtual working practices using Skype and Microsoft teams

STP Governance

- STP has no authority and is bound by current governance arrangements, it relies on partnership and trust between STP Partner Organisations through the STP Strategic Leadership Group (System CEO's)
- STP Priorities are driven nationally & locally and are influenced by System Leadership and STP Clinical Strategy Group
- Patient & Public involved is required in Every Delivery & Enablement Group, it's a requirement of individual workstreams to ensure this occurs as required.
- STP Programme Board is where system Programme Delivery and Enabling Workstreams come together to share progress and mitigate / escalate risk as required (this Group is due to be reconvened in April 18)

To contact a member of the team or ask any questions please contact:

STP Programme Director	Phil.Evans1@nhs.net	STP Programme Leadership
STP Urgent Care Director	Claire.Old1@nhs.net	System Urgent & Emergency Care
STP Head of PMO	Jo.Harding1@nhs.net	PMO Transformation & Enablement
STP Communication & Engagement Lead	pam.schreier1@nhs.net	System Communication & Engagement
STP Senior Project Administrator	J.Knott@nhs.net	STP Diaries, Meetings, Events Requests,
STP Programme Manager	Andrea.Webster5@nhs.net	Future Fit, Transport, Telford Neighbourhoods
STP Programme Manager	Penny.Bason@nhs.net	Future Fit, Population Health, Prevention,
STP Programme manager	Robgray@nhs.net	Digital Enablement
STP Programme Manager	sara.edwards3@nhs.net	Strategic Workforce
STP Programme Manager	Maggie.durrant@nhs.net	Estates, Back Office
STP Programme Manager	Paul.gilmore1@nhs.net	System Finances
STP Programme Manager	Jill.barker3@nhs.net	Urgent Care, MSK
Future Fit Programme Support	haley.barton1@nhs.net	Future Fit Programme Project Support
Future Fit Senior Communication & Engagement	niki.mcgrath@nhs.net	Future Fit Programme
Future Fit Communication & Engagement	kathryn.smith37@nhs.net	Future Fit Programme

All Resource is coordinated through STP Programme Leadership and PMO and area's of responsibility may change according to STP priorities.
The team work across all sites and are a combination of full and part time staff.

If you have a programme of work not already identified in this slide pack that you would like to see developed across our system that has clear **SYSTEM** benefits:
Please contact jo.harding1@nhs.net
Existing governance arrangements will still apply to all programmes of work in terms of approvals

Updated Version 3.0
Feb 2018

Shropshire, Telford and Wrekin
Sustainability & Transformation Programme Governance Structure

STATUTORY ORGS
Requirement to adhere to own governance procedures

Provider Boards
Commissioner Boards
Local Authority Cabinets

- Telford & Wrekin CCG
- Telford & Wrekin LA
- SaTH
- RJAH
- ShropCom
- SSSFT
- Shropshire CCG
- Shropshire LA

STP System Leadership Group

(System CEOs)

Health & Wellbeing Boards

Joint Health Overview Scrutiny Committee

STP Clinical Strategy Group

(System Clinical Leads)

STP Transformation Programme Delivery Board

System Enablers

- Strategic Workforce Group
- Communication & Engagement
- System Back Office
- Strategic Estates Group
- Digital Enablement Group
- System Finance Group

Telford & Wrekin

1. Community Resilience & prevention
2. Neighbourhood Teams
3. Systematic Speciality Review

- Local Maternity Services
- Muscular Skeletal Services
- Future Fit Sustainable Services Programme
- Frailty
- Development of Primary Care
- Mental Health
- System Cancer
- System End of Life programme
- UEC High Impact Changes

Shropshire

Neighbourhoods & Prevention

Out of Hospital Programme

1. Frailty Front Door
2. Primary Care Development
3. Hospital at Home / Crisis intervention

System Partners On Programme Delivery Board

- Health Watch Telford & Wrekin
- Local Pharmacy Committee
- Shropshire Partners in Care
- Powys Teaching Health Board
- Severn Hospice
- ShropDoc
- West Midlands Ambulance Service
- Patient Groups
- Voluntary Sector
- Welsh Ambulance Service
- Wider independent organisations
- System Neighbours
- Health Watch Shropshire
- Subject Matter Experts

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Health and Wellbeing Board
24th May, 2018

HWBB Joint Commissioning Report - Better Care Fund Update

Responsible Officer
Email: Tanya.miles@shropshire.gov.uk Tel: Fax:

1. Summary

1.1 This report provides an update on the progress on the Better Care Fund development and makes recommendations for taking forward the Partnership Agreement (pooled budget), integration, and linkages with the STP and system planning. It also provides the performance data for 17/18, Appendix A, performance data over time, Appendix B and BCF Quarter 4 return, Appendix C.

1.2 The Better Care Fund Plan outlines the HWBBs ambition for integration. The Board agreed in a very broad approach to integration that offers the ability to take into account a number of ways of working. The statement says that, *"Shropshire's HWBB believes integration is about putting Shropshire people at the heart of decision making. The Board uses evidence that is gathered through data and through engagement to develop a common purpose and agreed outcomes for people, with people; it is about taking a whole system approach to leading, designing and delivering services."*

1.3 The HWBB agreed that during 2017/18 the Shropshire Health and Care economy would focus on developing the Better Care Fund as a tool that fully supports integration. In line with the agreed statement above, this has meant that officers are working to make best use of our limited resources in a way that makes sense for people in Shropshire; working to maximise opportunities for joint working and minimise confusion for people as they navigate the system.

1.4 The BCF plan had final approval in November and through December, January and February, colleagues from the Council and the CCG have reviewed each line of the Better Care Fund spend and worked towards making recommendations for taking work and integration forward. An action plan has been developed to ensure that what is in the Better Care Fund are key pieces of work that will make a real difference to integration.

1.5 The Better Care Fund is seen nationally as a stepping stone to support system planning and integration, and as such high level conversations have been taking place about how the Shropshire system can make best use of pooling our resources to improve services and support the population's health and wellbeing, linking to the STP planning cycle. System leaders are working towards using the BCF to support a broader agenda, in line with our ambition for integration. This includes care navigation, Continuing Health Care (CHC), facilities management, equipment stores, and the system planning of the STP.

1.6 This new emphasis and ambition requires Shropshire Council and Shropshire CCG to take stock of where we are and where we want to get to, in order to make a real and positive

contribution to the health and wellbeing of Shropshire people. As such, the CCG and Local Authority are recommending steps to support our renewed ambition:

1.6.1 Updated Terms of Reference (ToR) for the Joint Commissioning Group – with more regular meetings and focus on pooled budgets and integration;
1.6.2 A new post for Better Care Fund manager hosted by the local authority– with increased emphasis on integration, as well as project support for a range of joint commissioning developments;
1.6.3 A joint working group (LA and CCG officers) to determine how to fully implement a pooled funding arrangement and section 75 Agreement.

1.7 As mentioned above, the latest BCF monitoring report is attached as Appendix A (Appendix B, performance over time) and the year-end Quarterly return is attached as Appendix C. The reports highlight good progress on all metrics (Delayed Transfers of Care, Non-Elective Admissions and Admissions to Care Homes).

1.8 In addition, the Joint Commissioning Group would like to provide details (below) of the funding received for an improved Individual Placement Support (IPS) employment model for those using secondary mental health services, following the receipt of additional grant funding from NHS England. Shropshire will receive approximately £294,500 in 18/19 and £289,843 in 19/20 and the Joint Commissioning Group is working to find sustainability from 20/21.

2. Recommendations

2.1 To agree the proposals set out in paragraph 1.6 above;
2.2 To note and provide comment on the Quarter 4 return; and
2.3 To note the new national investment in the IPS service (Enable in Shropshire) and opportunity for the STP to apply for Wave 2 funding (as described below) to support the population of T&W.

REPORT

3. **Risk Assessment and Opportunities Appraisal**
   3.1. (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)
   3.2. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.
   3.3. The schemes of the BCF and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research.
   3.4. Currently a key risk in this system is a lack of resource to support the BCF and lack of a Section 75 Partnership Agreement.

4. Background

BCF and Pooled budgets:

4.1 The “Integration and BCF planning requirements for 2017 -19” sets out the NHS England’s requirements on developing BCF plans in local areas. The NHS Act 2006, requires that in each area the CCG transfer minimum allocations into one or more pooled budgets established under section 75. For Shropshire the minimum sum for 2018/19 is £20.021m. Of this figure the CCG is required to spend £5.689m on out of hospital services and £7.779m on social care, leaving

£6.553m to be allocated to out of hospital services, social care, other services, or a combination of those.

4.2 The BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations must be signed off by the HWBB. It was agreed by Shropshire Council Cabinet in 2013 that a Section 75 pooled budget agreement would be developed to support the delivery of the BCF and that the Council would host this.

4.3 To date Shropshire has operated an "aligned budget" with joint decision making at the Joint Commissioning Group (previously HWB Delivery Group) and the Shropshire Health and Wellbeing Board. With no new money at the outset of the Better Care Fund, the initial plan focussed on drawing together areas of spend that aligned. Good progress has been made to work together to improve our prevention support, admission avoidance and delayed transfers of care (please see Appendices A-C for details and the BCF Quarter 4 return, with metrics).

4.4 Despite this good progress, the HWBB and Joint Commissioning Group recognised that much more could be done to improve services and support for Shropshire people. In 17/18 the focus was on working through each line of the budget to understand real value for money and consider where more joint working would provide better support for the community and reduce spend. The key areas that are recommended for development in this way are:

Prevention:

- VCSE Grants
- Care Navigation/ Social Prescribing
- Falls
- Carers
- Early Help

Admission Avoidance/ Delayed Transfers:

- Integrated Community Services
- Housing/ step down
- Assistive tech/ telecare/health/ equipment

4.5 Additional areas that have been noted for developing pooled funds through joint discussions include Continuing Health Care (CHC), public estate/ facilities management and equipment stores. Using the Better Care Fund joint working and pooled funding arrangement could support these initiatives going forward.

4.6 A detailed programme of work needs to take place now to move this development forward. Shropshire Council and Shropshire CCG will need to commit resource to this joint working and the Health and Wellbeing Board is asked to consider and endorse this. There is also a good opportunity here to link to wider system planning and tap into the resource of the STP. Whilst aligning budgets is a positive stepping stone towards greater integration ultimately it is necessary (and a legal requirement) to ensure that the BCF is managed through a formal s75 pooled budget.

System Planning:

4.7 There is opportunity to connect BCF into the wider system planning of the STP. The aims of the STP are:

1. To build resilience and social capital
2. Integrated care across the NHS and Social Care
3. More appropriate use of hospital care
4. Working as one health system
5. Sustainable workforce
6. Sustainable finances

The BCF can help support these aims by providing the legal framework for pooling budgets and supporting locality based working based on evidence and local need.

4.8 The STP is charged with developing and supporting system plans including:

- Future Fit – hospital reconfiguration
- Neighbourhood working and Out of Hospital programmes
- Embedding prevention in all system plans
- Workforce
- Estates management
- Back office functions
- Digital planning and delivery (including integrated care records)

The STP Programme Management Office (PMO) works with system strategic planners to support this work and there is opportunity to connect more closely with the Better Care Fund planning for both Shropshire and Telford and Wrekin. There is huge opportunities across the system to draw together programmes and support integrated planning and delivery.

4.8.1 As an example, one of the opportunities that the STP has supported is the funding application for funding for an improved IPS service in Shropshire. This investment will support partnership and integrated working to support people using secondary mental health services into work.

Individual Placement Support (IPS) Funding:

4.9 The STP has supported the Shropshire system to secure approximately £584,000 over two years to improve the support people in secondary mental health services receive to get (back) into work.

4.10 NHS England has launched a new transformation fund for Individual Placement and Support (IPS) services. It aims to support the expansion of IPS services so that more people who experience serious mental illness SMI can find and retain employment. Doubling of access to Individual Placement and Support (IPS) by 2020/21, helping those with SMI to find and retain employment, is one of the objectives set out in the *Five Year Forward View for Mental Health*.

4.11 Rates of employment are lower for people with mental health problems than for any other group of health conditions. IPS is an evidence-based approach to providing employment support for people experiencing serious mental health problems, shown to be twice as effective as vocational rehabilitation, and associated with reduced utilisation of other services, including use of inpatient admissions.

4.12 The funding has been made available in two waves; commencing in 2018/19: Wave 1: Expansion at pace within an STP area that already have high performing IPS services – as mentioned Shropshire has been successful with this wave and will receive £584,000 over two years; and commencing in 2019/20, Wave 2: Increasing provision in STP areas that do not have any IPS service provision (subject to confirmation later in 18/19).

4.13 For a number of years Shropshire has operated an IPS service, funded through the Better Care fund – Enable, which has a Fidelity score of Good. The funding will allow for the expansion of the service, improved partnership working across the system and place a focus on improving the Fidelity rating to Excellent.

4.14 A key consideration is how we will work in local areas to develop sustainability plans for the IPS service when the funding is no longer available. Social Impact Bonds are being explored to continue investment in this area, and we have partnered with the Mental Health and Employment Partnership to develop this opportunity to commission evidence-based

supported employment services for people with mental illness through the Life Chances Fund. Should the bid be successful it will provide Shropshire the opportunity to jointly fund this service on an outcomes based approach; which is seen as a positive new initiative that supports our strategic and commissioning intentions. Please see background papers below for link to the Life Chances fund information.

5. **Financial Implications**

5.1 The Better Care fund financial commitment for 2018/19 is explained in the chart below. This will be the basis for discussing and implementing the s75 Pooled budget.

BCF Funding Summary	**2018/19**	**Trail of Funding**
Revenue		
Schemes Commissioned and Funded by the CCG	£12,241,702	Comes from NHS England to the CCG. The CCG commissioned spend.
Schemes Commissioned and Funded by Shropshire Council	£699,637	Comes from Central Government to SC. SC commissioned or delivered.
Schemes Commissioned by Shropshire Council with CCG Funding	£7,779,302	Comes from NHS England to the CCG and then to SC. SC commissioned or delivered.
Schemes Commissioned by Shropshire Council with iBCF Funding	£8,288,253	Comes from Central Government to SC. SC commissioned or delivered.
Capital		
Disabled Facilities Grants and Social Care Capital Schemes Funded and Commissioned by Shropshire Council	£2,974,155	Comes from Central Government to SC. SC spends the money.
Total BCF 2017/18	**£31,983,049**	

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **For the final BCF plan please see HWBB paper here** **Life Chances Fund details here** **https://www.gov.uk/government/publications/life-chances-fund**
Cabinet Member (Portfolio Holder) **Cllr Lee Chapman**
Local Member n/a
Appendices Appendix A: Performance Summary 17/18 (below) Appendix B: Performance Summary over time 15-18 (below) Appendix C: BCF Quarter 4 Return (attached)

Appendix A – BCF Metrics 17/18

Better Care Fund – measures delivered by Shropshire Council

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.

Number of residential admissions is reducing

The following table shows the rate of admissions per 100,000 people

2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Profile (target)	150	300	450	600.3
Actual	83.5	150.8	317.7	449.7*
Performance	✓	✓	✓	✓

* Provisional end of year figure subject to year-end checks and audit

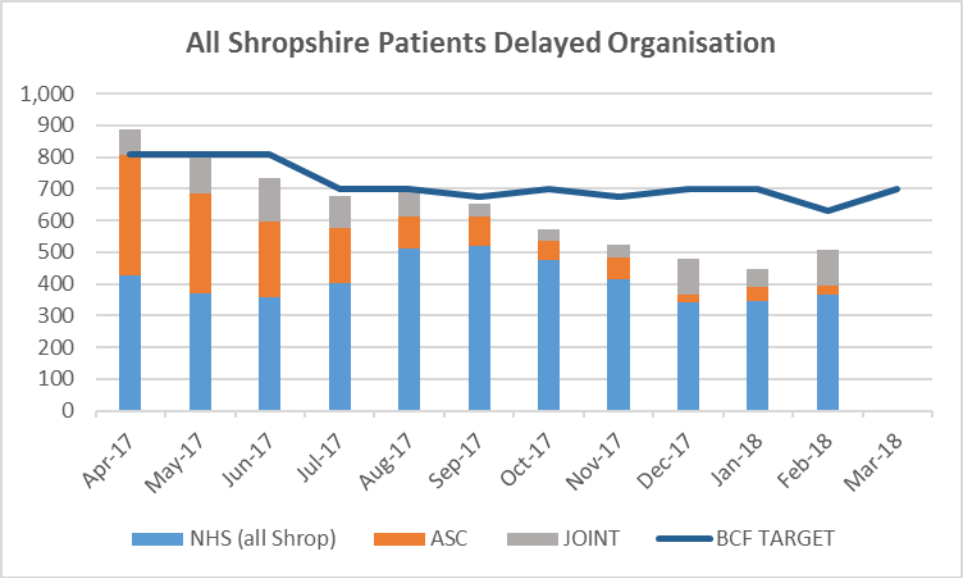
Performance is better than the profiled target. The number of people entering residential care during the year was 334 (449.7 per 100,000). This is a reduction of when compared to last year, 347 people (500.7 per 100,000). The service reiterates that its priority is to ensure that the most appropriate care package is provided at the right time to meet people's needs.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
This measure is reported in arrears.

2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Target	82%	82%	82%	82%
Actual	83.2%	81.09%	82%	
Performance	✗	✓	✓	

Performance throughout the year have remained around the 82% range and is in line with the target. As at the end of the period the percentage of older people who are still at home 91 days after discharge from hospital to reablement is on target. The age of patients and their complexity of conditions makes this a challenging measure to achieve. The service confirms their commitment to deliver support packages to ensure as many people as possible are able to remain safely in their homes. This measure is reported 3 months in arrears, those leaving hospital in quarter 4 will be surveyed in quarter 1 of 2018/19.

Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).
This is a joint measure with the NHS which records the combined number of patients who are delayed in their transfer of care from hospital.
The following chart shows the total monthly number of delayed days by organisation
Finalised Q4 data will be published 10th May 2018



During the current year the monthly number of delayed bed days has reduced. Jointly attributed delays have shown a recent increase in numbers. As a percentage of delays the joint delays are higher than regional and national rates. BCF performance for Q4 is better than target and is forecast to achieve the end of year targets.

ASC - 93% reduction in delayed patients* **

* April 2017 to February 2018

2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Target	2425	2077	2077	2031
Actual	2425	2035	1580	On target
Performance	✓	✓	✓	

The Better Care Fund targets for delayed transfer of care were established in July as part of the national improvement programme. Quarter 1 target was based on actual performance as data had been published at the time of target setting. Quarter 2 is in line with the target. Q3 is better than target whilst Q4 is forecast to also be better than target.

Non-Elective Admissions – Shropshire CCG Q2 – Q4 17/18

Month	Number of Non-Elective Admissions	Target and Total for Quarter
April	2552	
May	2705	
June	2651	**Target = 8327** **Total = 7,908**
July	2,714	
August	2,567	
September	2,468	**Target = 8,080** **Total = 7749**
October	2726	
November	2762	
December	2588	**Target = 8,729** **Total = 8,076**
January	2903	
February	2528	
March	2760	**Target = 8,475** **Total = 8191**

BCF Plan Non-Elective Admissions Targets

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
8,327	**8,080**	**8,729**	**8,475**

Data Source
NHS England
https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/

Appendix B
Overview of Adult Social Care performance for the Better Care Fund 2015 – 2018

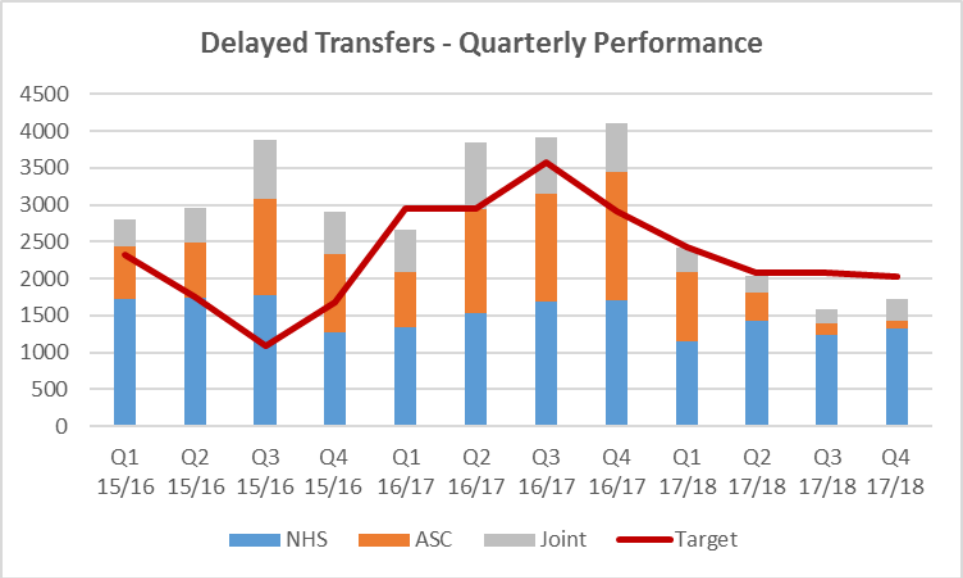
There are three measures which Adult Social Care contribute towards.

1. Transfer of Care from hospital
2. Admission to Residential Care
3. Reablement of patients to prevent re-admission to hospital

Performance over the period for each measure is as follows:

1. Transfer of Care from hospital

This measure is designed to prevent patients from experiencing delays in their discharge from hospital. This is a collaborative measure which requires the overall target to be achieved. In the first two years the measure was focussed on the rate of delays per 100,000 people. During 2017/18 this was changed to a daily delay rate. For comparative purposes the earlier targets have been changed to reflect the new measure.

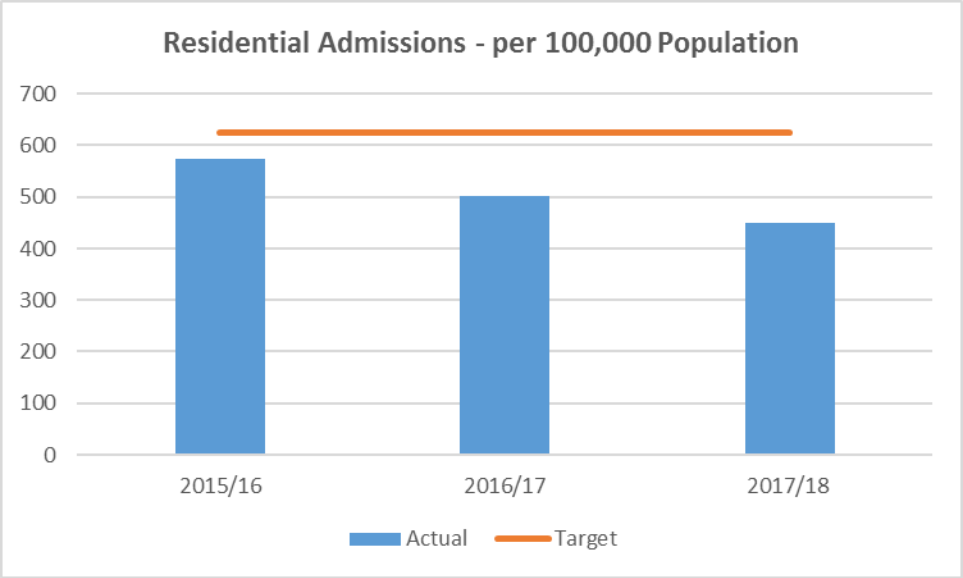


Performance from Q1 2015/16 to Q4 2016/17 was mainly above target with increases of delays attributed to Adult Social Care and to Joint attribution. 2017/18 has seen a significant reduction of delays attributed to both Adult Social Care and Joint Delays. NHS delays have seen a smaller but sustained reduction which has resulted in a collective achievement of targets in 2017/18. Average monthly delays by organisation are shown in the table below

	2015/16	2016/17	2017/18
NHS	543	523	429
ASC	318	444	131
Joint	181	241	88
Collective	**1042**	**1208**	**648**

2. Admission to Residential Care

Many older people wish to live at their own home for as long as possible and is a preferred lifestyle. Advances in technology and household modifications along with appropriate support can meet these preferences and offer a quality of life. The numbers of older people entering residential care over the period of the Better Care Fund programme has reduced. The service reiterates that its priority is to ensure that the most appropriate care package is provided at the right time to meet people's needs.



3. Patients discharged to Reablement services who remain at home 91 days after discharge

This measure is aimed at providing support to patients to help them adjust to living back at home after a period of hospitalisation. Performance over the period has fluctuated around the 80% mark. This measure is particularly challenging as patients are often elderly and have complex health needs.

Better Care Fund Template Q4 2017/18

Guidance

Overview

The Better Care Fund (BCF) quarterly monitoring template is used to ensure that Health and Wellbeing Board (HWB) areas continue to meet the requirements of the BCF over the lifetime of their plan and enable areas to provide insight on health and social integration.

The local governance mechanism for the BCF is the Health and Wellbeing Board, which should sign off the report or make appropriate arrangements to delegate this.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cell

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

If required, the row heights can be adjusted to fit and view text more comfortably for the cells that require narrative information. Please note that the column widths are not flexible.

The details of each sheet within the template are outlined below.

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference (hyperlinked) for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: A jointly agreed plan
Please note: This also includes confirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflation
National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 2017-19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
Please note that while NEA activity is not currently being reported against CCG Operating Plans (due to comparability issues relating to specialised commissioning), HWBs can still use NEA activity to monitor progress for reducing NEAs.
- Delayed Transfers of Care (DToC): The BCF plan targets for DToC for the current year 2017/18 should be referenced against the agreed trajectory submitted on the separate DToC monthly collection template for 2017/18.
The progress narrative should be reported against this agreed monthly trajectory as part of the HWB's plan

This sheet seeks seeks a best estimate of confidence on progress against targets and the related narrative information and it is advised that:
- In making the confidence assessment on progress against targets, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional estimate.
- In providing the narrative on Challenges, Achievements and Support need, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this very useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

4. High Impact Change Model

The BCF National Condition 4 requires areas to implement the High Impact Change Model for Managing Transfer of Care. Please identify your local system's current level of maturity for each of the eight change areas for the reported quarter and the planned / expected level of maturity for the subsequent quarters in this year.

The maturity levels utilised are the ones described in the High Impact Changes Model (link below) and an explanation for each is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area
Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement
Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement
https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide further detail on the initiatives implemented and related actions that have led to this assessment.
For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter and any impact to highlight, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

Hospital Transfer Protocol (or the Red Bag Scheme):
The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.

Further information on the Red Bag / Hospital Transfer Protocol:
A quick guide is currently in draft format. Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. However, the AEDB lens is a more representative operational lens to reflect both health and social systems. Where there are wide variations in their maturity levels, making a conservative judgment is advised. Please note these observed wide variations in the narrative section on 'Challenges'.
Also, please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making this assessment, which could be useful in informing design considerations for subsequent reporting.

To better understand the spread and impact of Trusted Assessor schemes, when providing the narrative for "Milestones met during the quarter / Observed impact" please consider including the proportion of care homes within the locality participating in Trusted Assessor schemes. Also, any evaluated impacts noted from active Trusted Assessor schemes (e.g. reduced hospital discharge delays, reduced hospital Length of Stay for patients awaiting care home placements, reduced care home vacancy rates) would be welcome.

5. Income & Expenditure

The Better Care Fund 2017-19 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant and the minimum CCG contribution. A large proportion of areas also planned to pool additional contributions from LA and CCGs. Instead of collecting Income/Expenditure on a quarterly basis as was the case in previous years 2015/16 & 2016/17, 2017/18 requires annual reporting of Income and Expenditure at a HWB total level.

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2017/18 by reporting any changes to the planned additional contributions by LAs and CCGs as was reported on the BCF planning template. Please enter the actual income from additional CCG and LA contributions in 2017/18 in the yellow boxes provided.
- Please provide any comments that may be useful for local context for the reported actual income in 2017/18.

Expenditure section:

- Please enter the total HWB level actual BCF expenditure for 2017/18 in the yellow box provided.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2017/18.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2017-18 through a set of survey questions which are overall consistent with those from previous years.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 9 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 10 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2017/18
3. The delivery of our BCF plan in 2017/18 had a positive impact on the integration of health and social care in our locality
4. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Non-Elective Admissions
5. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Delayed Transfers of Care
6. The delivery of our BCF plan in 2017/18 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
7. The delivery of our BCF plan in 2017/18 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:

8. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2017/18.
9. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2017/18?

As noted above, these are free text responses to be assigned to one of the following categories from the SCIE Integration Logic Model - Enablers summarised below. Please see link below for fuller details:
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

7. Narrative

This section captures information to provide the wider context around health and social integration.
Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.
Please tell us about an integration success story observed over reported quarter highlighting the nature of the service or scheme and the related impact.

Better Care Fund Template Q4 2017/18

1. Cover

Version 1.1

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Shropshire
Completed by:	Penny Bason
E-mail:	penny.bason@shropshire.gov.uk
Contact number:	01743 252767
Who signed off the report on behalf of the Health and Wellbeing Board:	Cllr Lee Chapman

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Income & Expenditure	0
6. Year End Feedback	4
7. Narrative	0

Better Care Fund Template Q4 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Shropshire

Confirmation of National Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	No	The section 75 agreement is still in draft to be agreed at the May HWBB. It was anticipated that this agreement would be signed early in 2018, however, the agreement has been part of the review of all BCF schemes, and this piece of work has taken longer than anticipated	24/05/18

Better Care Fund Template Q4 2017/18

3. Metrics

Selected Health and Well Being Board: Shropshire

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	On track to meet target	peforming well and working across the system to ensure that health and care consistently achieve target.	Dec - 2588, Jan 2903, Feb 2528 - TARGET Q4 - 8475.	n/a
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	right packages of care being provided at the right time. Currently any challenges are dealt with proactively within the system	Quarter 1 Quarter2 Quarter 3 Quart 4 150 300 450 600.3 83.5 150.8 317.7 449.7	n/a
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target	Challenges are being dealt within system	Quarter 1 Quarter2 Quarter 3 Quart 4 82% 82% 82% 83.2% 81.09% 82%	n/a
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	On track to meet target	peforming well and working across the system to ensure that health and care consistently achieve target, however work still to be done with health delays.	Quarter 1 Quarter 2 Quarter 3 Quarter 4 Q 1 - 2425 Q 2 - 2035 Q3 - 1580 Q4 - On target	n/a

** Your assessment of progress against the Delayed Transfer of Care target should reflect progress against the monthly trajectory submitted separately on the DToC trajectory template*

Better Care Fund Template Q4 2017/18

4. High Impact Change Model

Selected Health and Well Being Board: Shropshire

		Maturity assessment					Narrative			
		Q2 17/18	Q3 17/18	Q4 17/18 (Current)	Q1 18/19 (Planned)	Q2 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Established	Established	Established	Established	Mature		For planned care early discharge planning needs to be part of the GP 5 YFV and system planning - resource to support elements of planned care needs to be found	Significant work has taken place to and implement frailty pathway from the acute front door and early planning is embedded in this pathway as part of unplanned care, system yet to agree early planning process for planned care; for both planned care and	n/a
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Mature	Mature		key areas of work range from plans in place to mature eg. Daily dishcarge hub is established and working well on both sites and is considered mature, however the element of demand and capacity modelling needs to be refreshed	Commissioners refreshing demand and capacity modelling, SC have commissioned additionanl Pathway 3 beds, linked with STP Neighbourhoods work, link to Safer Budle and Red2Green on all wards	n/a
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Mature	Mature	Mature	Mature	Mature	Multidiscipliary teams work together to through the discharge hubs, FFAs completed, training and development taken place across acute staff and discharge teams. Dishcarge to Assesss steering group supports any issues	Challenges are worked through the D2A subgroup of the A&E Delivery Board	Integrated teams use a single assessment , and integrated discharge to assess arrange in place for all complex discharge, however work underway to audit why some decisions take a long time	n/a
Chg 4	**Home first/discharge to assess**	Mature	Mature	Mature	Mature	Mature	achieving targets regarding discharge within 48 hours of completion of the FFA, working to audit 48 hour visit by specialist (social worker or therapist) in the community following discharge	more work needed to improve pathway for those with cognitive impairment - audit being completed	Introduced processes to monitor 48 hour discharge following FFA, Implemented additional pathway 3 beds, Implementing Let's Talk local sessions in hospital to improve communication and understanding by patient, service user	n/a
Chg 5	**Seven-day service**	Not yet established	Not yet established	Not yet established	Plans in place	Established		Part of the STP planning process and significant issues relating to workforce have been acknowledged. The workforce stream of the STP is developing plans.	Working with STP transformational programme to develop 7 day services, ICS service specification has been reviewed and an update included in the BCF plan, brokerage being trialled 6 day per week,	n/a
Chg 6	**Trusted assessors**	Established	Established	Established	Established	Mature		Established for pathway 1&2 but not for pathway 3, system needs to complete demand and capacity modelling to determine P3 requirements	Care act requirements are incorporated in into pathways/ revision of the FFA, DTOC definitions and processes, Trusted Assessor for Care Home has been established and expected to bed in over the next 6 months	n/a
Chg 7	**Focus on choice**	Established	Established	Established	Established	Mature		consistency of approach a challenge, established in the acute hospital but not yet established within the Community Trust	A system choice communication plan is being developed and all literature is being reviewed. It will link to multidisciplinary discharge team, development of information and development of LTL in the acute hospital	n/a
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Mature	Mature		Care homes are established as part of the whole health and social care community and primary care support, there is variation between care homes on flow to the hospital. Timeliness of this work is challenged due to capacity in the system	Review to take place to understand variation and clinical input to care homes, need to ensure that support for care homes is joined up and embedded in the out of hospital model	n/a

Hospital Transfer Protocol (or the Red Bag Scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q2 17/18	Q3 17/18	Q4 17/18 (Planned)	Q1 18/19 (Planned)	Q2 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs
UEC	**Red Bag scheme**	Not yet established	Not yet established	Not yet established	Not yet established	Not yet established	funding is not available for this scheme	funding / knowledge and buy in to scheme	na	na

Better Care Fund Template Q4 2017/18

5. Income & Expenditure

Selected Health and Wellbeing Board: Shropshire

Income

	2017/18 Planned		2017/18 Actual	
Disabled Facilities Grant	£ 2,736,187		£ 2,736,187	
Improved Better Care Fund	£ 6,193,580		£ 6,193,580	
CCG Minimum Fund	£ 19,647,698		£ 19,647,698	
Minimum Subtotal		£ 28,577,465		£ 28,577,465
CCG Additional Contribution			£ -	
LA Additional Contribution	£ 699,637		£ 699,637	
Additional Subtotal		£ 699,637		£ 699,637

	Planned 17/18	Actual 17/18
Total BCF Pooled Fund	£ 29,277,102	£ 29,277,102

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2017/18	

Expenditure

	2017/18
Plan	£ 29,277,102
Actual	£ 23,826,255

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2017/18	£1,367,730 DFG balance carried forward into 2018/19. The remaining balance has been fully awarded as grants; the Local Authority is simply waiting for works to be completed and expenditure to materialise within the ledger. £3,866,294 iBCF balance carried forward into 2018/19. Shropshire Council has adopted an approach of prioritising expenditure on adults social care, meaning that existing social care services were already fully funded within the Council's 2017/18 revenue budget. Due to the late notification of the grant and delay to accompanying guidance, new schemes were not operational until Autumn/Winter 2017. The remaining grant balance is fully allocated over the next two financial years.

Better Care Fund Template Q4 2017/18

6. Year End Feedback

Selected Health and Wellbeing Board: Shropshire

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	The Better Care Fund has provided an opportunity for the system to collectively consider priorities and commissioning intentions. It has not always been straightforward but the BCF has been a catalyst for coming together.
2. Our BCF schemes were implemented as planned in 2017/18	Neither agree nor disagree	partially agree. We used 17/18 to fully review all schemes and determine value for money, and to consider how to move forward for 19/20. A result of this is that not all schemes have been implemented.
3. The delivery of our BCF plan in 2017/18 had a positive impact on the integration of health and social care in our locality	Agree	As in question 1 above
4. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Non-Elective Admissions	Agree	We are working hard across all priorities of the BCF to support people in shropshire to have improved the health and wellbeing; this includes keeping people out of hospital. The key schems for this work are the Frailty Front door pilot,(as described in the narrative and Q3 return), Carers support, and ICS.
5. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	Again the frailty programme has supported this aim as well has the dementia work and end of life support.
6. The delivery of our BCF plan in 2017/18 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	Multiple schemes have supported this aim; working collectively to support wellbeing, carers, care navigation and social prescribing, housing, ensuring that people have the right support in their communities has been key to delivering this metric.
7. The delivery of our BCF plan in 2017/18 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	As above, keeping people at home is a key focus for this health economy.

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and three Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

8. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2017/18.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest **successes**
Success 1	5. Integrated workforce: joint approach to training and upskilling of workforce	Joint approach to Social Prescribing, Integrated Community Services, Carers support, and Mental health (amongst others) have all contributed to this success.
Success 2	8. Pooled or aligned resources	Pooling and aligning resources has allowed the system to work collectively on key priority areas.

8. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2017/18.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest **challenges**
Challenge 1	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)	Funding deficit means that attention is focussed on reducing deficit , rather than potential improvements to joint working. Delivering services in a rural county is one of the underlying issues that exacerbates funding issues; this does not always seem to be recognised by central government.
Challenge 2	2. Strong, system-wide governance and systems leadership	While the system is working toward stronger system leadership, there is still much work to do here.

Footnotes:

Question 8 and 9 are should be assigned to one of the following categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

Better Care Fund Template Q4 2017/18

7. Narrative

Selected Health and Wellbeing Board: Shropshire

Remaining Characters:	13,830

Progress against local plan for integration of health and social care

Eight High Impact Model is supporting joint and integrated operations that include discharge to assess and multidisciplinary teams working together to improve services and patient/ service user experience. Real progress has been made with this model providing very good delayed transfer figures for the end of 2017/18 and into 2018.

BCF schemes in each priority area, Prevention, Admissions Avoidance and Transfers of Care, are moving forward well and reported to the Joint Commissioning Group, HWBB and the 8 High Impact Model to the A&E delivery group.

Prevention Highlights:

• Social Prescribing is developing at pace. The VCSE bid for the (DOH) fund for social prescribing and the programme was not successful unfortunately, however the programme is still moving forward and moved from the demonstrator site in Oswestry to 3 areas in the South of the County (Albrighton and Bishops Castle have started referrals), while detailed discussions are taking place in Shrewsbury;

• Social Prescribing is working to focus on systematically identifying people who are at health risk through GP records and a variety of referral organisations. The risks being considered include (but not limited to) mild frailty, diabetes, CVD, isolation and loneliness, carers, mental health.

• The work to draw together and integrate care navigation across primary care and social care has been integrated into 'out of hospital' programmer and Public Health and ASC are working to integrated 'let's talk local' sessions and social prescribing.

• Shropshire will be implementing the National Diabetes Prevention Programme in line with the local BCF programme for diabetes and CVD prevention;

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Remaining Characters:	16,621

Integration success story highlight over the past quarter

We have been working across health and care to develop an integrated level of support that includes care navigation, social prescribing, and social care. This programme is about developing a system where support is clear and accessible, and where people aren't bounced around the system. Our vision: 'We are an Alliance, helping people to live as well as they can'

What does this mean?

We will have a common brand

We will enhance what we have available, using our combined skills, abilities and resources to best effect for the people of Shropshire

We will include communities and partners as well as formal organisations

We will empower people

There will be an understood route to appropriate support

Principles:Creating seamless, clear and more efficient services / support for our population

Make best use of resource and best use of resource we already have in place (don't develop something new if it exists already) – An alliance

Work to clear organisational outcomes – healthier populations, self care

All decisions taken to create confidence in the system, to support workforce development, and new cultures

Supporting people and communities to support themselves (don't do for people and communities what they can do for themselves) What 'health' means is

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

Better Care Fund Template Q4 2017/18

Checklist

[<< Link to Guidance tab]

Complete Template

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? If no please detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics

	Cell Reference	Checker
NEA Target performance	D7	Yes
Res Admissions Target performance	D8	Yes
Reablement Target performance	D9	Yes
DToC Target performance	D10	Yes
NEA Challenges	E7	Yes
Res Admissions Challenges	E8	Yes
Reablement Challenges	E9	Yes
DToC Challenges	E10	Yes
NEA Achievements	F7	Yes
Res Admissions Achievements	F8	Yes
Reablement Achievements	F9	Yes
DToC Achievements	F10	Yes
NEA Support Needs	G7	Yes
Res Admissions Support Needs	G8	Yes
Reablement Support Needs	G9	Yes
DToC Support Needs	G10	Yes

Sheet Complete:	Yes

4. HICM

	Cell Reference	Checker
Chg 1 - Early discharge planning Q4	H8	Yes
Chg 2 - Systems to monitor patient flow Q4	H9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4	H10	Yes
Chg 4 - Home first/discharge to assess Q4	H11	Yes
Chg 5 - Seven-day service Q4	H12	Yes
Chg 6 - Trusted assessors Q4	H13	Yes
Chg 7 - Focus on choice Q4	H14	Yes
Chg 8 - Enhancing health in care homes Q4	H15	Yes
UEC - Red Bag scheme Q4	H19	Yes
Chg 1 - Early discharge planning Q1 18/19 Plan	I8	Yes
Chg 2 - Systems to monitor patient flow Q1 18/19 Plan	I9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q1 18/19 Plan	I10	Yes
Chg 4 - Home first/discharge to assess Q1 18/19 Plan	I11	Yes
Chg 5 - Seven-day service Q1 18/19 Plan	I12	Yes
Chg 6 - Trusted assessors Q1 18/19 Plan	I13	Yes
Chg 7 - Focus on choice Q1 18/19 Plan	I14	Yes
Chg 8 - Enhancing health in care homes Q1 18/19 Plan	I15	Yes
UEC - Red Bag scheme Q1 18/19 Plan	I19	Yes
Chg 1 - Early discharge planning Q2 18/19 Plan	J8	Yes
Chg 2 - Systems to monitor patient flow Q2 18/19 Plan	J9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q2 18/19 Plan	J10	Yes
Chg 4 - Home first/discharge to assess Q2 18/19 Plan	J11	Yes
Chg 5 - Seven-day service Q2 18/19 Plan	J12	Yes
Chg 6 - Trusted assessors Q2 18/19 Plan	J13	Yes
Chg 7 - Focus on choice Q2 18/19 Plan	J14	Yes
Chg 8 - Enhancing health in care homes Q2 18/19 Plan	J15	Yes
UEC - Red Bag scheme Q2 18/19 Plan	J19	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	K8	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	K9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams, if Mature or Exemplary please explain	K10	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	K11	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	K12	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	K13	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	K14	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	K15	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	K19	Yes
Chg 1 - Early discharge planning Challenges	L8	Yes
Chg 2 - Systems to monitor patient flow Challenges	L9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	L10	Yes
Chg 4 - Home first/discharge to assess Challenges	L11	Yes
Chg 5 - Seven-day service Challenges	L12	Yes
Chg 6 - Trusted assessors Challenges	L13	Yes
Chg 7 - Focus on choice Challenges	L14	Yes
Chg 8 - Enhancing health in care homes Challenges	L15	Yes
UEC - Red Bag Scheme Challenges	L19	Yes
Chg 1 - Early discharge planning Additional achievements	M8	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	M9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	M10	Yes
Chg 4 - Home first/discharge to assess Additional achievements	M11	Yes
Chg 5 - Seven-day service Additional achievements	M12	Yes
Chg 6 - Trusted assessors Additional achievements	M13	Yes
Chg 7 - Focus on choice Additional achievements	M14	Yes
Chg 8 - Enhancing health in care homes Additional achievements	M15	Yes
UEC - Red Bag Scheme Additional achievements	M19	Yes
Chg 1 - Early discharge planning Support needs	N8	Yes
Chg 2 - Systems to monitor patient flow Support needs	N9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	N10	Yes
Chg 4 - Home first/discharge to assess Support needs	N11	Yes
Chg 5 - Seven-day service Support needs	N12	Yes
Chg 6 - Trusted assessors Support needs	N13	Yes
Chg 7 - Focus on choice Support needs	N14	Yes
Chg 8 - Enhancing health in care homes Support needs	N15	Yes
UEC - Red Bag Scheme Support needs	N19	Yes

Sheet Complete:	Yes

5. Income & Expenditure

	Cell Reference	Checker
2017/18 - Actual CCG additional contribution income	G14	Yes
2017/18 - Actual LA additional contribution income	G15	Yes
2017/18 - Difference between plan & actual income Commentary	E21	Yes
2017/18 - Actual Spend	D31	Yes
2017/18 - Difference between plan & actual expenditure Commentary	E33	Yes

Sheet Complete:	Yes

6. Year End Feedback

	Cell Reference	Checker
Statement 1 - Joint working Delivery Response	C10	Yes
Statement 2 - BCF Scheme Delivery Response	C11	Yes
Statement 3 - Health & Social Care Integration Delivery Response	C12	Yes
Statement 4 - NEA Delivery Response	C13	Yes
Statement 5 - DTOC Delivery Response	C14	Yes
Statement 6 - Reablement Delivery Response	C15	Yes
Statement 7 - Residential Admissions Delivery Response	C16	Yes
Statement 1 - Joint working Delivery Commentary	D10	Yes
Statement 2 - BCF Scheme Delivery Commentary	D11	Yes
Statement 3 - Health & Social Care Integration Delivery Commentary	D12	Yes
Statement 4 - NEA Delivery Commentary	D13	Yes
Statement 5 - DTOC Delivery Commentary	D14	Yes
Statement 6 - Reablement Delivery Commentary	D15	Yes
Statement 7 - Residential Admissions Delivery Commentary	D16	Yes
Success 1 category	C22	Yes
Success 2 category	C23	Yes
Success 1 response	D22	Yes
Success 2 response	D23	Yes
Challenge 1 category	C27	Yes
Challenge 2 category	C28	Yes
Challenge 1 response	D27	Yes
Challenge 2 response	D28	Yes

Sheet Complete:	Yes

7. Narrative

	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

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Health and Wellbeing Board
Meeting Date 24th May 2018

Item Title **Shropshire, Telford & Wrekin Local Maternity System (LMS) Transformation Plan**

Responsible Officer Fiona Ellis
Programme Manager – Shropshire, Telford & Wrekin Local Maternity System Transformation

Email: Fiona.ellis3@nhs.net

1. Summary

This report shares with the Board members the work of the Local Maternity System (LMS) in delivering the five year transformation of maternity services in accordance with the national NHS England agenda.

2. Recommendations

The Health and Wellbeing Board are recommended to note the information in this report and the report attached as Appendix A.

REPORT

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

4. Financial Implications

5. Introduction

This report shares with the Board members the work of the Local Maternity System (LMS) in delivering the five year transformation of maternity services in accordance with the national NHS England agenda.

6. Background

Following the publication of the national review of maternity services (Better Births 2016); a transformation plan for maternity services in Shropshire, Telford and Wrekin has been developed through the Shropshire, Telford and Wrekin Local Maternity System. This plan sets out how transformation will be achieved in line with the requirements of Better Births which are to;

Improve choice and personalisation of maternity services so that:

- All pregnant women have a personalised care plan;

- All women are able to make choices about their maternity care, during pregnancy, birth and after their baby is born;
- Most women receive continuity of the person caring for them during pregnancy, birth and after their baby is born;
- More women are able to give birth in midwifery settings (at home and in midwifery units)

Improve the safety of maternity care so that all services:

- Have reduced rates of still birth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2030[1] as outlined in NHS England's 'Saving Babies Lives, A Care Bundle for reducing stillbirth'.
- Are investigating and learning from incidents and sharing this learning through their LMS and with others;
- Are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement Programme.

7. Implementation

A local multi-agency board is in place to oversee and drive the required transformation supported by the Sustainability Transformation Partnership. This will be an evolving process over five years and not a static process. The first version of the plan was submitted on 31st October 2017 with positive feedback given to the system. A second version was required to be submitted 12th February 2018 to include feedback on additional lines of enquiry. (The version in appendix 1 is dated February 2018). Oversight and monitoring of the plan is undertaken via the NHS England Regional Maternity Board reporting into the National Maternity Transformation Board.

The Local LMS work is supported by Programme Manager – Fiona Ellis and Programme Support Officer- Helen White, working with leads from all partners across the work streams stated within the plan.

In addition to the plan delivery work there are supportive measures in place nationally to share best practice and bid for non- recurrent transformational funding.

The ethos of the local plan is that it is driven in co-production with those who are using our services and the work of the Maternity Voices Partnership will be key in ensuring we deliver the transformation that meets to needs of local women and their families.

Here is a link to the plan and associated appendices: http://www.shropshireccg.nhs.uk/get-involved/reviews-and-projects/better-births-local-maternity-transformation-lms/

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices **APPENDIX AShropshire, Telford & Wrekin Local Maternity System (LMS) Transformation Plan**

[1] https://www.england.nhs.uk/wp-content/uploads/2017/02/national-maternity-review-report.pdf

TRANSFORMATION PLAN

IMPROVING OUTCOMES OF MATERNITY SERVICES IN SHROPSHIRE AND TELFORD & WREKIN

A FUTURE VISION AGREED IN PARTNERSHIP

2017 - 2021

Foreword

Across Shropshire, Telford and Wrekin each year around 5,000 babies are born. In planning and delivering maternity services, we often focus on the birth of a child and don't always think about the lifelong journey each child and their parents and carers will have. This plan aims to change that. The birth of a child is a very significant event and what happens before, during and after that event has a long-term impact on the emotional and physical wellbeing of the child, their parents and carers. In delivering the vision outlined in *Better Births*, together we will ensure we understand what we need to do so that services for pregnant women, babies and their families have a positive impact on children, their parents and carers in the longer term.

Our priority in transforming maternity services is ensuring the safety of women and their babies at all times. As an Local Maternity Services(LMS), we are aware that maternity services in Shropshire, Telford and Wrekin over the last few years have been under scrutiny in relation to safety and the care of women and their babies. We recognise this is very difficult for women and their families who are currently using the services in Shropshire or who have done so in the past. We have been considerate of the safety improvements that have been made to date and this plan and all its partners will ensure that learning from all external reviews is fully embedded as we move forward to enable the highest possible level of safety to be achieved for all.

This is the start of a new chapter for maternity services in Shropshire, Telford and Wrekin. Through the work of this plan a range of professionals will work together with women and their families to re-build trust and to provide assurance in relation to the quality and safety of services. We will ensure we listen to and learn from each other, constantly improving services and experiences and developing a learning culture.

Through implementing this plan we will strengthen how we work together in planning, delivering and improving services for pregnant women, babies and their families. Services will be safer. Women across Shropshire, Telford and Wrekin will have easy access to a range of good quality services for them and their babies regardless of where they live. Women will continue to have a choice in the care they receive and will be more likely to know the midwife that will care for them throughout pregnancy, birth and after their baby is born. The way we offer services will be different – the services women and their babies receive will be more personalised and designed around their individual needs and preferences.

We are delighted that right from the beginning of this journey of transformation, women and their families have come forward to work together with other maternity system partners to transform services. This is something we will build on throughout and beyond this plan to ensure that we always work in genuine co-production.

We would like to thank everyone who has helped to develop this plan and who will enable the transformation to be delivered over the coming years.

Christine Morris
Senior Responsible Officer: Shropshire, Telford and Wrekin LMS

The Shrewsbury and Telford Hospital NHS Trust
Shropshire County Clinical Commissioning Group
Telford and Wrekin Clinical Commissioning Group

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1 Introduction to the Plan

The National maternity Review *'Better Births, The Five Year Forward View for Maternity Care'*[i] *(Better Births)* was published in February 2016. This set out a vision for transforming maternity services for women and their families across England.

Shropshire, Telford and Wrekin have established a Local Maternity System (LMS) to ensure service transformation happens at a local level. This Plan describes how the LMS will transform local maternity services by 2020/21. It will deliver the requirements of Better Births, which are to:

Improve choice and personalisation of maternity services so that:

- All pregnant women have a personalised care plan;
- All women are able to make choices about their maternity care, during pregnancy, birth and after their baby is born;
- Most women receive continuity of the person caring for them during pregnancy, birth and after their baby is born;
- More women are able to give birth in midwifery settings (at home and in midwifery units)

Improving the safety of maternity care so that all services:

- Have reduced rates of still birth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2030 as outlined in NHS England's 'Saving Babies Lives, A Care Bundle for reducing stillbirth'[ii].
- Are investigating and learning from incidents and sharing this learning through their LMS and with others;
- Are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement Programme.

BETTER BIRTHS VISION

"Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

And for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries."

2 Our Vision

More **Women** and their families will:

- Be healthier during their pregnancy and will have a better understanding of how to keep themselves and their baby healthy
- Have better information about pregnancy and parenthood that is personal to their circumstances
- Have support with their emotional wellbeing throughout their pregnancy and after their baby is born
- Have more choice in the care they receive and will feel involved in decisions about their care
- Be able to access a wider range of services closer to home
- Know the midwife caring for them throughout pregnancy, birth and after the baby is born
- Give birth in a midwifery led setting
- Be involved in how services are designed and delivered

Staff will…

- Feel proud of the services they deliver
- Work within a learning culture and receive regular training alongside those they work with
- Be well supported by service leaders
- Act as advocates for the women they care for and feel empowered to deliver great service

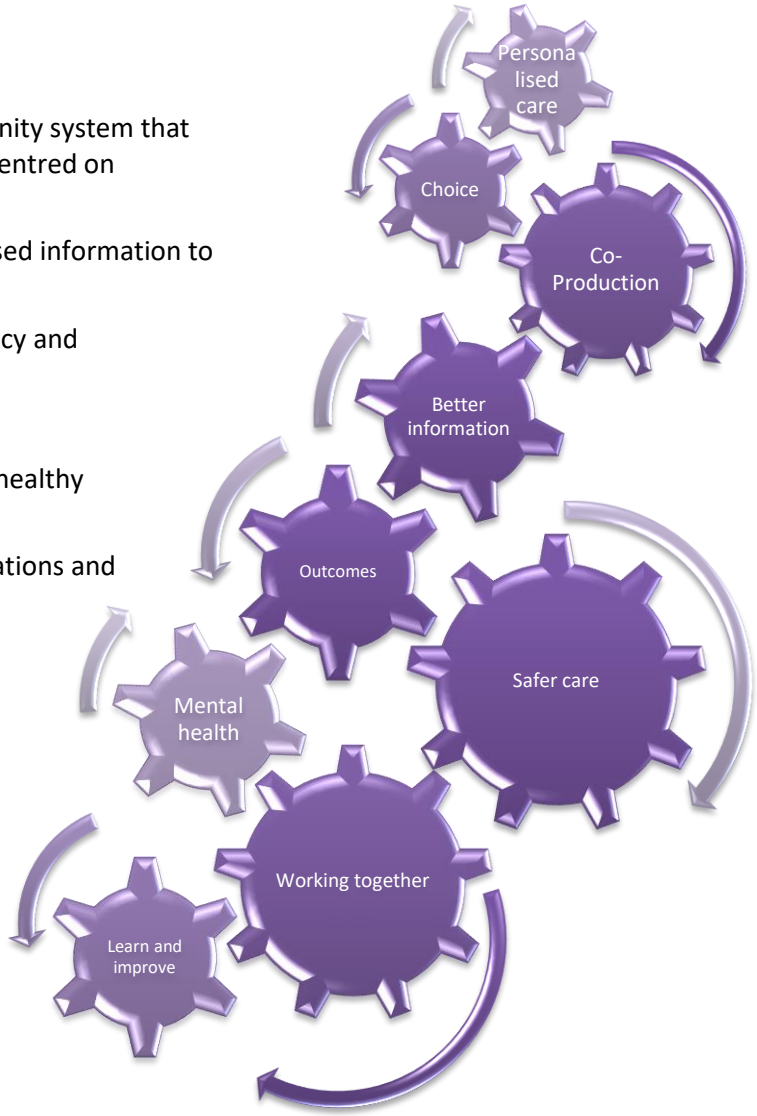
Services will be…

- Safer
- Designed and delivered in partnership with women and their families
- Working better together through community hubs
- Constantly learning and improving
- Sharing more information with each other

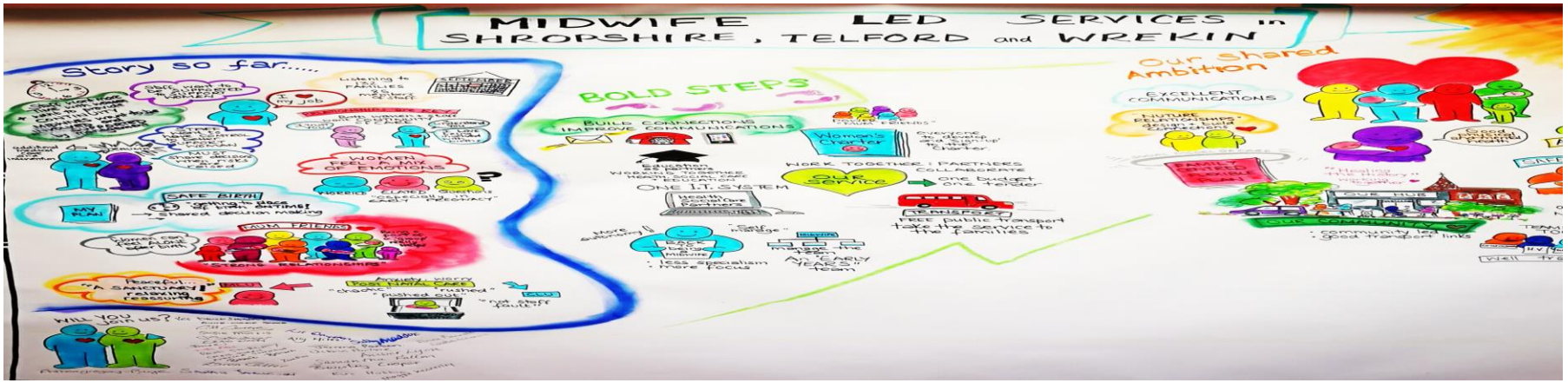
3 Our Pledge

We will:

- Work together as stakeholders in true co-production to design and deliver a local maternity system that provides women and their families with a safe, quality service that is personalised and centred on individual needs and circumstances.
- Ensure every woman has a personalised care plan. Women will be able to access unbiased information to help them make decisions about their care from a range of available choices.
- Ensure every woman knows the midwife who will deliver their care throughout pregnancy and once their baby is born.
- Ensure most women know the midwife who will deliver their care during labour.
- Ensure all women of child bearing age understand how and have the opportunity to be healthy and well before, during and after their pregnancy.
- Deliver safer care. We will improve protocols between professionals and across organisations and will evidence that we continuously improve services and learn from our experiences.
- Improve access to perinatal mental health services so that all women can access support with their emotional wellbeing.
- Improve consistency and availability of postnatal care.
- Ensure that those who work together train together. We will improve how professionals work together and learn from each other.
- Improve outcomes for women and their families by working together across health, social care and early help services.



4 Co-Production, Leadership and Governance



The Shropshire, Telford and Wrekin LMS is committed to co-production[iii].

This means that we strive to always work in partnership with a range of stakeholders in designing and delivering services, including those who receive or may receive maternity care.

We have developed this LMS plan in partnership with stakeholders to ensure the vision we propose is realistic. However, we know that we need to develop co-production even further and is something we will strive to do, embedding co-production at the heart of all activity as this plan is progressed. Co-production will become 'business as usual' by 2020/21.

We have started our co-production journey through the review of midwife-led services. Those who have used services, have an interest in midwifery led services and professionals working in or with midwifery led services have worked together with commissioners to start to design a future model of midwifery led care.

The image at the top of this section is the start of an illustration showing the ideas and thoughts of those who have used services, have an interest in midwifery led services and professionals working in or with midwifery led services about midwifery led services in Shropshire, Telford and Wrekin. This will be completed once all the service design workshops have taken place.

Co-production is a concept, rather than a single action. It is a way of working that brings professionals and those who use services together as equal partners in designing and delivering services. The midwife-led unit review, which is a key element of service transformation for maternity services, has been undertaken in co-production. However, in order for co-production to be fully implemented at all levels, further development will take place through the work of the LMS to embed a culture of co-production across the Shropshire, Telford and Wrekin Local Maternity System. This will involve:

- Formalising an understanding across the LMS on what co-production is and the principles that will guide its implementation
- Embedding a co-production ethos at all levels (LMS, Organisational, Service Delivery)
- Reviewing the effectiveness of the co-production approach, including :
  - the co-production process itself and how well everyone works together
  - social, wellbeing and environmental outcomes
  - the full costs and benefits, including added value

1

iv

The LMS will use a jigsaw model for the management of change, to ensure that co-production is effective at all levels.

The LMS will aim to have co-production embedded by 2021. To achieve this, new relationships between staff and people who use services will be developed where people who use services are recognised as experts in their own right. There will be respect for the experience and skills that everyone brings to the process and an emphasis on all the outcomes that people value, rather than just those, such as clinical outcomes, that currently the LMS organisations most commonly measure.

[1] For further information please see Appendix 8

The development and delivery of this plan is overseen by the Shropshire, Telford and Wrekin (LMS) Programme Board. The Shropshire, Telford and Wrekin LMS Programme Board is accountable to the Shropshire, Telford and Wrekin Sustainability and Transformation Plan (STP) Board.[v] The diagram below shows the governance structure for ensuring maternity transformation is delivered.

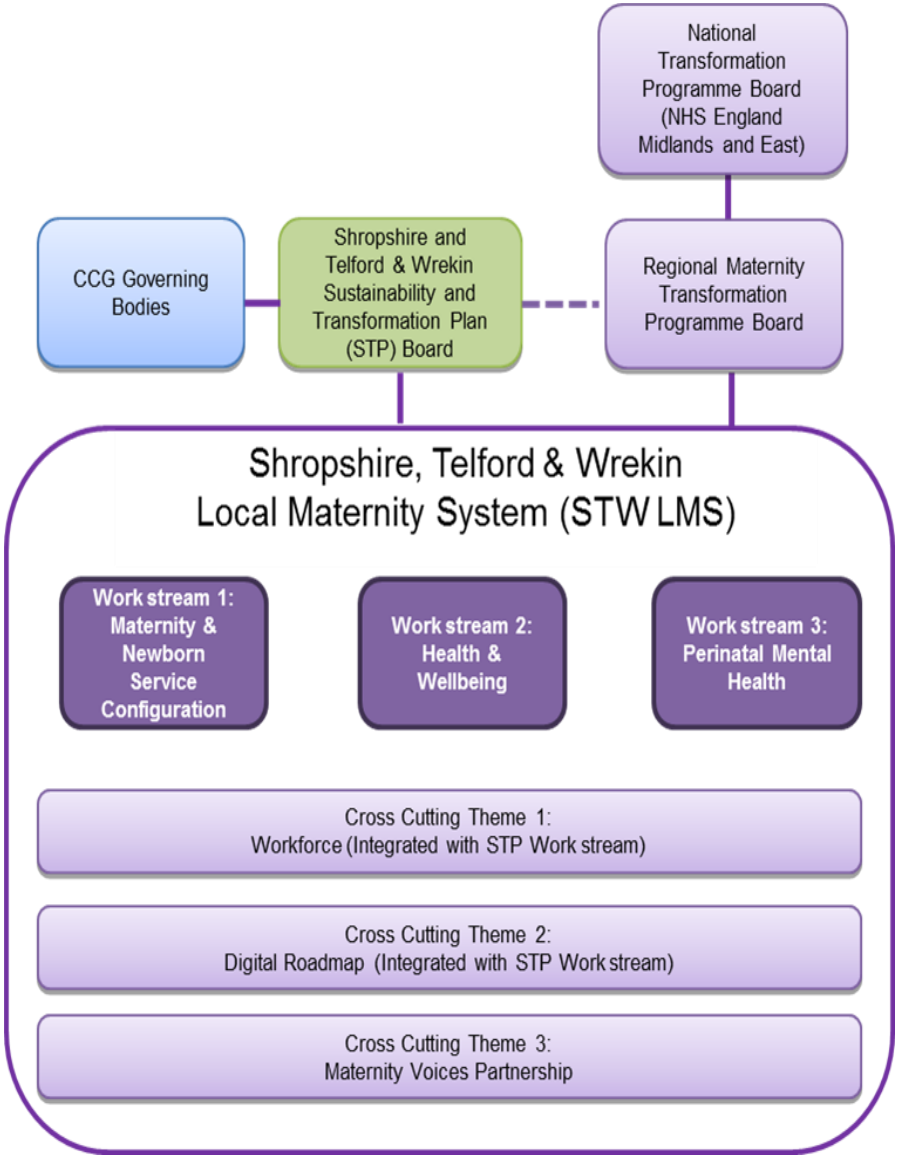
Statement from STP Chair

As Chair of the STP, one of the things that has struck me since I moved to Shropshire is the commitment and vitality within communities in support of their local health services. There is a strong sense across the county that people recognise what we do well and equally there is a shared understanding of where we must go further to transform the experience, sustainability, quality, safety and outcomes that we offer our patients.

The transformation of maternity services is part of the broader Sustainability and Transformation Plan (STP) of one health care system working together. Any changes will rightly be influenced by the knowledge and experience of mothers and their families. Some of whom we have already cared for and some we will care for in the future.

This LMS plan will therefore look forward to ensure that we provide a state of the art maternity service that uses the digital and technological advances that will support a modern workforce for the years to come.

Simon Wright: STP Chair



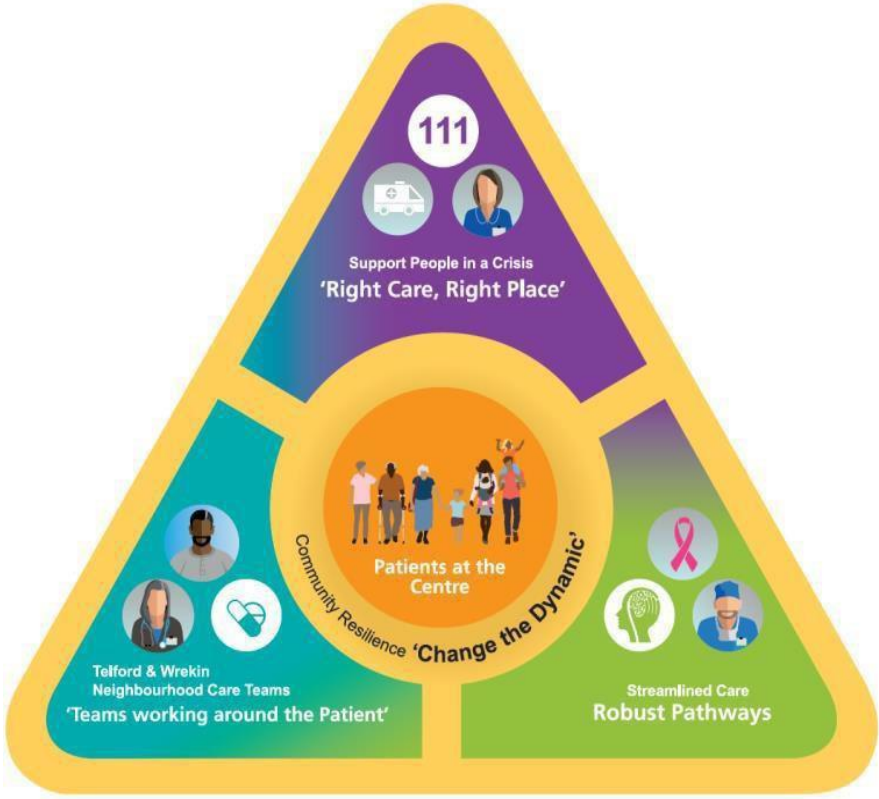
The LMS Programme Board will ensure the required transformation is achieved through the work of three workstreams and three cross-cutting themes.

Through the governance arrangements into the STP Board, the LMS will ensure that the maternity transformation adopts all of the STP principles where appropriate, including place based care.

Helping to deliver the STP vision

The transformation delivered through this plan is specific to maternity services. However, this will sit within the context of the broader Sustainability and Transformation Plan (STP) for Shropshire, Telford and Wrekin. In implementing this plan, consideration will be given to how the maternity transformation can support the delivery of the priorities of the STP, including the development and implementation of placed based models of care, which aims to bring care closer to home.

2



[2] For further information please refer to Appendix 1

4.1 Workstreams

4.1.1 Workstream 1: Maternity & Newborn Service Configuration

The design of maternity and neonatal services is fundamental to ensuring service transformation. This workstream will look at what needs to change so that maternity and neonatal services offer the level of choice, personalisation and safety that Better Births requires.

4.1.2 Workstream 2: Health and Wellbeing

Maternity and neonatal services care for women and their babies during pregnancy, birth and in the early days after birth. However, enabling women and their families to live healthy lives needs much more than this. This workstream will focus on the transformation that needs to take place to enable women and their families to lead healthier, happier lives in the longer term. Partners across the health economy will work together to implement strategies and services to improve women's health before, during and after pregnancy as well as the health of their babies.

4.1.3 Workstream 3: Perinatal Mental Health

This workstream will transform services so that women and their families have much better access to information, advice and services to support them with emotional health and wellbeing during pregnancy and after their baby is born. Professionals will also have a better understanding of perinatal mental health.

4.2 Cross-cutting Themes

4.2.1 Cross-cutting Theme 1: Workforce

To enable the required transformation to occur, there needs to be significant changes to the existing workforce. This workstream will deliver improvements to the culture, skills and availability of the workforce.

Work together
Learn from each other

4.2.2 Cross-cutting Theme 2: Digital Roadmap

A key focus of Better Births is around improving the use of technology in the delivery of maternity services. Through the Sustainability and Transformation Plan, this workstream will seek to implement technological improvements for women and their families as well as professionals in order to support the transformation required.

Shared data
Electronic Records

4.2.3 Cross-cutting Theme 3: Maternity Voices Partnership

The maternity voices partnership is responsible for ensuring that stakeholders, including women, their families and professionals always work together in designing and delivering maternity services. It will also improve communication between women and their families with professionals in relation to maternity services.

Co-production
Effective communication

4.3 Delivery and Assurance

The LMS transformation programme will be monitored, assured and evaluated through measures that will evidence delivery against outcomes for women and their families, babies and staff.

A baseline self-assessment against the recommendations outlined in Better Births has been undertaken. [3]This will be updated throughout the life of the plan to evidence progress in transformation. The table below sets out the current position and projected improvements against key measures associated with delivering the requirements of Better Births.

Further detail about how the improvements will be delivered is contained within the 'Delivering the Vision' section of this plan.

Shropshire, Telford and Wrekin Local Maternity System – Improvement Plan					
Area of Improvement	**Position 31.03.2017**	**Target 31.03.2018**	**Target 31.03.2019**	**Target 31.03.2020**	**Target 31.03.2021**
Stabilised and adjusted rate of stillbirth (3 year rolling average)	4.0/1000 (2013-2015 average)	3.7/1000	3.4/1000	3.2/1000	3.0/1000
Stabilised and adjusted rate of neonatal death (3 year rolling average)	1.6/1000 (2013-2015 average)	1.5/1000	1.4/1000	1.3/1000	1.2/1000
Rate of direct maternal death	To be confirmed (5 year average)	n/a[4]	n/a	n/a	n/a
Rate of intrapartum brain injury	2.1/1000 (HIE rate[5])	1.9/1000	1.8/1000	1.7/1000	1.5/1000
% of women with personalised care plans	0%	0%	100%	100%	100%
% women booking before 12 weeks 6 days gestation	87.7%	91%	94%	96%	98%
% women booking before 9 weeks 6 days	41.6%	45%	50%	55%	60%
Choice available for[6] antenatal care	Measure in development	Measure in development	Measure in development	Measure in development	Measure in development

[3] Further information on the self-assessment can be found in Appendix 10
[4] Work is underway to develop measures that will evidence improvements in reducing the likelihood of maternal deaths and improving investigations
[5] Hypoxic Ischemic Encephalopathy is a reduction in the supply of oxygen to the brain and other organs (hypoxia)

% women able to choose from 3 places of birth	100%	100%	100%	100%	100%
% women able to choose from 4 places of birth	100%	100%	100%	100%	100%
Choice available for postnatal care	Measure in development	Measure in development	Measure in development	Measure in development	Measure in development
% women who have continuity of carer throughout antenatal and postnatal care	85%	90%	95%	98%	99%
% women who have continuity of carer throughout antenatal, intrapartum and postnatal care	Measure in development	Measure in development	20%	25%	30%
% women giving birth in midwifery led settings including home birth	14% (688/4928)	15%	17%	20%	25%
Increase in investment in Perinatal Mental Health Services	£27,000	£27,000	To be confirmed pending funding bid	To be confirmed. Awaiting amount of increased funding in CCG Baselines	To be confirmed. Awaiting amount of increased funding in CCG Baselines
Number of new women seen by Perinatal Mental Health services			96	240	360
Increase in the number of women reporting they are confident in	Measure in development	Measure in development	Measure in development	Measure in development	Measure in development

[6] Through working in co-production we will define what we mean by choice in antenatal care and choice in postnatal care, identify the current baseline and project our improvements over the course of transformation.

5 Patient Safety and Quality of Care

The safety of mums to be and their babies is the most important factor in delivering maternity services. The performance of service providers is monitored to ensure services are delivering appropriate, safe, quality care that is delivered at the right time.

In Shropshire, Telford and Wrekin each commissioning organisation (organisations that are responsible for planning and purchasing services for their local population) has processes in place to monitor the performance and quality of the services. These processes have recently been strengthened through the introduction of a separate Contract Quality Review Process for maternity services in Shropshire, Telford and Wrekin. In delivering this plan, the monitoring of performance, quality and safety will be further improved through the introduction of a quality and safety improvement system across the whole LMS.

[7]

Serious Incidents

Serious incidents in healthcare are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant particular attention. It is important that these events are reported on and investigated so that we can respond appropriately when things go wrong. This is a key part of the way that the we can continually improve the safety of the services provided and commissioned. The underreporting of safety events is often noted to be the result of an unfavorable culture that attributes 'blame' when things go wrong. In partnership, we wish to enable a safety culture to flourish reinforcing safety as our top priority. Ultimately, by reporting and investigating incidents, complaints and concerns, staff will be more confident in the care they provide and we will be better able to identify gaps in processes. This can only be achieved through good leadership, by building a shared vision and by helping everyone feel safe and accountable and proud to work within a supportive learning culture. The steps we will take to achieve this will be included in the Quality and Safety Improvement Framework.

Between April 2014 and October 2017 there have been 15 serious incidents reported (as defined by NHS England's serious incident criteria). Themes identified include:

- Monitoring babies' heart beats effectively before they are born
- Understanding changes to pregnant women's risk factors
- Ensuring babies are born in a place that can best meet their needs

Other incidents that are not categorised as serious incidents are thoroughly reviewed using a high risk case review process to ensure learning is identified and changes in practice are implemented. Through the transformation of maternity services, we will improve the way that we investigate and learn from incidents to help reduce the risk of similar incidents happening again. We will improve the way that we communicate and work with families when outcomes are not as expected.

[7] Further information on safety and quality of maternity services in Shropshire, Telford and Wrekin can be found in Appendix 6

Saving Babies' Lives

Partners within the LMS have developed and implemented a number of initiatives in order to improve safety of services in line with the requirements of the national Saving Babies' Lives initiative, which was launched in 2016. Saving Babies' Lives is designed to reduce stillbirth and early neonatal death. It brings together four elements of care in order to achieve the required reduction. The boxes below describe the improvements that have been made to date and the further work that will be delivered through maternity transformation.

Reducing smoking in pregnancy

Currently:

- All women are asked about their smoking status at booking.
- Women who are smoking at booking or have recently stopped are referred (unless they opt out) to the smoking cessation service.
- All women are offered a carbon monoxide test booking.
- All women should discuss smoking at each clinical contact.

Additional activity through maternity transformation:

- Smoking cessation services will be held alongside local antenatal services. This will allow women to attend both appointments on the same day in the same location.

Raising awareness of reduced fetal movement

Currently:

- All women are provided with a leaflet highlighting the importance of identifying reduced fetal movement at the start of the third trimester.
- All women are reminded of the importance of monitoring fetal movements throughout the third trimester.
- All women are encouraged to attend their local maternity unit for assessment and monitoring if they experience reduced fetal movements.
- Monitors, with on-board electronic analysis, are located in all of the midwife led units and the consultant unit.

Additional activity through maternity transformation:

- There will be investment in better equipment, which is standardised.

Risk assessment and surveillance for fetal growth restriction (FGR)

Currently:

- Women at highest risk of FGR are offered a number of ultrasound scans in the third trimester depending upon their level of risk. The service standards currently offered are not in line with guidance.

Additional activity through maternity transformation:

- Partners within the LMS will work together to achieve service standards in line with Saving Babies' Lives guidance.
- Ultrasound scan locations will be targeted to areas of high need across the STP footprint.
- Detection rates will be assessed using the new software (called GAP) in order to monitor the effectiveness of the service.

Effective fetal monitoring during labour

Currently:

- All staff members required to assess Cardiotogographs (CTG – the machine which monitors the baby's heartbeat and movements) are regularly trained in CTG interpretation

Additional activity through maternity transformation:

- Intrapartum CTGs (CTGs taken during labour) will be archived electronically for review and teaching.
- Intrapartum CTGs will be displayed live outside the labour room in order for staff to assess using fresh eyes on a regular basis throughout labour.
- There will be investment in better equipment, which is standardised.

Maternal and neonatal health safety collaborative

This is a 3 year national programme to support improvement in the quality and safety of maternity and neonatal units across England. The overall aim of the programme is to reduce the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2030. The LMS are engaged with the collaborative and SaTH will join the collaborative in April 2018.

Joining the collaborative will help with building our capability in quality improvement and will provide us with structured support to develop innovative plans that lead to measurable improvements.

Sign up to Safety

A safety improvement plan has been in place since 2015. This has led to a number of safety improvements to date including enhanced training for professionals and investing in better equipment.

The findings from the external reviews that are currently ongoing will inform further developments in this area.

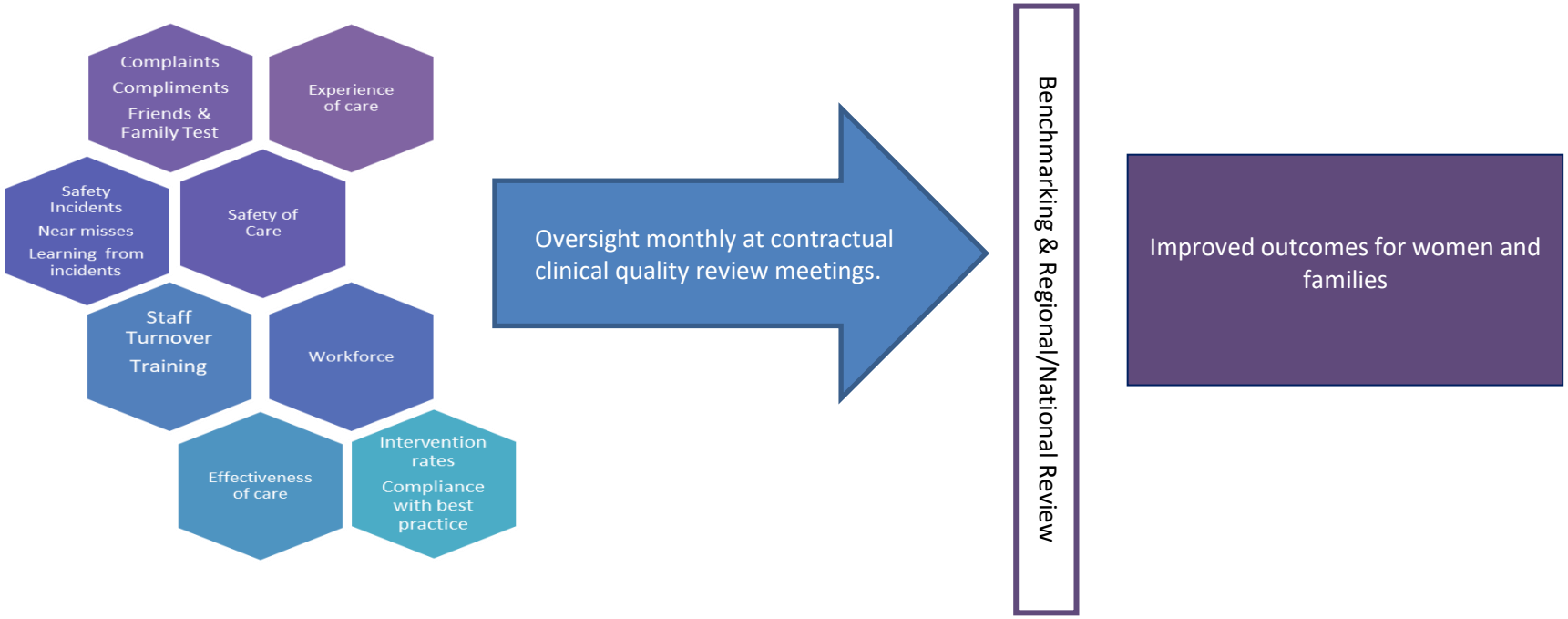
The National Maternity Safety Strategy published in November 2017 set out the Department of Health's ambition to reward those who have taken action to improve maternity safety, including a CNST incentive scheme. Clinical Negligence Scheme for Trusts (CNST) is a scheme that NHS providers pay into in order for the NHS Litigation Authority to handle all clinical negligence claims that may arise. Although membership of the scheme is voluntary, all NHS Trusts in England currently belong to the scheme. For SaTH maternity services as a whole, the cost of this is nearly £5.8million per year.

For 2018/19, SaTH will be submitting evidence of delivery of each of the 10 criteria in the CNST incentive scheme in order to receive a 10% reduction in CNST rate. This will release in the region of £580,000 which can be re-invested in safety improvement activities within maternity services. The ten safety improvement criteria that will be met are:

1. Are you using the National Perinatal Mortality Review Tool to review perinatal deaths?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?
4. Can you demonstrate an effective system of medical workforce planning?
5. Can you demonstrate an effective system of midwifery workforce planning?
6. Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?
7. Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'inhouse' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

In order to gain assurance, performance on services delivered is measured against quality indicators for maternity. In 2016/17, the services for Shropshire, Telford and Wrekin were within the expected range and in line with national performance. The diagram below illustrates the information considered as part of this process.



5.1 Safeguarding

Safeguarding is of paramount importance to all services provided across Shropshire, Telford and Wrekin. Throughout the LMS, safeguarding will be the 'golden thread' throughout all workstreams and cross-cutting themes.

Processes are compliant with CQC best practice and national directives and reviewed on a frequent basis both across the LMS and by external agencies. All partners across the LMS work effectively in the interests of the child and adult.

Actions are currently being implemented across the maternity service that enhances safeguarding based on the recommendations outlined in the 2017 CQC report 'Review of Health Services for Children Looked-after and Safeguarding in Telford and Wrekin'[vi]. All actions are monitored via clinical quality review meetings to provide assurance regarding progress made.

Local safeguarding arrangements within maternity services include:

- ✓ Maternity Safeguarding Alert System
- ✓ Named midwife for safeguarding
- ✓ Specialist midwives for:
  - vulnerable women
  - bereavement
  - public health
  - young mothers
- ✓ Safeguarding and supporting women with additional needs group (SSWWAN)
- ✓ Named doctor and neonatologist are members of child death overview panel
- ✓ Teenage safeguarding pathway
- ✓ Strong links to multi agency safeguarding hubs
- ✓ Mandatory safeguarding training and supervision
- ✓ Safeguarding audits and links to local safeguarding boards

Shropshire, Telford and Wrekin have safety at the forefront of all planning and delivery of maternity services

All actions taken will improve the quality of care, providing seamless care to women and their babies across organisational boundaries and will provide personalised care to each woman, her baby and family

Safeguarding will be the 'golden thread' throughout the LMS

Concerns raised by service users will be heard and acted upon by whoever receives the issue anywhere across the LMS, and when things do go wrong, there will be swift learning taken following a high quality investigation

Greater continuity of care will be provided through visible multi-professional leadership, improving and integrating pathways that progress outcomes, including prevention, mental health, neonatal and postnatal care all accessible through a Community Hub Model

SSCB Shropshire's Safeguarding Children Board Child Protection
Keeping our Children Safe From Harm

Keeping Adults Safe in Shropshire Board

Telford & Wrekin Safeguarding Adults Board

Telford & Wrekin Safeguarding Children Board

6 About Shropshire, Telford and Wrekin

The county of Shropshire has borders with four English counties as well as having the English/Welsh border to the west. Therefore, in planning maternity transformation it is important to consider the needs of those accessing services in Shropshire, Telford and Wrekin as well as women from Shropshire, Telford and Wrekin who access services over the borders.

Shropshire Clinical Commissioning Group (CCG) covers a large geography with issues of physical isolation and low population density within a mix of rural and urban ageing populations. Shropshire is a large rural county with a population of approximately 308,000 that is set to rise to 320,600 by 2020.

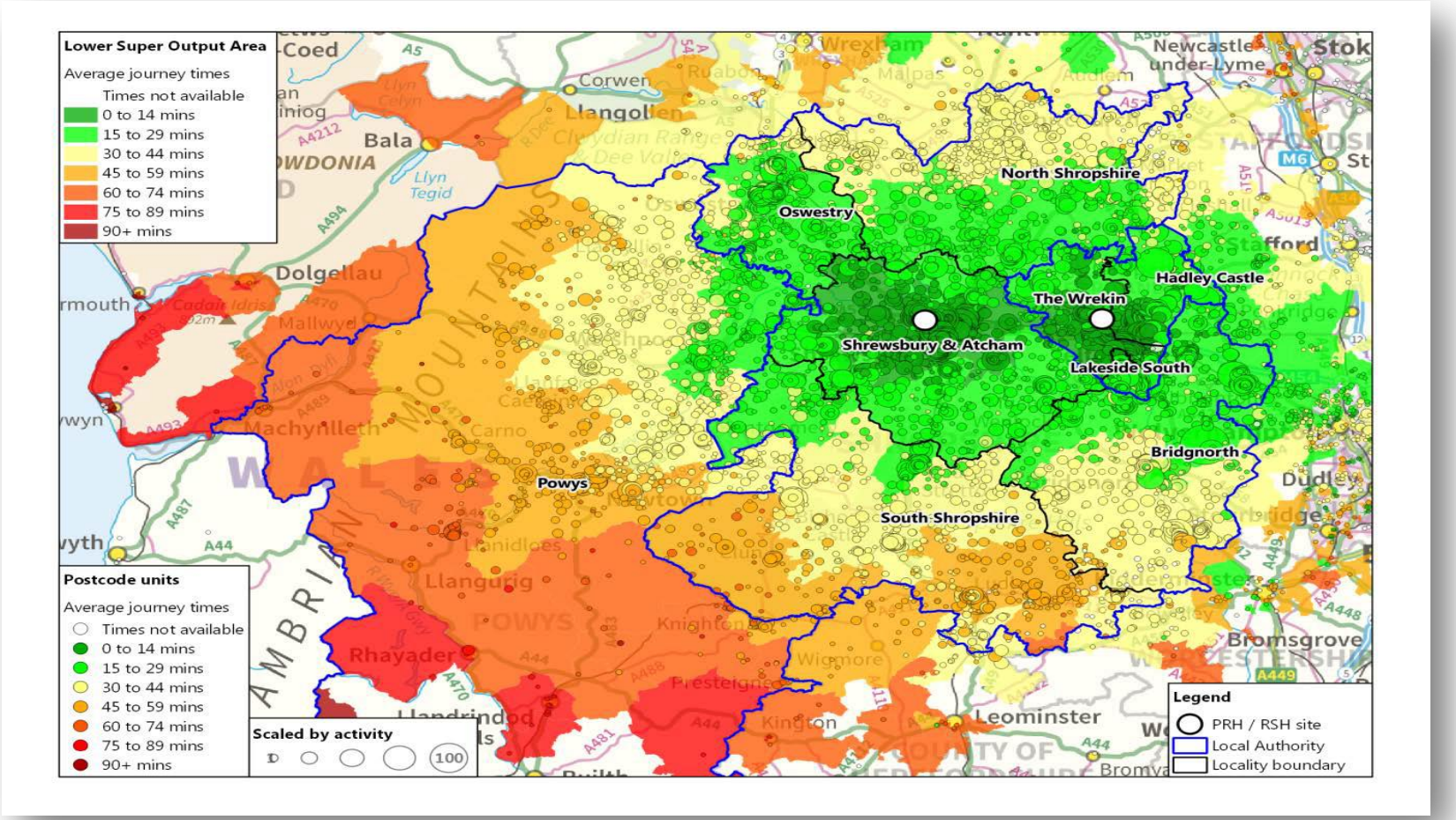
Telford & Wrekin CCG has a large, younger urban population within areas of rurality. Telford is ranked amongst the 30% of most deprived populations in England. The population is approximately 170,000 and due to grow to 198,000 by 2031; the percentage of people who are aged over 85 is set to increase by 130%. Telford and Wrekin has a higher proportion of households with dependant children than the national average and a lower proportion of households where all residents are aged over 65.

[9]

The Shropshire, Telford and Wrekin health and social care economy comprises two CCGs, four main NHS providers, two Councils and a range of smaller private and third sector providers.

The overall population within the footprint is approximately 480,000 people, but a number of outlying populations, most notably Powys, access services at providers within Shropshire; whilst Powys is not officially part of the LMS footprint, we believe it is important to include the Powys population in the LMS and for the community to be represented on the LMS Board.

[9] Further information about the demographics of the county can be found in Appendix 1.



As a large rural area, access to services is an important consideration in planning and designing services. This image shows the journey times to the two main hospitals from across the area. Patients using public transport may have significantly longer journey times.

7 Current Offer

7.1 Before getting pregnant

Across Shropshire, Telford and Wrekin a range of services are on offer to support people before getting pregnant. Healthy Lifestyles Services (Telford & Wrekin) and Help 2 Change (Shropshire) offer free advice, information and support around health and lifestyles to enable individuals to feel better, healthier and have more energy. They offer support and help around eating healthily, being more active, reducing alcohol consumption, stopping smoking and feeling better about yourself.

Contraception, sexual health and family planning clinics are available across the county to support planned pregnancies. In addition, specialist services are available within the county to help couples conceive (fertility services) and provide them with pre-conception advice (maternity services).

Women can access information, advice and support in relation to their mental health through local mental health services and their GP.

7.2 Care before the baby is born (antenatal care)

Around 5,500 women book to receive maternity services with the maternity services provider in Shropshire, Telford and Wrekin (Shrewsbury and Telford Hospitals Trust – SaTH) each year. The majority of routine antenatal care is delivered by community midwives. The smaller community teams have between 200-400 attendances a month, with the larger community teams having approximately 2,500 attendances a month.

Women have a hand-held record within which professionals document their antenatal care. Women take this document with them to appointments for the professionals to update.

Women are referred to maternity services in one of two ways – through their GP or by referring themselves through one of the midwife led units. Booking directly with the midwife led units is quicker, but essential information that the GP holds may not be shared. Women can choose how they access routine antenatal care. Women can access antenatal care at one of the 5 midwife led units, a clinic at their GP practice or through the midwife visiting them at home. Women with a higher level of need can access obstetric care through clinics at Princess Royal Hospital or Royal Shrewsbury Hospital. There are also obstetric clinics held in Ludlow and Oswestry midwife led units.

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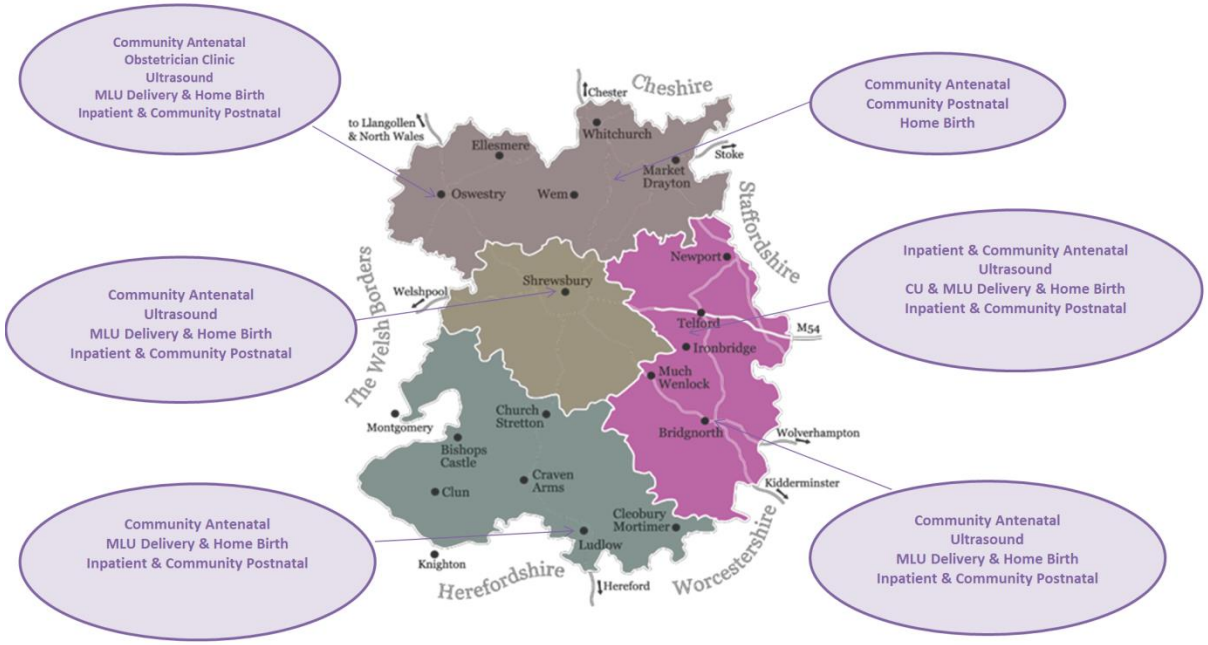
[10] For further information please refer to Appendix 2.6



This map shows which elements of service are available in different parts of the county. Through implementing Workstream 1, there will be more equity across the county with regards to the types of services available in the community.

- ✓ Women can access information online via the SaTH website and maternity apps.
- ✓ Women have continuity of carer during pregnancy. Community midwives work in small teams of 4-6, so women are likely to know the midwife they see during their pregnancy.
- ✓ Women can access specialist joint obstetric mental health clinics, which are held fortnightly.
- ✓ Women can access psychological therapies through the IAPT service.
- ✓ Most women who require in-patient care because of their mental health needs during pregnancy or in early motherhood, access services from the Brockington Unit in Stafford. The service provides assessment, treatment and care for women suffering from mental health problems associated with pregnancy and childbirth including severe postnatal depression and puerperal psychosis.

Across the county there is support to stop smoking during pregnancy through Help2Quit (Shropshire) and the Public Health midwifery service (Telford and Wrekin). Women access the service via a referral at booking (unless they opt out) and can also be referred to the service throughout their pregnancy by midwives and sonographers, as well as accessing the service through self-referral. All midwives and women support advisors receive annual training about smoking during pregnancy as part of the annual statutory training programme delivered by the public health midwife.

In Telford and Wrekin, a support programme is offered to all women with a BMI greater than 30 at booking. The service is called 'Healthy Mums' and offers support during pregnancy and after delivery until the child is 6 months old. The programme aims to support women to maintain a healthy weight gain during pregnancy and supports weight loss after delivery. Currently 71% (2016-17) women gain no more than the healthy 10kg during their pregnancy. In 2016-17 the service was averaging 52 referrals per month.

7.3 Giving Birth (Intrapartum Care)[11]

Women have a range of options in relation to where they choose to give birth in Shropshire, Telford and Wrekin. These are:

- 1 x Consultant Unit (CU) (Telford – Princess Royal Hospital)
- 1 x Alongside Midwifery Led Units (MLU) (on the same site as the consultant unit)
- 4 x Freestanding MLU (not on the same site as consultant unit – Shrewsbury, Oswestry, Bridgnorth, Ludlow)
- Home birth

Women giving birth in the consultant unit are not likely to know the midwife or doctor delivering their baby. However, those giving birth in a midwife led unit or at home are likely to know the midwife caring for them during labour.

Women who wish to use a different service provider for their care in labour can request funding from the Clinical Commissioning Group.

[11]Where numbers are given for 'births', this is the number of babies born. Where numbers are given for 'deliveries' this is the number of women who have given birth e.g. if a woman has twins, this will be one delivery but two births.

7.4 Care after the baby is born (postnatal care)

After giving birth, women and their babies receive care at one of the inpatient postnatal units or in the community. Women are likely to know the midwife providing their postnatal care. The midwife is likely to be one of the same midwives who provided care for the woman during her pregnancy. Once the baby is 10 days old, the midwives hand over the care to the Health Visiting Team. Some young vulnerable mothers will continue to be supported through the Family Nurse Partnership. Health visitors are trained to support women with their mental health needs and women can access more specialist services in the community or as an inpatient if they need to.

Both Shropshire and Telford & Wrekin offer a breastfeeding service. Shrewsbury and Telford Hospitals have been awarded the full UNICEF baby friendly Initiative, as well as Shropshire Children Centres. Across the county there is breastfeeding support offered by health visitors, breastfeeding facilitators and volunteers.

Both Telford & Wrekin Council and Shropshire Council commission 0-19 services including Health Visiting, School Nursing and Family Nurse Partnership. They offer a range of services to support during pregnancy and being a parent. They offer mandated visits for all women antenatal and postnatal at 10-14 days, 6-8 weeks, one year and two years. They also offer additional support, help and advice for families classed as targeted, vulnerable and complex. They offer support on a variety of areas such as breastfeeding, weaning, healthy eating, sleeping and parenting.

7.5 Care for new-born babies (neonatal care)

The majority of babies that are born are healthy and remain with their mother. During the first few days of their life, they are cared for by midwives who support their mother in the general care of the baby. Screening examinations of the babies are carried out by the midwives either in the hospital or community setting.

A proportion of babies will require an increased level of care provided by neonatal staff from the Neonatal Unit (NNU). The Neonatal Unit within the Shrewsbury and Telford Hospital (SaTH) is a Local Neonatal Unit (LNU). This is defined by British Association of Perinatal Medicine as: providing special care and high dependency care and a restricted volume of intensive care (as agreed locally) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit (NICU). The two closest NICUs are located at the University Hospitals of North Midlands in Stoke and New Cross Hospital in Wolverhampton.

SaTH Maternity and Neonatal department completed a successful project in 2017 around the investigation of babies admitted to the NNU at term (i.e. not premature) and the possible ways to reduce the number of such admissions. Since then a range of professionals meet regularly to examine the background to babies admitted to the neonatal unit at term. The group are using the template suggested by the national ATAIN Programme (avoiding term admissions into neonatal units), which is led by clinical experts, to ensure their work is robust.

8 What do we know about the needs and preferences of women and the needs of their babies?

8.1 What women and their families say is important to them

During summer 2017, the views of women and their families in relation to maternity services were gathered and considered. This involved looking at existing feedback that the CCGs, SaTH and HealthWatch had received as well as gathering new information about what women and their families said was important to them. [12]

Existing feedback shows that in general women and their families are happy with the services they receive. Women and their families say that the following things are important to them:

[12] For further information on the views of women and their families please see Appendix 8.1

8.2 What does our data tell us? [13]

Across Shropshire, Telford and Wrekin there are an estimated 78,700 women of a child bearing age (16-44 years). Projections indicate that the numbers of women of childbearing age will be relatively static. Projections also indicate that the proportions of the population which are aged 0-4 years old will remain broadly similar in Telford, Wrekin, and Shropshire in 2025 and 2035.

In Shropshire there are on average 3,400 conceptions in women of all ages each year, 18% (615 conceptions) end in termination, which is lower than the national average. In Telford and Wrekin there are on average 2,615 conceptions in women of all ages every year. Just over a fifth, 21% (550 conceptions) end in termination, which is similar to the England average (21%).

In Telford and Wrekin, a total of 367 women smoked at delivery in 2015/16, compared to 295 women in Shropshire. Maternal smoking is significantly high in Telford and Wrekin. However, rates have started to decline in the past two years, falling below 20%. The rate of smoking in pregnancy in Telford and Wrekin was 18.1% in 2015/16, compared to 12.3% in Shropshire and 10.1% in England as a whole.

In 2014 in Telford and Wrekin the rate of under 18 conceptions was significantly higher than the England average and double the rate in Shropshire. Teenage conception rates in Telford and Wrekin have historically been significantly higher than the England average, whereas in Shropshire rates have been significantly lower.

In Telford and Wrekin, over a quarter women aged 16-44 years live in communities classified within the most deprived fifth of areas in England. This compares to 5.8% in Shropshire.

It is estimated that 71% of all adults in Telford and Wrekin carry excess weight (i.e. overweight or obese). This is significantly worse than the national average of 64.8%. It is estimated, that circa 22,250 women of child bearing age (15-44 years) carry excess weight in Telford and Wrekin. In Shropshire 65.2% of all adults are estimated to be overweight or obese, which is not significantly different to the England average.

Levels of breastfeeding (both initiation at birth and duration at 6-8 weeks) have been historically low in Telford and Wrekin, but rates have improved slowly. In 2015/16 almost a third, 33.5% of infants (655 babies) were not breastfed at birth, which is significantly worse than the average for England 25.7%. In Shropshire just under a quarter, 24.7% of infants (605 babies) were not breastfed at birth in 2015/16, which is similar to the national average. By 6-8 weeks of age breastfeeding has dropped further. In 2015/16 63.7% of infants were not receiving any breast milk in Telford and Wrekin (2,044 babies), which is significantly worse than the England average of 56.8%. In Shropshire 54.1% of infants (2,771 babies) were not breastfed at 6-8 weeks.

[13] For further information please refer to Appendix 2.1,2.5,2.5,3.1,3.2,3.3,3.4,3.7,5.1

Trends in infant mortality rates fluctuate due to the small number involved, but since the mid 1980s in Shropshire, Telford and Wrekin rates have been declining overall across the decades. The three year rolling average rates have been significantly higher than the England average for the past five years.

There are a similar number of perinatal deaths (stillbirths and deaths before 1 week) in Shropshire, Telford and Wrekin – on average 17 per year and rates are similar to the England average.

There are on average 2,100 live births in Telford and Wrekin each year, compared to on average 2,820 in Shropshire. There are on average 10 neonatal deaths within the first 4 weeks of life in Telford & Wrekin. The neonatal mortality rates in Telford & Wrekin from the period 2012-14 and 2013-15 were significantly worse than the England average. In Shropshire there are on average 6 neonatal deaths per year and rates are similar to the England average.

Of the women accessing SATH maternity services in 2016/17, 85.1% gave birth in the Consultant Unit at Princess Royal Hospital. This is in line with the findings of the national maternity review[1] (87% women nationally give birth in a consultant led unit). Most women in Shropshire, Telford and Wrekin give birth within the county. However, some women choose to give birth out of county. These are normally women living on the borders. The most frequent out of area hospitals accessed by Shropshire, Telford and Wrekin women to deliver are Wrexham Maelor, Worcester Royal Hospital and Hereford County Hospital.

Shrewsbury and Telford Hospitals Trust (SaTH) have around 5,000 births each year. Over 92% births are in relation to Shropshire, Telford and Wrekin patients, the remaining births are of patients from elsewhere. The number of babies born in Shropshire, Telford and Wrekin is summarised in the table.

SATH Maternity Services : Births 2016/17

Maternity Unit	Shropshire Patients	Telford & Wrekin Patients	Powys Patients	Patients from other areas
Consultant Unit	2,016	1,830	216	132
Shrewsbury MLU	142	0	0	0
Wrekin MLU	135	199	0	3
Bridgnorth MLU	67	2	0	8
Oswestry MLU	50	0	0	2
Ludlow MLU	31	0	0	5
Home	41	21	1	1
Born before arrival (without presence of midwife or obstetrician)/other	8	8	2	8
Total	**2,490**	**2,060**	**219**	**159**
Total Births 2016/17	**4,928**			

The number of births are projected to remain relatively static during the transformation timescale, with births projected to be 4,989 in 2020/21

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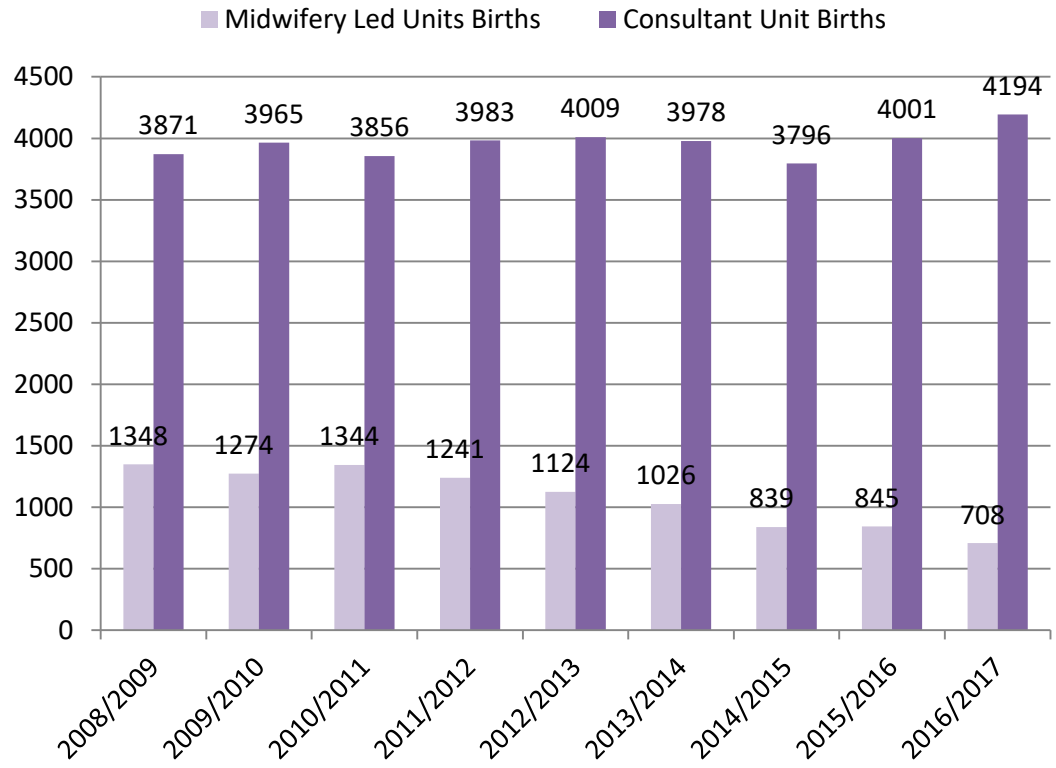
[14] For further information please refer to Appendix 2.1,2.6

Over the last nine years, the births within the midwife-led units or at home have steadily declined from approximately 1,350 (26% of total activity) to 708 (14% of total activity), as illustrated in the graph below.

SATH Summary Birth Figures 2008-2017



In Shropshire, Telford & Wrekin, many women intend to give birth at midwife led units, but go on to deliver in the consultant unit. In 2015 and 2016, 3,921 women intended to give birth in a MLU or at home. However, only 1,498 (38.2%) of women who intended to give birth in a MLU or at home actually did so. The change of intended place of delivery most commonly occurs during the antenatal period and is usually associated with a change in risk to the mother or the baby.

Through this transformation plan we will explore how we can enable more women to have a midwife led birth.

Most women (90%) and their babies receive inpatient postnatal care on either the Postnatal Care Ward at Princess Royal Hospital, the Wrekin MLU or Shrewsbury MLU. 10% of women receive some or all of their postnatal care at either Ludlow, Bridgnorth or Oswestry MLU.

This table shows the total bed days available at the MLUs compared to the bed days used in 2016/17

MLU	Total bed days available per year	Total bed days used 2016/17 (% utilisation)
Wrekin	13 x 365 = 4,745	Not available[15]
Shrewsbury	10 x 365 = 3,650	647 (18%)
Bridgnorth	4 x 365 = 1,460	321 (22%)
Oswestry	6 x 365 = 2,190	570 (26%)
Ludlow	4 x 365 = 1,460	239 (16%)

In 2016/17 the MLUs cared for around 2,074 women in the postnatal period that gave birth on the Consultant Unit. The majority of these women were cared for postnatally at Wrekin MLU (1,406). Shrewsbury cared for 331 women postnatally, with Ludlow, Oswestry and Bridgnorth caring for 91, 106 and 140 women respectively.

On average women who have a postnatal stay, stay at the MLUs for around two and a half days. The number of women having a postnatal stay varies across the MLUs. In 2016/17 the freestanding MLUs each had approximately 5-15 women each month having a postnatal stay. The alongside MLU has a higher number of women staying each month. After leaving the hospital/MLU, women receive postnatal care from midwives in the community.

[15] Data is currently recorded by site. Information about postnatal stays specifically in the MLU was not available at the time of writing this report, as information relating to Princess Royal Hospital includes activity in the consultant unit as well as the MLU.

Estimated prevalence rates of perinatal mental health difficulties for Shropshire, Telford and Wrekin are displayed in the below table.

Rates of perinatal psychiatric disorder	per thousand maternities	Estimated number of women affected per year – England	Estimated number of women affected per year – Shropshire (2,490 births)	Estimated number of women affected per year – Telford and Wrekin (2,060 births)	Estimated number of women affected per year – Shropshire, Telford and Wrekin (4,550 births)
Postpartum psychosis	2/1000	1,380	5	4	9
Chronic serious mental illness	2/1000	1,380	5	4	9
Severe depressive illness	30/1000	20,640	75	60	135
Post-traumatic stress disorder	30/1000	20,640	75	60	135
Mild - moderate depressive illness and anxiety states	100-150/1000	86,020	250 – 375	200 - 300	450 - 675
Adjustment disorders and distress	150-300/1000	154,830	375– 750	300 - 600	675 – 1,350

9 Finance & Sustainability

The Shropshire and Telford & Wrekin Health Economy is currently under significant financial pressure and the Sustainability and Transformation Plan (STP) describes the significant financial challenge (£126m) that the local health system needs to address over the next 5 years. STP partners are in agreement that in order for our NHS to continue to provide services for the future, changes need to be made now.

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There is not enough money for us to continue as we are and we need to make changes to take full advantage of recent rapid progress in treatments and technology.

The overall reconfiguration of acute hospital services in Shropshire (Future Fit) forms part of the system plan to find where £74 million could potentially be used differently and more effectively to improve services for the local population.

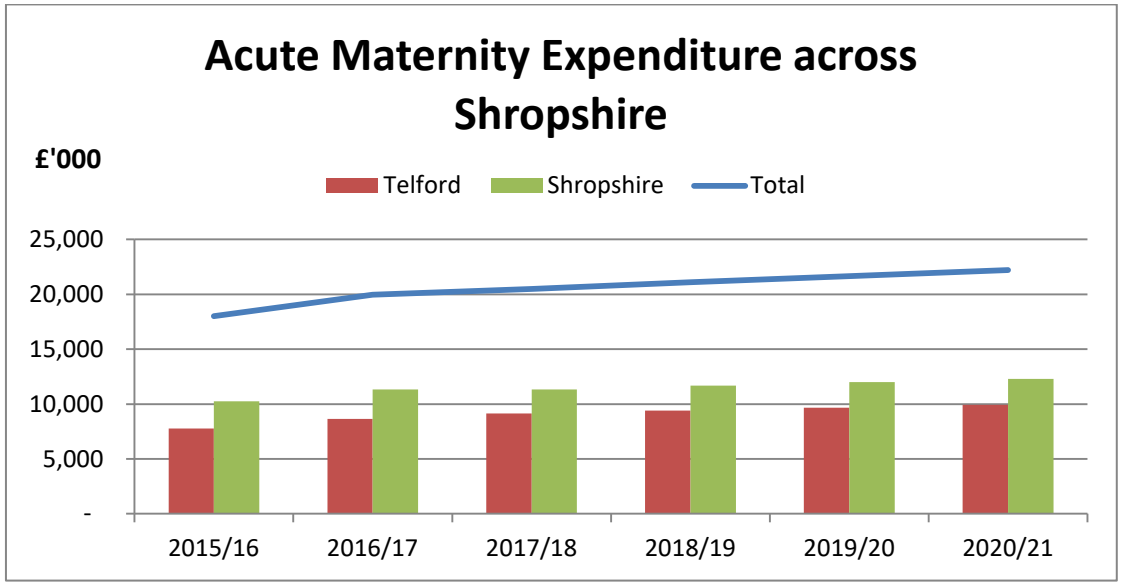
Added to the proposals NHS providers have a target of saving £62 million through efficiency improvements, successful implementation of the STP will put Shropshire and Telford & Wrekin in a good position at the end of the next five years to have services which are sustainable in the long term as well as meeting the public's healthcare needs more effectively.

The LMS sits within the STP and will need to deliver maternity transformation within this context. The current main provider of maternity services, Shrewsbury and Telford Hospitals NHS Trust, is currently running the service at a loss of £7m per year. This will need to be addressed as part of this plan.

Cost pressures have been identified by our main provider in terms of additional midwives to meet Birthrate plus standards and additional sonographers for extra scans. The outcome of the Midwife Led Unit (MLU) review may also have an impact on the financial sustainability of community MLUs. Savings opportunities should materialise due to a reduction in incidences of harm, time savings due to the development and rollout of an electronic care record, increasing home births and reductions in use of agency staff. As the plan progresses a full activity and finance model will be worked up in line with the current STP and Future Fit assumptions.

17

[16] For further information please refer to Appendix 1
[17] For further information please refer to Appendix 2.3



This graph shows how much is currently spent on maternity services across the local health economy. The spend has been split between the two clinical commissioning groups and shows how spend has increased over the last 3 years. The graph then goes on to show projected spend up to 2020/21 based on the current growth assumptions within the STP.

- **Note that 2017/18 figures are the forecast position for the year**
- **Note that 2018/19 projected figures are based on growth assumptions within the Shropshire STP (3.0% 2018/19, 2.7% 2019/20 and 2.6% 2020/21)**

On average 94% of the spend represented above is spent at Shrewsbury and Telford Hospitals NHS Trust.

The needs of women accessing maternity services are assessed and classified against three different pathways, which are defined at a national level (standard, intermediate and intense). The proportion of women within each of the different pathways in 2016/17 in Shropshire, Telford and Wrekin is provided in the table below and includes a comparison to other areas. The plan aims to reduce the number of women with high risk pregnancies and also therefore reduce the associated costs.

		Number (%) Women		
		Shropshire	Telford & Wrekin	West Midlands CCGs 2015/16
Stage of Pregnancy	**Level of Need**			
Antenatal	Standard	1450	892	49.20%
		-51%	-39%	
	Intermediate	1134	1147	41.80%
		-40%	-51%	
	Intense	264	220	9%
		-9%	-10%	
Delivery	Without complications/co-morbidities	2133	1720	-
		-80%	-78%	
	With complications/co-morbidities	528	473	-
		-20%	-22%	
Postnatal	Standard	1643	1097	70.60%
		(63.4%)	-55.80%	
	Intermediate	940	860	28%
		-36.30%	-43.70%	
	Intense	7	9	1.40%
		-0.30%	-0.50%	

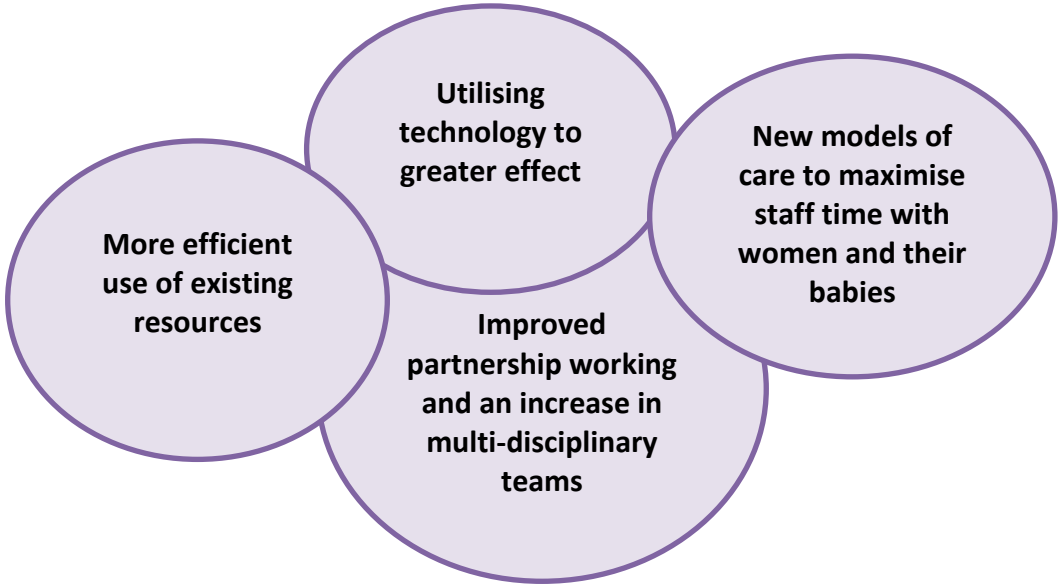
The maternity pathway payment system was introduced in April 2013 to:

- reduce variance in the way organisations describe and record antenatal and postnatal care
- encourage more proactive care, delivered closer to home
- encourage a more woman-focused approach to maternity care

For each of the stages shown above, a woman chooses her pathway provider, identified as the 'lead provider'. The commissioner makes a single payment to the lead provider of each stage to cover the cost of care, the level of which depends on clinical factors that affect the extent and intensity of care a woman is expected to need.

Women may still receive some of their care from a different provider for clinical reasons or to support their choice. This care is paid for by the lead provider that will have received the entire pathway payment from the commissioner.

The majority of the maternity transformation will need to be delivered by the Local Maternity System within existing resources. This will be achieved and sustained through:



The Local Maternity System has received funding from NHS England to support transformation activities. This funding (£77k 2017/18, £150k 2018/19) has been allocated to secure a Programme Manager, Project Support Officer and Clinical Backfill as well as co-production and engagement activity.

To support the pace and scale of transformation required, the Local Maternity System will seek to secure additional funding/reduce existing spend, where available. This will include the following:

- NHS England Transformation Funding
- West Midlands Perinatal Mental Health Service User Forum Development Funds 17/18
- Perinatal mental health community services development fund wave 2
- CNST Incentive Scheme

Further detail on funding the transformation is provided in Appendix 11.

10 Delivering the vision – the Programme of transformation

The programme of transformation is still in the early stages. Some of the detail in relation to specifically what will be delivered is not yet known. The details will be confirmed once the reviews set out in workstream plans are complete. Once all the reviews are complete the future maternity offer can be confirmed.

The proposals from each of the reviews will set out in detail how service, pathway and process improvements will be made to ensure the requirements of Better Births are delivered, including in relation to:

- ***Improving safety of maternity care***
- ***Personalised care planning***
- ***Choice of services***
- ***Continuity of carer***
- ***Increasing the number of women giving birth in midwifery led settings***
- ***Perinatal mental health***

Shropshire, Telford and Wrekin Maternity Offer		
	Current Offer	**Offer 31.03.2021**
Before Pregnancy	- All women have access to universal public health services relating to healthy lifestyles - Women with a specialist need have access to mental health services	- Women will receive targeted support to help them lead a healthy lifestyle before, during and after pregnancy - Staff receive regular training and up to date information about mental health and healthy lifestyles for those planning a family - All women have access to a pre-conception health check - All women have access to advice and support in relation to their emotional health and wellbeing
Antenatal	- Access to services is unclear and disjointed - All women have the same team of 4-6 midwives caring for them throughout their pregnancy - Women arrange their own appointments throughout pregnancy - Ultrasound scanning is available in most parts of the county - Day Assessment is available in some parts of the county - Obstetric clinics are available in some parts of the county - All women have hand held notes	- Access to services is through a single route, which is clear and well publicised - All women have the same team of up to 4 midwives caring for them throughout their pregnancy - Women are provided with a plan of all appointments at the start of pregnancy, which fit around their work and personal commitments - Ultrasound scanning is available in all parts of the county - Day assessment is available in all parts of the county

	- All women have access to general information within the handheld notes and online, including in relation to mental health - Women with an identified mental health need receive support through a specialist service	- Obstetric clinics are available in all parts of the county - All women have access to electronic, personalised care plans - All women have access to electronic personalised information and advice - All women have access to peer support - All women have access to support with their emotional health and wellbeing
Birth	- There is a full choice of birth settings available (Consultant Led Unit, Alongside Midwifery Unit, Standalone Midwifery Unit and Home Birth) - Some women know the midwife delivering their baby/ies	- There is a full choice of birth settings available (Consultant Led Unit, Alongside Midwifery Led Unit, Standalone Midwifery Led Unit and Home Birth) - Most women know the midwife delivering their baby/ies - More women have a midwifery-led birth
Neonatal	- Babies can access a Neonatal Unit offering Intensive Care, High Dependency and Special Care cots within the county - The reason for babies needing to access the neonatal unit are examined by a multi-disciplinary group using the ATAIN programme template and identify and implement service improvements. - Newborn Infant Physical Examination (NIPE) takes place within 72 hours at a time and place convenient for the mother. - Transitional Care: Babies that are small, early or those born to mothers with diabetes, but do not need specialist neonatal care, may require transitional care. Such care aims to keep mother and baby together. Currently in SaTH this is offered on the postnatal ward. There is no specific area on the ward. Babies and mothers are kept together and cared for by midwives. Some babies (up to 4) are kept in incubators.	- Babies can access a Neonatal Unit offering Intensive Care, High Dependency and Special Care cots within the county - The reason for babies needing to access the neonatal unit are examined by a multi-disciplinary group using the ATAIN programme template and identify and implement service improvements. - Newborn Infant Physical Examination (NIPE) takes place within 72 hours at a time and place convenient for the mother. - New transitional care models are in place to reduce unnecessary admissions to neonatal units, keep mother, and baby together. - Regular, multidisciplinary local reviews identify why a term baby has been admitted to the neonatal unit and implement service improvements.
Postnatal	- All women have the same team of 4-6 midwives caring for them in the community after they've had their baby/ies - Health Visitors trained in cognitive behavioural therapy support women with their emotional wellbeing - Women with an identified mental health need receive support through a specialist service	- All women have the same team of up to 4 midwives caring for them in the community after they've had their baby/ies. This is the same team of midwives who cared for them during pregnancy. - All women have access to support with their emotional health and wellbeing

		- All women have access to peer support - All women have access to electronic, personalised advice and information
Quality and Safety	- All women are asked about smoking status at booking. Women who are smoking at time of booking are referred to smoking cessation services - All women are offered a CO test at booking - Women at highest risk of fetal growth restriction are offered additional scans. Service standards are not currently in line with RCOG guidance. - Women receive information and guidance about reduced fetal movements throughout pregnancy. - CTG monitors, with on-board electronic analysis, are located in all of the MLUs and the CU. - The CCGs monitor the quality of services using a quality dashboard - The Patient Experience Team conduct investigations into patient safety incidents and ensure improvements are made. - Lead Midwife and Lead Consultant for risk add additional expertise to identifying and implementing improvements.	- All women are asked about smoking status at booking. Women who are smoking at time of booking are referred to smoking cessation services. - Smoking cessation services run alongside local antenatal services allowing women to attend both appointments on the same day in the same location - All women are offered a CO test at booking - Women at highest risk of fetal growth restriction are offered additional scans. Services offered are in line with RCOG guidance. - Ultrasound scan locations are targeted to areas of high need to improve uptake. - Women receive information and guidance about reduced fetal movements throughout pregnancy. - CTG monitors, with on-board electronic analysis, are located in all of the MLUs and the CU. - Intrapartum CTGs are archived electronically for review and teaching. - Intrapartum CTGs are displayed live outside the labour room in order for staff to assess using fresh eyes on a regular basis throughout labour. - The LMS partners monitor the quality of services across the pathway using a LMS joint quality dashboard. - The Patient Experience Team conduct investigations into patient safety incidents and ensure improvements are made. - Lead Midwife and Lead Consultant for risk add additional expertise to identifying and implementing improvements. - Detection rates using the GAP software assess the effectiveness of the service in the detection of FGR. - Enhanced training programme is in place to ensure high quality investigations are undertaken.

Workstream one: Maternity and newborn service configuration	
This workstream includes: – Review of the current service configuration for maternity and new-born services – Implementation of the recommendations from the 'Action on Neonatal Mortality' programme – Development and implementation of recommendations for service improvements in line with *Better Births* for midwifery led services, consultant led services and neonatal pathways – Development and implementation of personalised care plans – Development and implementation of outcomes and performance monitoring framework – Development and implementation of improved quality and safety improvement system	**Outcomes:** – Services are safer – Women have a choice in the services they receive throughout pregnancy, during birth and after the baby is born – Women understand the care they are receiving and feel involved in decisions about their care – Women and their families find it easy to access a range of services related to pregnancy, birth and early parenthood – Women receive care that is personal to their needs and circumstances

Key activities

Activities	Timeframe
Midwifery led services review	Q4 2017/18
Consultant unit review	Q1 2018/19
Neonatal pathways review	Q1 2018/19
Development of maternity offer	Q2 2018/19
Development and implementation of Personalised Care Plan Framework	Q1 2018/19
Development and implementation of new service pathways to improve transition	Q1 2018/19
Development and implementation of outcomes and performance monitoring framework	Q2 2018/19
Implementation of quality and safety improvement system	To be confirmed

Success will be measured by:

- A reduction in the rates of stillbirth and neonatal death, maternal death and brain injuries
- An increase in the number of women giving birth in community settings
- An increase in the number of women who have continuity of carer throughout pregnancy, birth and after their baby is born
- An increase in the proportion of women reporting they felt they had a choice about their care during pregnancy, birth and after their baby is born
- An increase in the proportion of women reporting that they understood about the care they received and felt involved in decisions about their care
- An increase in the number of women who have personalised care plans
- An increase in the number of women with access to electronic records and information
- Evidencing improvements in investigating and learning from incidents and sharing learning with others
- Evidencing full engagement in the development and implementation of the national maternity and neonatal quality improvement programme
- The proportion of women accessing maternity services before 10 weeks of pregnancy
- Earlier provision of appropriate information at the onset of pregnancy
- Fewer days spent accessing maternity care although receiving more care episodes for all women
- A reduction in the number of days in which women and their babies are separated whilst their baby receives care

Related recommendations in *Better Births*

1.1 : Every woman has a personalised care plan
1.3 : Women can choose the provider of their care through a NHS Personal Maternity Care Budget
1.4 : Women can make decisions about the support they need during birth and where they would prefer to give birth
2.1 : Every woman has a midwife who is part of a team of 4-6 midwives
2.2 : Each team of midwives has an identified obstetrician
2.3 : Community hubs should enable them to access care in the community from their midwife and from a range of others services, particularly for antenatal and postnatal care.
2.4 : Midwives liaise closely with obstetric, neonatal and other services to ensure women get what they need
3.1 : Providers have a board level lead for maternity services, routinely monitor quality and safety and take necessary action to improve
3.3 : Rapid referral protocols are in place to ensure that the woman and her baby can access more specialist care when they need it
3.4 : Teams collect data on quality and outcomes in order to improve services
3.5 : There should be a national standardised investigation process when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence.
3.6: There is already an expectation of openness and honesty between professionals and families, which should be supported by a rapid redress and resolution scheme, encouraging rapid learning and to ensure that families receive the help they need quickly
4.2: Women have access to their midwife as they require after having their baby
4.3 : There is smooth transition between midwife, obstetric and neonatal care and to ongoing care in the community
4.4 : A review of neonatal services has taken place
5.1 : Those who work together, train together
5.2 : Multi-professional training

5.4 : A nationally agreed set of indicators is in place to track, benchmark and improve the quality of maternity services
5.5 : Multi-professional peer review is available and used locally
6.1: Local Maternity System is in place
6.2 : Maternity Clinical Networks are in place and Shropshire, Telford and Wrekin are active members
6.3 : Commissioners are commissioning against clear outcome measures. Providers are empowered to make service improvements
6.4 : Early adopter sites are up and running

Workstream two: health and wellbeing	
This workstream includes: – Implementing the offer of preconception health checks – Enhancing existing initiatives and introducing new initiatives to improve the health and wellbeing of parents/carers and future parents/carers, including in relation to smoking, obesity, diabetes, hypertension, screening, immunisations and vaccines. – Enhance existing initiatives and introducing new initiatives to ensure every child gets the best start in life – Working across the health economy to ensure advice, support and services are in place for women before, during and after pregnancy in relation to health and wellbeing – Ensure services are in place to promote pregnancy planning and the promotion of contraceptive choices (including in the post partum period) – To ensure the workforce is well equipped to offer advice support and signposting to improve their health – Ensuring preventative services and advice during pregnancy are offered across the county within community hubs – Delivering a programme of Making Every Contact Count (MECC) training to a range of professionals – Strengthening links and pathways between maternity, health visiting and other professionals to offer early support with health and wellbeing	**Outcomes:** – Women have a healthy lifestyle before getting pregnant – Women are healthy during pregnancy – Women understand how to keep themselves and their baby healthy in the longer term – Professionals work within a culture where improving health and wellbeing and reducing health inequalities is understood and acted upon – Babies and infants are healthier and grow to be healthy children and adults

Key activities

Activities	Timeframe
Improve uptake and impact of making every contact count (MECC)	Q1 2018/19
Develop and implement new information and pathways in relation to contraception and sexual health.	Q1 2018/19
Improve training for professionals and access for women in relation to healthy lifestyle services	Q1 2018/19
Stop smoking services review	Q4 2018/19
Obesity services review.	Q1 2018/19
Diabetes services review.	Q3 2018/19
Hypertension services review.	Q3 2018/19
Breastfeeding services review.	Q2 2018/19
Screening Programmes review.	Q3 2018/19
Immunisation Programmes review.	Q3 2018/19

Success will be measured by:

- An increase in the uptake of screening and immunisations for pregnant women
- An increase in the update of screening and immunisations for babies and infants
- An increase in the number of professionals trained in MECC
- An increase in the range of professionals trained in MECC
- A reduction in the prevalence of obesity, smoking, diabetes and hypertension during pregnancy
- An increase in breastfeeding rates

Related recommendations in *Better Births*

2.3 Community Hubs should enable women to access care in the community from a range of services
2.4 Midwives liaise closely with obstetric, neonatal and other services to ensure women get what they need
4.2 Postnatal care must be resourced appropriately. Women should have access to their midwife as they require after having had their baby
4.3 There is smooth transition between midwife, obstetric and neonatal care and to ongoing care in the community
5.1 Those who work together, train together
5.2 Multi-professional training

Workstream three: Perinatal Mental Health

This workstream includes:

- Developing and publishing new information for women from pre-conception to 12 months post-delivery with advice on how to improve their emotional mental health and wellbeing
- Developing and implementing improved perinatal mental health services
- Improving partnership working
- Upskilling the workforce
- Promoting holistic care that supports parent-infant interaction and family relationships

Outcomes:

- Women understand how to improve their emotional mental health and wellbeing
- Women feel confident in managing their emotional health and wellbeing
- Women feel well supported in relation to their emotional health and wellbeing
- Professionals feel confident in their knowledge of perinatal mental health and the local services available

Key activities

Activities	Timeframe
Improved skills and pathways within primary care	Q4 2017/18
Improved skills and pathways within maternity services	Q4 2017/18
Improved information on and access to mental health advice and support in the community for women of childbearing age	Q1 2018/19
Increased availability of specialist perinatal mental health services	Q1 2018/19*

*If successful with a bid for early funding, the new service will commence during 2018/19. Otherwise, the transformation will occur in 2019/20 when the additional funds will be received.

Success will be measured by:

- An increase in the proportion of women reporting they are confident in managing their emotional mental health and wellbeing
- An increase in the proportion of women reporting that they receive regular information and advice in relation to managing their emotional mental health and wellbeing
- An increase in investment in Perinatal Mental Health Services
- An increase in the proportion of professionals who report they are confident in giving advice and support to pregnant women and new mothers in relation to their emotional mental health and wellbeing
- An increase in the range of services available for women in Shropshire, Telford and Wrekin in relation to perinatal mental health

Related recommendations in *Better Births*

2.3: Community Hubs should enable women to access care in the community from a range of services
2.4: Midwives liaise closely with obstetric, neonatal and other services to ensure women get what they need
3.3: Rapid referral protocols are in place to ensure that the woman and her baby can access more specialist care when they need it
4.1: There is significant investment in perinatal mental health services
4.2: Postnatal care must be resourced appropriately. Women should have access to their midwife as they require after having had their baby.
4.3: There is smooth transition between midwife, obstetric and neonatal care and to ongoing care in the community
5.1: Those who work together, train together
5.2: Multi-professional training

Cross Cutting theme one: workforce	
This workstream includes: – Establishing the current workforce baseline for the LMS. – Identifying future workforce configuration based on the transformed service model. – Implementation of role transformation. – Implementation of community hub teams. – Workforce planning to meet demand and manage turnover and retention; ensuring sufficient flexibility, capacity and capability in the service – Ensuring sufficient flexibility, capacity and workforce planning to meet demand. – Ensuring organisational Boards routinely monitor information about quality, including safety and take necessary action to improve quality. – Implementation of professional midwifery advocate roles (underpinning feedback/learning cycle). – Developing and implementing a robust workforce development plan across the local health economy to embed a culture of training together as well as ensuring the local health economy has the right numbers and skills of people with continuous development and multi-disciplinary team working. – Influencing cultural change to enhance flexibility and reach of the workforce in relation to health economy approach to care in ensuring a women focused ethos and culture of co-production. – Supporting learning and development systems. – Identifying and supporting Maternity Services Champions.	**Outcomes:** – Every woman knows the midwife who delivers her care throughout pregnancy, during birth and after the baby is born. – Every woman receives care that is joined up, as professionals involved in her care work closely together. – Women and their families receive a good quality service that is constantly improving. – People working in and with maternity services feel well supported and valued. – People working in and with maternity services feel proud of the services available. – People working in and with maternity services routinely work together and train together.

Key Activities

Activities	Timeframe
Establish the current workforce baseline for the LMS	Q4 2017/18
Identify future workforce configuration	Q4 2017/18
Develop and implement a workforce development plan across the local health economy	Q2 2018/19
Influence cultural change to ensure a women focused ethos and culture of co- production	Q4 2018/19

Success will be measured by:

- Appropriate skill mix within teams across the health economy taking into account role redesign and transformation
- An increase in the number of women who know the midwives caring for them during pregnancy, birth and after the baby is born
- An increase in the number of multi-professional training opportunities available
- An increase in the number of professionals accessing multi-professional training
- An improvement in satisfaction and advocacy rates reported through staff surveys

Related recommendations in *Better Births*

2.1 Every woman has a midwife who is part of a team of 4-6 midwives.
2.2 Each team of midwives has an identified obstetrician.
3.2 Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi professional training. CQC should consider these issues during inspections.
3.6 There is already an expectation of openness and honesty between professionals and families, which should be supported by a rapid redress and resolution scheme, encouraging rapid learning and to ensure that families receive the help they need quickly.
4.1 There is significant investment in perinatal mental health services.
4.2 Women have access to their midwife, as they require after having their baby.
5.1 Those who work together, train together.
5.2 Multi-professional training.

Cross Cutting theme two: Digital Roadmap	
This workstream includes: - Improving connectivity across the area to improve record keeping and information sharing. - Development and implementation of an electronic patient record. - Identification/development and implementation of Digital information/ apps for women and their families in relation to becoming pregnant, pregnancy and having a baby. - Identification of potential investment required in relation to software, infrastructure and equipment. - Identifying women's preferences in relation to format of an electronic personalised care plan. – Work with professional stakeholders to identify how systems can better link together/organisations can work from the same system to share information. – Work with information system providers to develop a system that meets the needs of women and the professionals working with them. – Work with women to develop an interactive digital maternity tool that is kept up to date.	**Outcomes:** – Women and their families only need to tell their story once. – Health professionals have up to date information at all times. – Every woman has easy access to a personalised care plan. – Every woman and their family has access to unbiased information through an interactive digital maternity tool.

Key Activities

Activities	Timeframe
Identify baseline and develop integrated improvement plan across LMS	Q1 2018/19
Develop and Implement Electronic Patient Record	Q4 2018/19
Develop systems around Web-based Patient Information	Q4 2017/18
Develop systems to enable effective Information Sharing	Q1 2018/19
Identify and implement solutions to improve connectivity and remote access	Q4 2018/19

Success will be measured by:

- An increase in the number of professionals with access to electronic patient records
- An increase in the number of women with access to electronic patient records
- An increase in the number of midwives with remote access to up to date electronic patient information
- A reduction in the number of professionals reporting issues with information sharing
- An increase in the number of women reporting that they only needed to tell their story once

Related recommendations in *Better Births*

1.1 Every woman should develop a personalised care plan, with their midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses and after the birth.

1.2 Unbiased information should be made available to all women to help them make their decisions and develop their care plan drawing on the latest evidence, and assessment of their individual needs, and what services are available locally. This should be through their digital maternity tool.

5.3 Use of electronic maternity records should be rolled out nationally, to support sharing of data and information between professionals, organisations and with the woman. Commissioners and providers should invest in the right software, equipment and infrastructure to collect data and share information.

Cross Cutting Theme Three: Maternity Voices

This workstream includes:

- Ensuring that the LMS Plan is fully co-produced by the establishment of the Maternity Voices Partnership and that the Maternity Voices Partnership is self-sustaining
- Developing and implementing a co-production approach that all partners will use in designing, delivering and improving maternity services
- Develop and implement a communication and engagement plan
- Upskilling the workforce in the 'Experience Led Commissioning' approach to service re-design

Outcomes:

- Women and their families feel that they have a say in how services are designed and delivered
- Professionals from a range of agencies feel that they have a say in how services are designed and delivered
- Women and their families feel well informed about maternity services
- People who are or have used the services are fully engaged in the Maternity Voices Partnership Co-ordinating Group, if they wish to be
- People who use or have used the services, who wish to be, are part of the wider Maternity Voices Partnership and know how to participate
- The other workstreams are able to engage / know how to engage with people who are or have used maternity services.

Key Activities

Activities	Timeframe
Understand issues and ideas regarding information sharing and identify potential solutions	From Q3 2017/18
Design and implement co-production approach	From Q4 2017/18
Develop and implement a communication and engagement plan	From Q3 2017/18

Success will be measured by:

- A reduction in the number of professionals reporting issues with information sharing
- An increase in the number of women reporting that they only needed to tell their story once
- An increase in the number of women who feel involved in decisions about the care they receive
- An increase in the number of women and their families who feel they can influence improvements to services
- An increase in the number of women and their families who feel they can influence system change
- An increase in the number of women and their families who feel well informed about maternity services
- An increase in the number of women and their families who know where to go to get information about maternity services

Related recommendations in *Better Births*

1.2: Unbiased information should be made available to all women to help them make their decisions and develop their care plan

3.2: Boards should promote a culture of learning and continuous improvement to maximise quality and outcomes from their services, including multi-professional training. CQC should consider these issues during inspections

5.1: Those who work together should train together. The Nursing and Midwifery Council and the Royal College of Obstetricians and Gynaecologists should review education to ensure that it promotes multi-professionalism and that there are shared elements where practical and sensible

5.3: Use of electronic maternity records should be rolled out nationally, to support sharing of data and information between professionals, organisations and with the woman. Commissioners and providers should invest in the right software, equipment and infrastructure to collect data and share information.

RP16: Local maternity systems should be responsible for ensuring that they co-design services with service users and local communities

RP17: Maternity Voices Partnership will need to establish a committee structure

RP18: A Maternity voices partnership should have a defined programme of work and be adequately resourced

Appendices:

Appendix 1 Shropshire and Telford STP
Appendix 2 Maternity
Appendix 3 Health and Wellbeing
Appendix 4 Perinatal Mental Health
Appendix 5 Neonatal
Appendix 6 Safety and Quality
Appendix 7 Workforce
Appendix 8 Engagement and Co production
Appendix 9 Workstream Project Plans
Appendix 10 Self Assessment against Better Births and Performance Monitoring Framework
Appendix 11 Funding the Transformation

References: (End Notes)

[i] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[ii] https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf

[iii] http://coalitionforcollaborativecare.org.uk/wp-content/uploads/2016/07/C4CC-Co-production-Model.pdf

[iv] https://www.scie.org.uk/publications/guides/guide51/what-is-coproduction/index.asp

[v] http://www.sath.nhs.uk/wp-content/uploads/2016/11/Shropshire-and-Telford-Wrekin-STP-Full.pdf

Shropshire Council

NHS Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
Meeting Date

Item Title: Annual Director of Public Health Report 2016/17

Responsible Officer
Email:gordon.kochane@shropshire.gov.uk
Rod.thomson@shropshire.gov.uk

1. **Summary**
   The working draft of the Annual Director of Public Health Report 2016/17 for awareness and comment. Attached as Appendix A

2. **Recommendations**
   The Shropshire Health and Wellbeing board are recommended to note the content and format of the Annual Report

REPORT

3. **Risk Assessment and Opportunities Appraisal**
   (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

4. **Financial Implications**
   None

5. **Background**
   The Annual Director of Public Health Report summarises the achievements and challenges in improving the health and quality of life for residents of Shropshire during 2016/17.

6. **Additional Information**
   None

7. **Conclusions**
   For the HWWB to note the content and format of the Annual Report.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices Appendix A Draft Annual Report of the Director of Public Health Shropshire

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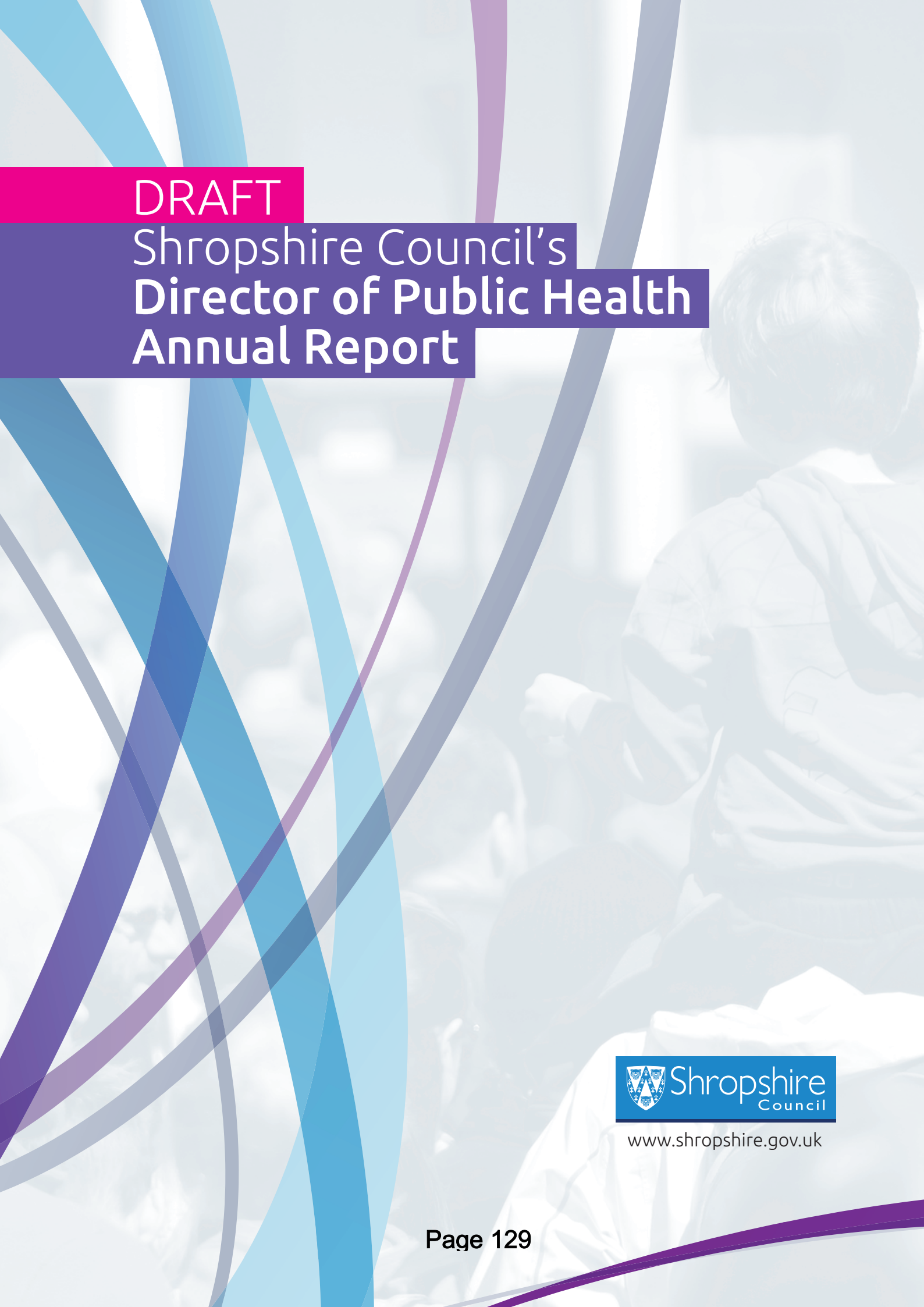
DRAFT

Shropshire Council's **Director of Public Health Annual Report**



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Introduction

by Professor Rod Thomson, Director of Public Health, Shropshire Council

Our vision is for Shropshire people to be the healthiest and most fulfilled in England. The most recent data for 2016/17 indicate that in comparison to the other local council areas, people in Shropshire are generally healthier than other communities with higher average life expectancy. For example, compared with the England average Shropshire has fewer children which are overweight or obese, more physically active adults, fewer cancer and cardiovascular deaths and higher rates of self-reported happiness.

There are however, still challenges which need continued focus. Health inequalities still exist between the wealthiest and poorest across our communities, where life expectancy is almost 6 years lower for men and 2.6 years lower for women in the most deprived areas of the county compared to the least deprived areas. These inequalities are being addressed through a combination of evidence based public health interventions, the commissioning of a new Emotional Health and Wellbeing Service for 0 to 25 year olds and the piloting of new models of care such as social prescribing to create improved links between primary care and non-clinical services which can make a positive impact to an individual's wider needs.

In addition, Public Health continue to work with our partners across the health and social care sector as well as the broader public, private and third sectors to contribute and influence wider programmes of care including the Sustainable Transformation Plan (STP) for Shropshire and the Better Care Fund. An example of this includes the Healthy Lives programme which is being piloted in Oswestry using funding from the Better Care Fund. The programme involves partners from the NHS, local authority, fire service and voluntary community sector organisations working together with the purpose to improve the health and wellbeing of the local community. The aim of the programme is to promote independence for people to help them remain in their own home for longer, supporting communities to be resilient and reduce demand on care services.

A further opportunity realised during 2016/17 has been with the council's Regulatory Services and Trading Standards teams joining under the Public Health umbrella, to create a cohesive approach to promote and protect our environment, protect the health and wellbeing of our communities and support our economy.

As such the focus of this year's Annual Report is on the wider determinants of health with a spotlight focus on both Regulatory Services and Trading Standards to discuss what they do, why they are important and how they link in with developing community resilience and wellbeing. In addition, an overview of the Healthy Lives programme provides a more detailed account on the social prescribing activities in Shropshire and how they can address issues such as loneliness, mental health and prevention of type 2 diabetes. A message on road safety in Shropshire has been included to provide an overview of the work that the Safer Roads Partnership has been involved with to address safety and accidents on our roads and to address the most recent published data which suggests we have a higher rate of serious road traffic accidents compared to the England average.

Finally this report provides a summary of the achievements and initiatives which are available in Shropshire to help people live longer and happier lives. Contact details and links for further information within the report are provided to find out more about services which may be of most interest to you and to promote ease of access to encourage choices which can help people to have longer, healthier, happier and more productive lives.

Chapter 1: Public Health Vision

Our health is determined by our genetics, lifestyle, the health care we receive and the wider economic, physical and social environment.

It is therefore important that a combination of targeted programmes which support effective health promotion and building resilience, enable people to remain independent at home, and easy to access and joined up care are used; to provide the best opportunities to increase the health and wellbeing across our communities.

The aligned vision of Shropshire Public Health and the Health and Wellbeing Board is

"for Shropshire people to be the healthiest and most fulfilled in England"

We aim to achieve this through partnership working with the wider health and social care economy and providing quality and cost effective Public Health services. The diagram below illustrates the areas we need to consider to achieve our vision.

In addition, Shropshire Public Health contributes towards Shropshire Council's outcomes of;

- Protecting and improving health, wellbeing and safety and enabling communities to be resilient
- Creating cleaner, safer, healthier and sustainable environments
- Supporting economic growth

Delivery of the Public Health vision is supported by the Shropshire and Telford and Wrekin Sustainability and Transformation Plan (STP). The STP has placed a priority ambition to address the causes of poor health by;

- Focusing on communities to utilise the skills and knowledge of local people and organisations,
- Supporting people to lead healthier lives
- Develop Neighbourhood Care Teams where GPs, social care, community nurses, therapists and mental health workers increasingly work together to provide a consistent range of services at local level.

The Shropshire and Telford and Wrekin STP can be viewed **here.**

Chapter 2:
The population of Shropshire

There are 310,100 people living in Shropshire (Office for National Statistics, 2014) which are distributed across the following age bands;

0 to 15 years

Shropshire: 16.8%
England: 19%

16 to 64 years

Shropshire: 60.4%
England: 63.5%

65 years and over

Shropshire: 22.9%
England: 17.6%

Life expectancy for men and women is higher than the England average. However, on average only the first 64 years for men and 66 years for women are without chronic condition or ill health.

Shropshire: 80.3 years
England: 79.5

Healthy life expectancy: 64.8 years

Shropshire: 83.8 years
England: 83.1

Healthy life expectancy: 66.0 years

Life expectancy for men and women from more deprived areas is lower than those who are least deprived;

- Most deprived males have a shorter life expectancy for an average of 5.8 years compared to least deprived
- Most deprived females have a shorter life expectancy for an average of 2.6 years compared to least deprived

Projections

It is important we understand the demographics within our communities across the county as this directly impacts the choices and behaviours people make as well as providing an overview of the services they are most likely to access from the health and social care system. Shropshire already has an above average population size of people aged over 65 years, however, projections by the Office for National Statistics suggest these numbers are set to increase significantly by 2031. This therefore highlights the importance of promoting healthy behaviours and early interventions to people now, in order to reduce their risk of developing complications and long term illness in later life.

Projected population changes in Shropshire by 2031

Increase in Shropshire population size to 338,000

Oswestry district to experience highest level of growth of population

70% increase in number of people aged 65 to 84 years to 83,500

195% increase of people aged 85 years or more

Increase in children below 9 years and people aged 20 to 29 years

A reduction in the proportion of people aged 30 to 44 years and 15 to 19 years

Demographics and determinants of health within Shropshire

Our society has made some great progress in treating illness. However, we could spare many people the anxiety and pain of a wide range of conditions, if we helped them to prevent these from occurring in the first place.

A key consideration for Public Health services are the influence of the wider determinants of health and the association with health inequalities. It is therefore also necessary to consider these factors when making commissioning and planning decisions to ensure a whole system approach to promoting healthy and happy lives.

Major wider developments	Leading risk factors	Accessibility and responsiveness
Financial status	Tobacco	Primary care (eg GP practice)
Employment and work environment	High blood pressure	Secondary care (eg hospital)
Education	Alcohol	Preventative care (measures taken to prevent diseases)
Housing	Cholesterol	Community services
	Being overweight	

It is recognised that Shropshire faces challenges due to the large geographic size, limited telecommunication infrastructure in some parts of the county and difficulties for some residents that may live in isolated areas being able to access certain facilities and services.

Influence on these wider determinants of health are being addressed through programmes such as Social Prescribing (which provides referral links between healthcare professionals and non-medical services), the Healthy Lives Programme (see page xx), influencing the Sustainable Transformation Plan (STP), the Economic Growth Strategy for Shropshire and partnering with teams throughout Shropshire Council and the NHS to deliver the Better Care Fund, the NHS England Five Year Forward View and the Shropshire Health and Wellbeing Strategy. The regulations that Regulatory Services advise on and enforce, such as the regulation of polluters, rented accommodation providers, food businesses and workplaces, are key to tackling the wider determinants of health.

Benchmarking Health in Shropshire

In comparison to other local council areas in England, people in Shropshire are generally healthier than other communities with higher average life expectancy.

In line with trends experienced in the rest of the country, Shropshire has seen a rise in the number of people with long term health problems due to illnesses such as diabetes and conditions such as obesity.

Most of these long term conditions and illnesses are the cause of premature death (before the age of 75 years), yet are preventable. Making changes to lifestyles can make a significant difference in reducing the risk of developing, for example, heart or lung disease. In addition, through working with partner services to identify and respond to the wider determinants of health for an individual and/or their family (such as addressing issues of debt, appropriate housing and loneliness), a more stable environment can be created for supporting individuals to make these changes.

A number of key factors can make a significant difference in reducing risk of chronic illness or premature death including;

- Stopping smoking to reduce risk of a range of chronic conditions including respiratory disease and a number of different types of cancer.
- Being physically active (at least 150 minutes per week for adults) which can help promote good bone health and balance, improve mental wellbeing and reduces risks of heart disease, cancer and dementia
- Eating a balanced, nutritious diet in addition to being physically active can help maintain a healthy weight and reduce the risk of stroke or heart attack as well as reduce the chance of developing type 2 diabetes
- Not drinking too much alcohol can reduce risks of liver disease, cancer, alcohol related accidents and early death.

Shropshire Public Health Dashboard

The Public Health dashboard is a national tool that supports local authorities to make decisions on how they should prioritise resources across a range of public health service areas. Each local authority has also been given a ranking and category description about how local delivery compares with all other local authorities and on a like-for-like basis.

Shropshire has a national rating of 34 out of 150 Local Authorities which is substantially above average.

Shropshire is performing better than the England average for;

- **Obese children** (17.4% in school year 6 compared to 19.8% national)
- **Physically active adults** (62.2% compared to 57% national)
- **Violent crime** (14.9% compared to 17.2% national)
- **Premature deaths: Better than the national average**

Shropshire is performing worse that the England average for;

- **Smoking status at time of delivery** (12.4% compared to 10.7% national)
- **Statutory homelessness** (2.9 per 1,000 households compared to 0.9 per 1,000 households national)
- **People killed and seriously injured on roads** (43.1 per 100,000 compared to 38.5 per 100,000 national)

Source: National Audit Office

Performance comparison to our similar Local Authority areas

Above Average

Child obesity: rank 7th of 15 similar Local Authorities
NHS Health Checks: rank 5th of 15
Alcohol Treatment: rank 2nd of 15

Below Average

Tobacco Control: rank 12th of 12
Drug Treatment: rank 11th of 15
Best Start in Life: rank 9th of 14
Sexual Health: rank 9th of 15

Priorities for Shropshire Public Health are addressed via three overarching programmes

Starting well through a healthy child programme

Living well by tackling obesity and health inequalities

Ageing well by prevention of long-term conditions

Starting Well

Children and Young People's Health

Many of the greatest health gains can be made when children are given the best start possible. Shropshire Public Health is committed to ensuring that local children and young people have the very best start in life and grow up healthy, happy and safe within supportive family environments.

How is Shropshire performing in terms of children's and young peoples' health?

Themes for the health of Shropshire children and young people in 2016/17

Shropshire is performing better than the England average in that:

7.8% children aged 4 to 5 years are obese
England: 9.3% (2015/16 PHE)

17.4% children aged 10 to 11 years are obese
England: 19.8% (2015/16 PHE)

45.9% of infants are totally or partially breastfeeding at 6-8 weeks
England: 43.2% (2015/16 PHE)

95.9% uptake of MMR vaccination
England: 91.9% (2015/16 PHE)

97.9% uptake of vaccinations for diphtheria, pertussis, tetanus, Hib and polio (5 in 1 vaccine)
England: 95.2% (2015/16 PHE)

Performing worse than the England average

455.3 per 100,000 hospital admissions for dental care for children aged under 4 years
England: 241.4 per 100,000
England: 280.1 per 100,000
(2013/14 – 2015/16 PHE)

409.3 per 100,000 admissions for asthma for children aged under 9 years
England: 280.1 per 100,000
(2015/16 PHE)

Performing similar to the England average

17 out of every 1,000 conceptions were for females under 18 years
England: 20.8 (2015/16 PHE)

33.5 for every 100,000 alcohol specific hospital stays per year were for people under 18 years
England: 37.4 per 100,000
(2013/14 – 15/16 PHE)

Source: Shropshire Health Profile 2017 https://fingertips.phe.org.uk/

Living Well and Ageing Well

The health of people in Shropshire is generally better than the England average however, it is important we continue to support and work with communities and local services to ensure we can maintain performance (as a minimum) and strive to continue for improvements in the health and wellbeing of our population.

Themes for the health of Shropshire adults in 2016/17

Shropshire is performing better than the England average

344 per 100,000 new STIs recorded
England: 795 per 100,000 (2016)

62.2% physically active adults England: 57% (2015)

601 per 100,000 early cardiovascular deaths England: 746 per 100,000 (2013-15)

130.5 per 100,000 early cancer deaths England: 138.8 per 100,000 (2013-15)

Performing worse than the England average

16% of households experience fuel poverty England: 11% (2015)

Performing similar to the England average

59% of adults over 18 years are overweight or obese
England: 61.3% (2015/16)

17.2% adult smokers
England: 15.5% (2016)

Source: Shropshire Health Profile 2017 https://fingertips.phe.org.uk/

Shropshire Wider Determinants of Health:

Mental Health	• Higher self-reported happiness • Lower self-reported anxiety rates
	• Similar number of fruits and vegetables consumed per day
Education and Children's services	• 57% of pupils achieved 5 A*-C GCSEs including English and Maths in 2015/16 – similar to the England average of 58%
	• 14% (6,765) of children aged under 16 years were classed as living in poverty in 2013 - lower than the England average of 20% (2014)
Economy	• 6% of people within Shropshire aged 16 to 64 years have no qualifications (2015) - significantly lower than the England average of 8% • 4% of people aged 16 to 18 years in Shropshire are NEET[1] - lower than the England average of 5% (Public Health Outcomes Framework www.phoutcomes.info)
	• 2.9 out of every 1,000 households in Shropshire were classified as homeless in 2015/16 - higher than the England average of 0.9 per 1,000 households
	• 14,380 people in Shropshire experienced income deprivation based on the IMD2015[2] • Average house price in Shropshire of £164,623[3]
Employment	• 6% of unemployed working age adults in Shropshire were claiming out of work benefits in November 2015 compared to 9% England average • 4% of working age people in Shropshire were unemployed in 2015 - similar to the England average of 5% (NOMIS) • 32% of unemployed people in Shropshire aged 16 to 64 years wanted to work[4] - similar to the England average (NOMIS www.nomisweb.co.uk)

Crime	• 14.9 violent crime offenses per 1,000 people – significantly lower than the England average of 17.2 offenses per 1,000 people • 27.1 hospital admissions due to violent crime per 100,000 people between 2012/13 to 2014/15 in Shropshire - significantly lower than the England average of 47.5 per 100,000 (Public Health Outcomes Framework www.phoutcomes.info)
	• Increases for incidents of; o Violence against a person: 62% or 14 per 1,000 people o Sexual offences: 61%, 1.7 per 1,000 people o Drug offenses: 2%, 1.4 per 1,000 people o Possession of weapon offenses: 53%, 0.3 per 1,000 people o Public order offenses: 57%, 1.5 per 1,000 people o Miscellaneous crimes against society: 28%, 0.8 per 1,000 people
	• Recorded crime in Shropshire increased 16% between 2014 and 2015 • There were 44.1 crimes per 100,000 people in 2015 - lower than the England average rate of 69.3 crimes per 100,000 people (Police recorded crime, Home Office)

Green highlighted text = better local performance compared to the England average
Red highlighted text = worse local performance compared to the England average

[1] Not in education, employment or training

[2] Index of multiple deprivation: a government tool which assesses levels of deprivation within communities based on income, employment, health and disability, education, housing, crime and living environment

[3] At March 2016 (prices rose by 2.1% between March 2015 and March 2016 based on land registry records)

[4] People not in employment who want a job but are not classed as unemployed because they have either not sought work in the last four weeks or are not available to start work.

Road Safety in Shropshire

A Safer Roads Partnership (part of West Mercia Police) has been established to reduce the number of people killed and injured on the roads across Herefordshire, Shropshire, Telford & Wrekin, Warwickshire and Worcestershire. This is achieved through the working of partner agencies across the four counties to reduce collisions and casualties on the roads through speed enforcement, engineering, road safety education, training courses and awareness raising campaigns.

Although currently Shropshire is above the national England average for people killed or seriously injured on the roads (which is reflected across West Mercia) there are fluctuations each year where a smaller number of large incidents can cause distortions. The Safer Roads Partnership reviews the nature of incidents to determine appropriate marketing and communication messages to be aimed at the most at risk groups, which for 2016/17 included;

Motorcycles

Variety of age riders on 500cc+ machines, leisure riders on summer evenings/weekends and commuters

- High risk routes identified and signed up with Think Bike road signs
- Campaign activity at bike events
- Biker Down scheme on collision scene management, first aid and general casualty care, science of being seen

Pedestrian Safety

All age group focus on distraction, visibility issues and appropriate use of the highway

- Campaign and social media
- Tied in with drink/drug drive messages

Cyclist Safety

Highest risk group are those aged 21 to 35 years with just over two-thirds occurring on restricted roads and the remainder on national speed limit roads

- Campaign and social media including working with schools
- Bikeability training
- Be Safe Be Seen cycle safety initiatives focusing on cycling in darker months and issue of visibility/distribution of high vis material/lights etc

Young Drivers
Get Real Behind the Wheel, in partnership with the IAM,Shropshire Advanced Motorists and Motorcyclists aimed at 17 to 24 year olds.

- Advanced driver training of young people

Older Drivers
Local data does not show a spike for older drivers however there is a need to address medical issues and failure to look/judge

- Promotion of support packages available to this age group from Age UK and the Council
- Target awareness campaigns at retirement complexes

Road Traffic Accidents in Shropshire

- There are more accidents which occur on rural roads compared to urban roads in Shropshire
- Just over four out of five serious or fatal road accidents in Shropshire between 2011 and 2015 occurred on rural roads.
- Three out of five of these accidents occurred on a rural road with a 60mph speed limit.
- There are a similar proportion of traffic accidents on both urban roads and rural roads with a 30mph limit.

What does this mean?

We need to continue to work with our partners to promote a range of targeted road safety programmes for how local road users and those who commute through our county can travel safely and reduce risk of accidents.

As most serious road traffic accidents occur on rural roads with a national speed limit of 60mph in Shropshire we need to be mindful of ensuring wetarget the most appropriate measures where both safety and managing traffic can be balanced.

For more information on the Safer Road Partnerships and upcoming campaigns visit https://www.westmercia.police.uk/roadsafety

Chapter 3 Spotlight Focus: Regulatory Services

Regulatory Services have recently combined with the Public Health family in Shropshire and deliver a diverse range of environmental health, animal health, biodiversity and ecology services which support Public Health and promote and improve individual wellbeing and community safety. This work deals with environmental factors such as noise and air pollution, access to safe, good quality food and the safety and health of workplaces and standards of rented housing.

The work of Regulatory Services is concerned with upstream interventions which aim to prevent poor health and inequalities before they present as medical conditions. The team works with a range of partners to tackle the wider determinants of health in order to protect our residents, our environment and our economy.

Ways in which Regulatory Services seek to maintain health and prevent illness include;

Protection of the integrity of the food chain

From farm to fork, minimising disease risks and protect animal welfare.

- Over 4000 food premises registered and inspected in Shropshire
- Nearly 4000 registered feed businesses in Shropshire
- 432 cases of food poisoning and infectious disease cases reported in Shropshire in 2017
- 4000 farms and 6 livestock markets visited regarding Animal Health

Food Hygiene Interventions – Fit for 5

Safe Food is vital to protect our health. Our Health Protection Team carry out a range of food hygiene interventions in premises where food is sold or served. Currently over 94% of food premises are broadly compliant which means that they achieve a score of 3 or more in the national food hygiene rating system. There are over 4000 food premises registered within Shropshire and we undertake a risk based programme to carry out spot checks, advice visits, business support interventions and training amongst a wide range of food business in Shropshire, including multinational manufacturers to artisan specialist food producers. The aim of these interventions is to ensure that the food produced and sold in Shropshire is safe to eat and prevent episodes of food poisoning. In 2017 there were over 400 cases of food poisoning reported to the team. We are now in the process of launching a 'Fit for 5' initiative whereby business can access relevant information, training and coaching to allow them achieve a 5 rating and increase compliance which will have a positive effect on the health of the public in Shropshire.

Create cleaner, safer, healthier and sustainable environments

Investigating statutory nuisance complaints, air pollution monitoring, inspecting privately rented housing, providing an accredited Pest Control Service and working with Development Management colleagues and developers to protect natural resources and reduce impacts of new developments. Living in poor housing can lead to an increased risk of cardiovascular disease and be of detriment to people's mental and emotional well-being. Problems such as damp, mould, excess cold and structural defects, which increase the risk of an accident, also present hazards to health. 30 % of private housing within Shropshire fails the Decent Homes Standard overall, this is a challenge to all involved in housing provision. 23,000 private rented homes exist in Shropshire and we also regulate 35 licensed Houses in Multiple Occupation (HMOs).

Housing case study - summarised

An 83 year old lady had been living alone in a pre-1920's cottage, for approximately 60 years paying minimal rent. The only form of heating was a Rayburn in the lounge. The property did not have a bathroom with the tenant having to boil a kettle on the Rayburn in order to wash. There was a tin shack outside, which housed the toilet formed of a metal drum with a toilet seat placed on top. There was no method of drainage therefore waste was buried in the garden.

The electrical installation within the property was obsolete, with baker light fittings. In addition there was a double plug socket above the kitchen sink which was highly likely to be exposed to water from the kitchen.

Numerous holes within the structure of the dwelling allowed easy access for pests in to the property. There had been sightings of rodents therefore traps and poison had been placed throughout the property.

Dampness throughout the dwelling was evident, likely to be a combination of rising, penetrating dampness with an element of condensation. Although difficult to ascertain without a structural engineers report – there was some question regarding the integrity of the gable end wall due to a large crack visible both internally and externally.

Due to the numerous serious hazards a Prohibition Order was served. The lady agreed not to return to the property and obtained more suitable accommodation.

Environmental and Public Protection activities annually include:

- Around 800 noise nuisance complaints are reported to Shropshire Council annually.
- Outdoor air pollution contributes to approximately 40,000 early deaths a year in the UK. Shropshire has a diverse industrial base and has over 114 industrial premises that are controlled by the environmental permitting regime to seek to reduce emissions.
- Our professional operatives carry out over 3000 Pest Control treatments which prevents the spread of pest borne diseases.
- Over 2000 private water supplies require risk assessment and sampling to ensure a wholesome water supply to over 14000 users of these private supplies.
- An impact of the rich heritage of UK's industrial past is a legacy of land contamination. We have produced a Contaminated Land Strategy to protect human health and the environment by the identification of potentially contaminated sites. We monitor over 85 Special Sites of Scientific Interest and ramsar sites which are wetlands of significant value.
- We support the work of colleagues in Development Management by assessing proposed developments in terms of their potential impact upon members of the public and the environment and make appropriate recommendations. We advise on over 2000 + planning consultations and over 1500 + consultations related to natural assets / ecological matters and almost 700 related to air, land and noise pollution matters.

Co-ordination of Shropshire Council's response to anti-social behaviour and raising awareness of scams to support communities to be resilient.

UK consumers are estimated to lose about £3.5 billion to scams every year with older victims more likely to lose larger sums of money and be repeatedly scammed. The impact of these scams is not only financial; they have a detrimental impact on the health and wellbeing of older and at risk people who are often socially isolated and in declining mental health.
The support of economic growth, through working with businesses to help them achieve good levels of legal compliance and robustly enforce legislation in line with our enforcement policy in order to deter rogue businesses which pose significant risks to the public.

A 95 year old gentleman living alone had been replying to and sending money off to free prize draws and buying overpriced items from magazines. The gentleman had been entering prize draws for several years but had not won anything apart from being sent a few small and insignificant 'gifts'; but he was convinced he would win eventually and receive the money promised to him.

Further visits led to the gentleman revealing boxes of chequebook slips, receipts and all the information on the prize draws he was so close to winning. In his spare bedroom he had piles of unopened items; pills, potions and bottles of liquid that had cheaply printed labels in French, which he could not understand and could not remember ordering.

We spoke to his daughter who said she had been trying to tell her father that it was all rubbish and not to waste his money for years but he would not listen to her. She was extremely grateful for our help. The gentleman eventually granted permission for officers to clear his bedroom of what was simply rubbish! He eventually confided in the officers that he had lost in the region of £20,000 through entering draws and from buying items from catalogues.

Chapter 4 Spotlight Focus: Trading Standards and Licensing

The Trading Standards and Licensing Service is part of Public Health with responsibility, together with Regulatory Services, for delivering a range of statutory duties that primarily aim to:

- Protect and improve health, wellbeing and safety and enable communities to be resilient
- Create cleaner, safer, healthier and sustainable environments, and
- Support economic growth.

The Service administers the Blue Badge Scheme across Shropshire on behalf of the Department for Transport (DfT), provides the full range of licensing functions, undertakes parking enforcement, including the first stage of the associated penalty charge notice processing, and delivers those trading standards functions that relate specifically to safety and 'fair trading'. The Service is committed to an intelligence led and risk based approach and works with a range of partners, both internally and externally to Public Health and the Council, in order to ensure the Council complies with its consumer protection and business related statutory duties and to deliver the outcomes set out above.

In 2016/17 highlights delivered by the Service include:

- A total of 5,075 Blue Badge applications were received with 4,750 (94%) of these granted to Shropshire residents who have a disability that severely impacts their mobility. A total of 14,583 people in Shropshire currently hold and use a Blue Badge. Blue Badges have helped people to more readily access goods, services and other facilities and in doing so this has increased independence and improved the health and well-being of individual badge holders and, where relevant, also that of their carers. There is anecdotal information indicating the impact on social care services is reduced as a result of people using Blue Badges.

  The operation of the Blue Badge Scheme is supported by the work of the Parking Enforcement Team who have undertaken 7,163 hours of 'on the beat' enforcement to encourage compliant, sensible and safe parking; this

includes checks to ensure only valid Blue Badges are used and fraudulent use is minimised. It also reduces congestion on Shropshire's roads and in town centres which, together with other strategic development and transport plans, helps to tackle poor air quality. It reduces the risk of blocked bus lanes/major traffic routes and increases the ability of emergency services to gain access to incidents across the county thus making roads safer and protecting drivers and pedestrians from the risk of injury and death.

- Over 6,500 licences, permits, registrations, notices and consents were administered and enforced to protect the health, safety and welfare of people, animals and the environment and to prevent financial loss and fraud. These involve controls over premises supplying alcohol, late night refreshment and certain types of entertainment, together with personal licences, hackney carriages (taxis) and private hire, gambling premises and small society lotteries, skin piercing, explosives and fireworks, caravan sites, pavement permits, pleasure boats and vessels, sex establishments, riding establishments, animal boarding and breeding, pet shops, performing animals, dangerous wild animals, scrap metal and the distribution of free printed matter.

  The introduction of the Council's revised Hackney Carriage and Private Hire Licensing Policy on 1 April 2015 aims to protect the safety and welfare of the public who live, work and visit Shropshire. This policy has, in its first two years of operation, driven a significant change in the approach taken towards safeguarding vulnerable individuals through the hackney carriage and private hire licensing regime. Proactive enforcement is carried out, for example, exercises to ensure private hire drivers were not willing to pick up

passengers in the street without an existing booking were undertaken. Four breaches were found, which led to successful prosecutions and a period of suspension for the drivers in each case. In addition, 71 vehicles were inspected for safety and compliance with Council conditions.

There has been a considerable shift in the type of vehicles now licensed as hackney carriages and private hire vehicles following changes that require compliance with European Emission Standard 5 (Euro 5). The percentage of Euro 5 and Euro 6 vehicles now licensed as a direct result of the Council's policy change has increased from 20% to 61%, Euro 4 vehicles have decreased from 45% to 39% and the Council no longer licenses any Euro 3 vehicles. The total societal cost saving associated with the estimated reduction in pollutant levels as a result of these changes is estimated to be £517,770; this is a 40% reduction compared with the costs estimated in 2015. These changes impact directly on air quality and it is well documented that air quality directly affects both peoples' health and the environment.

- A programme of market surveillance and intelligence led age-restricted products test-purchasing exercises were undertaken in relation to the supply of alcohol and tobacco, including e-cigarettes. A total of 44 premises were visited with 11 (25%) of those selling alcohol or tobacco products to an under 18 year old volunteer. Enforcement action was taken against the relevant businesses and individuals in accordance with the Council's Better Regulation and Enforcement Policy.

  Typically such action can lead to prosecution and licence review and two Shropshire businesses faced this in 2017. One received fines and costs

totalling £4,300 for selling both alcohol and cigarettes to minors and failing to display a notice identifying the legal ownership of the business. The premises licence was also reviewed, which resulted in revocation of the licence. The second sold alcohol to minors and failed to display their alcohol premises licence. The fines and costs in this case totalled £1,003 and again the premises licence was reviewed, which resulted in the suspension of the licence to sell alcohol for 3 months and the removal of the Designated Premises Supervisor. This work was supported by 301 inspections to licensed premises to advise new businesses and ensure compliance with existing premises licences.

This work recognises the harmful effects caused by alcohol and tobacco on the health and well-being of people and specifically aims to reduce the availability and supply of these products to children and young people. In the short-term, the work highlights the adverse impacts of the consumption of alcohol and tobacco and targets those individuals who are prepared to act illegally with robust enforcement. In the long-term, it aims to normalise reduction and cessation of the consumption of these products in order to significantly improve the health of future generations.

- The service has responded to complaints and other intelligence concerning unfair and fraudulent business practices that adversely impact on individuals and communities, particularly those involving doorstep crime and rogue traders where older and more vulnerable people, as well as small businesses, are more likely to be targeted and are at risk of becoming repeat victims suffering substantial financial losses. The impact of such practices is not only financial; it has a detrimental impact on the health and wellbeing of victims, particularly as those individuals who are targeted are often socially isolated and in declining mental health, or are businesses where resources are limited and resilience to the impact of any crime is lower. In order to tackle this type of criminality, 11 multi-agency roadside check operations and 4 inspections of scrap metal sites were undertaken to disrupt criminal activity and provide advice. It has been demonstrated that where it can be evidenced that advice has been given to traders who are subsequently found to be committing doorstep crime either in Shropshire or elsewhere in the country, local authorities have been able to prosecute more effectively under relevant legislation.

- Unsafe products directly affect the health and wellbeing of consumers. Poorer consumers, who are likely to be more vulnerable as a result of this, are also at greater risk of being injured or suffering a fatality as a result of an unsafe product as they are more likely to buy cheap products that have not been subject to robust design and testing processes required by national and international safety legislation and standards.

- The Service undertook an investigation into the sale and supply of unsafe 'hoverboards' where it was found that the importer had failed to establish that the products being imported met UK safety requirements before placing them on the market, this was despite being advised not to sell the boards unless the business could demonstrate that they did comply. Following examination, one of the boards was found to pose a 'high risk' to users. The company and director were successfully prosecuted in relation to the unsafe hoverboards and also for misleading consumers about the basis of the price of the products. Both the company and the director faced fines and costs totalling £6,416.

For more information on Blue Badge and parking in Shropshire: http://www.shropshire.gov.uk/parking/

For more information on licensing in Shropshire: https://www.shropshire.gov.uk/licensing/

For more information on trading standards in Shropshire: https://www.shropshire.gov.uk/trading-standards/

Chapter 5:
Healthy Lives Programme

To achieve the Shropshire ambition to become the healthiest, most fulfilled people in the country, we need to replace 'fixing disease' towards promoting and maintaining health; recognising there are no easy solutions to this but working collectively to identify and test out solutions.

The Healthy Lives Programme combines the key prevention deliverables of the Better Care Fund, Shropshire CCG, Public Health, NHS providers and the voluntary sector to take a whole system approach to improve health & wellbeing, promote independence for people to remain in their own home for longer, support communities to be resilient and reduce demand on care services. The programmes cover a range of key target groups, and local preventable health challenges;

COPD & Respiratory	**Falls Prevention**	**Supporting Carers**	**Making Every Contact Count**
Diabetes & Cardiovascular Health	**Housing & Fuel Poverty**	**Fire Safe and Well Visits**	**Mental Health & Dementia**
Social Prescribing			

Healthy Lives Case Study: Fire Safe and Well Visits

Shropshire Fire and Rescue Service is working with Shropshire Council and Citizen's Advice to better identify and support the most vulnerable members of our community (including the elderly, disabled and people living alone). The scheme expands the home fire safety checks to give support, guidance and ability to directly refer to other appropriate support advice following. Need is identified through asking questions/ observations of the home environment including lifestyle, warmth, social isolation and slips, trips and falls. If a householder answers "Yes" to any question and agrees to a referral, it will trigger an automatic email from the fire service to the appropriate organisation and the householder will be contacted by that organisation within 28 days.

For more information on Safe and Well Visits contact the Shropshire Fire Prevention Team on 01743 260 260 or visit www.shropshirefire.gov.uk

Healthy Lives and Social Prescribing

A Social Prescribing model is being tested in the Oswestry area with referrals from four GP practices, Adult Social Care, the voluntary sector, the local pharmacy, Family Matters, and the mental health team. The model builds on the existing Community and Care Co-ordinator programme that has been in place for a number of years in GP practices.

Social prescribing provides GPs and other referrers with a formal referral pathway into these health-promoting community assets, targeting patients with

social or behavioural factors that pose a risk to their health. The programme offers more than signposting, as it includes support from an advisor, along with data recording and governance. The community interventions are quality assured, with outcomes reported back to the prescriber.

Social prescribing is a response to the fact that most long-term illness results from risk accumulated across the life course from a combination of social factors and unhealthy behaviours. These impacts are not an inevitable consequence of ageing but result from social circumstances and how we live our lives.

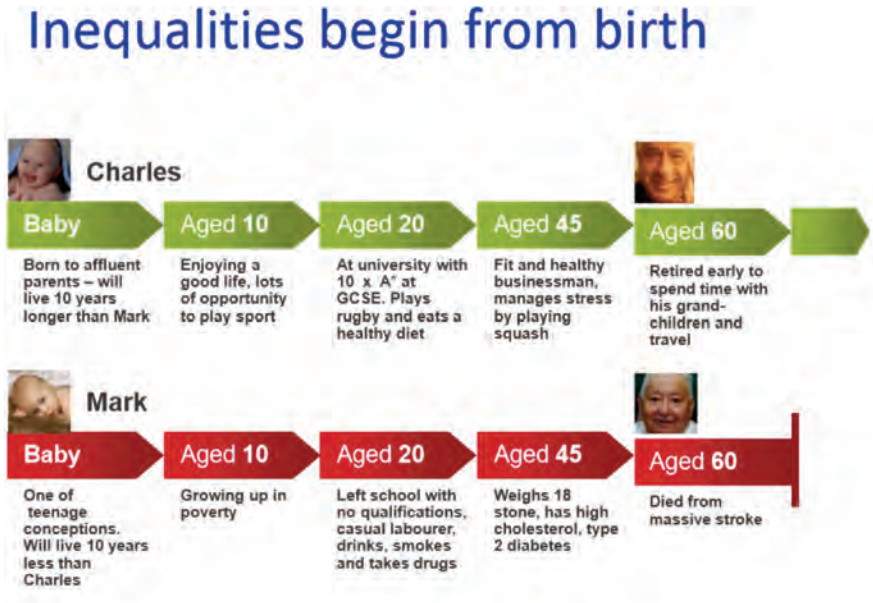
Social prescribing provides:

Clear referral pathways from health services to non-clinical interventions in the community as an alternative or complement to traditional medical prescribing and hospital referral.

A holistic approach that focuses on preventive health and supported self-care.

An infrastructure to promote community-based population health, including needs assessment, behaviour change support, and asset-based community development.

By addressing the wider determinants of health, and targeting patients most at risk, social prescribing helps to reduce inequalities in health.



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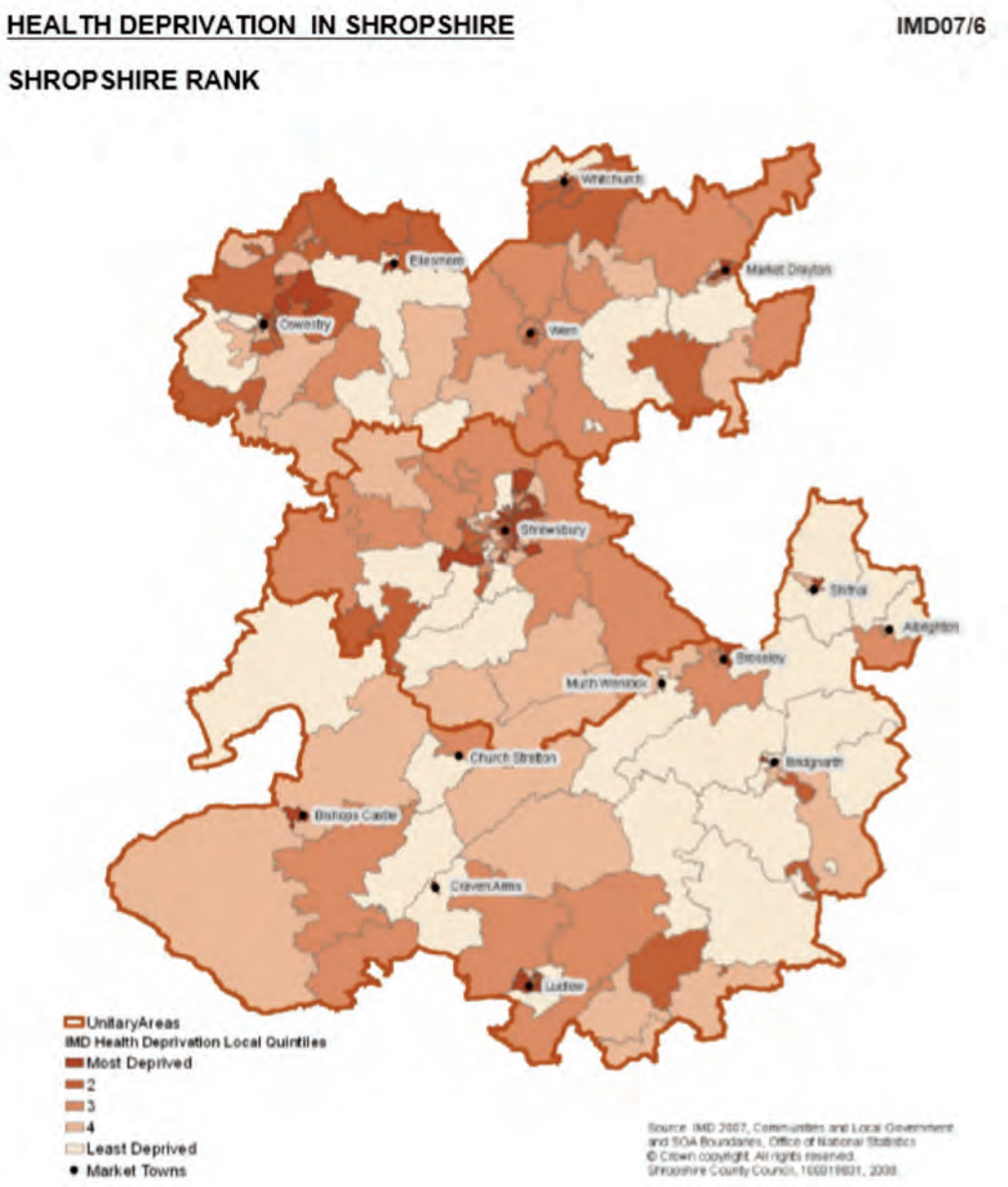


The pathway for social prescribing is illustrated below:

There are approximately 18 providers offering approximately 50 interventions ranging through benefits advice, housing support, physical activity sessions, creative arts, access to lifestyle change programmes and other community based activities. Many are provided by local voluntary sector organisations and community groups.

A proactive approach is taken to identify people who are at risk of developing ill health or are beginning to become unwell, the demonstrator site is initially targeting people who:

- Have lifestyle risk factors
- Have mental health difficulties, including isolation/loneliness
- Have long term conditions
- Are carers

Early feedback from those referred is showing that many of the concerns raised cover a range of issues relating to mental health, loneliness, debt and benefits advice, lifestyle issues such as weight, lack of physical activity, dementia.

Social prescribing is one model which may result in significant changes that can support primary care and other organisations to reduce the current pressures facing primary care. Whilst there are local resources in place with similar aims and objectives (with positive results) there is no one overarching social prescribing model that has been externally evaluated and/or that has robust governance and consistent measurements in place. It is the intention to pilot the model initially, evaluate this and if successful expand on a Shropshire wide basis, for this reason the programme is being evaluated by Westminster University and will report in 2018.

Social Prescribing: Jackie's Story

Jackie is in her 70's and was referred to Social Prescribing due to risk of social isolation. She used to lead a full life and enjoyed socialising with her husband, but was recently bereaved and moved into the area. She enjoys talking to others but was unsure how to meet people and socialise in this area. She was also concerned about keeping mobile safely due to her arthritis and sight problems.

Claire, our Social Prescribing Advisor, had a good initial meeting with the lady, discussing her concerns and interests and agreeing the Social Prescribing interventions she would like to become involved with (Get Up & Go – activity sessions for the over 60's, improving balance, co-ordination and muscle strength; Age UK Day Centre).

Go and introduced her to another Social Prescribing client, to encourage them both to attend. Both ladies enjoyed the session which involved seated volleyball and Boccia and Claire has encouraged them to continue to attend. The lady was also referred to the Age UK Day Centre but at that time, there was a waiting list. In the meantime she has been introduced to a new day centre run by Connect for Life. Claire will remain in contact and offer 3 month follow-up.

Social Prescribing: Nell's Story

Nell, 83, was identified as having prediabetes after having a blood test through her GP practice. She was invited to attend a prediabetes information session delivered by Help2Change. There, Nell was able to find out more about prediabetes and how to stop or slow the progression to type 2 diabetes. Nell had been trying to eat healthily and had been reducing her fat intake but at the session found out that it was most important to reduce carbohydrate intake and increase physical activity. Participants at this session were invited to receive one to one support with the social prescribing advisor.

Nell met with the social prescribing advisor and was able to discuss her individual concerns and together they came up with an action plan to support her change in lifestyle. Nell has now been taking part in Get up and Go physical activity sessions for the over 60's to improve balance, coordination and strength. Nell has now lost 3lbs so far and receives regular support from Help2Slim and the Social Prescribing advisor in order to maintain her new healthy lifestyle.

Public Health Programmes and Achievements in 2016/17

Starting Well

It is important that all people have the opportunity for the best start in life with the intention of providing a smooth transition into adulthood. A positive cumulative lifetime impact can be gained from programmes aimed in the early years throughout all later stages of life.

Help2Quit in Pregnancy

Smoking during pregnancy increases the chance of premature birth, miscarriage and perinatal death. It also increases the risk of developing a number of respiratory conditions, attention and hyperactivity difficulties, learning difficulties, problems of the ear, nose and throat, obesity and diabetes.

Shropshire continues to have a higher proportion of women who smoke at time of delivery during 2016/17 compared to the England average, however, local rates of smoking in pregnancy have reduced from 16.4% in 2004/5 to 12.4% in 2016/17. This reduction has been supported by Shropshire's Help2Change service which delivers a comprehensive programme of support for pregnant women and their families and has achieved recognition for this in a commendation from the National Advisor Awards.

All pregnant smokers in Shropshire are referred by the midwife for advice on stopping smoking; Help2Quit supported 161 pregnant women with a quit attempt. The service is flexible and offers a choice of venues including GP practice, pharmacy, community, home visits and telephone support. Help is extended to family, partner / friends as well. Partnership working with school nurses and Family Nurses has increased accessibility for younger women who smoke during pregnancy.

For further information and advice on quitting smoking call 0345 6789 025 or visit www.healthyshropshire.co.uk

Online Parenting Courses

Antenatal course: Understanding pregnancy, labour birth and your baby

This antenatal online course gives practical information about pregnancy and birth, whilst at the same time introducing parents to their baby. The course explains how and why parents are important to a baby and their development. The course was developed by Registered Midwives working with health professionals in the Solihull Approach team. It has the same content as the Solihull Approach face to face antenatal course, which has the same name 'Understanding pregnancy, labour, birth and your baby'.

To access the course:

1. Go to www.inourplace.co.uk and click 'START NOW'
2. Fill in your details to register & sign in
3. Scroll down & find 'Understanding Pregnancy'
4. Click on 'Take course'
5. Click 'Already have a discount coupon?'
6. Type in this code (this is your 'coupon'): SHRPSOLIHULLAPPROACHANT
7. click 'Apply coupon'

Postnatal course: Understanding Your Baby

This course gives parents information about their baby's brain development and their baby's physical and emotional development. It shows how important the baby parent relationship is to a baby's development.

The course looks at baby's sleeping, feeding, crying, playing and childcare options. The course was developed by Health Visitors working with health professionals in the Solihull Approach team.

To access the course:

1. Go to www.inourplace.co.uk click 'START NOW'
2. Fill in your details, to register & sign in
3. Scroll down & find 'Understanding Your Baby'
4. Click on 'Take course'
5. Click 'Already have a discount coupon?'

6. Type in this code (this is your 'coupon'): SHRPSOLIHULLAPPROACHPOSTN
7. Click 'Apply coupon'

Maternal mental health

Perinatal mental health refers to a woman's mental health during pregnancy and the first year after birth. The illness affects up to 20% of women, and covers a wide range of conditions including antenatal depression, postnatal depression, anxiety, perinatal obsessive compulsive disorder, postpartum psychosis and post-traumatic stress disorder (PTSD). If left untreated, it can have significant and long lasting effects on the woman and her family.

Health Visitors undertake emotional mental health assessments as part of the new birth and 6 to 8 week visits as well as when they have additional contact with mothers where appropriate.

If mothers are assessed as having perinatal mental health issues that are mild to moderate depression or anxiety then the Health Visitor can offer a low level cognitive behaviour therapy (CBT) intervention or access to self-help tools as part of a standard operating procedure. They also offer referral to IAPT (Improving Access to Psychological Therapies) or specialist services as required.

To raise awareness of perinatal mental health, an information leaflet is given out during pregnancy to all expectant parents.

To improve emotional health literacy, the following programmes are delivered by Health Visitors, Midwives and Children's Centres across Shropshire (who are currently jointly trained by the Public Health Children and Young People Team and the Parenting Team in Children's Services);

- Antenatal
- Understanding pregnancy
- Labour, birth and your baby programmes
- Online antenatal courses are also available in addition to an online postnatal course.

Health Visiting and School Nursing

Local Authorities are responsible for commissioning Public Health Nursing Services for 0-19 year olds and up to 25 where additional needs are identified. A new 0-25 Public Health Nursing Service contract was developed and put out to tender in 2016/17 which was awarded to Shropshire Community Health Trust commencing on 1st October 2017. The new service combines health visiting, Family Nurse Partnership and school nursing.

The 0-25 Public Health Nursing Service was designed to enable the tailoring of services to what is needed within communities across the county, improve accessibility of services and improve child health. These include;

Child health surveillance and development review	Child health protection, immunisation and screening	Information, advice and targeted support for families & young people with additional needs	Health promotion & prevention	Defined support in the early years & education settings for children with complex health needs

Mental Health in Children, Young People and Young Adults

There is an estimated 1 in 10 children between the age of 5 and 15 years with a significant mental health problem in the UK with approximately 4,000 children and young people in Shropshire estimated to have a diagnosable mental health condition. The most common presenting issues are related to self-harm, depression, domestic violence in the home, post abuse distress and drugs and alcohol misuse. Higher risk of developing a mental health condition is associated for children in care, those in contact with the youth justice system, children living in the most deprived households and children with caring responsibilities for other family members. School related problems are frequently cited to include bullying, learning difficulties, peer relationships or school related anxiety.

Children who are mentally healthy are able to develop psychological, emotionally, intellectually and spiritually. Mental health is accompanied by a sense of personal

wellbeing, an ability to get along with others, to be able to cope with the normal range of problems/setbacks and learn from them. It is estimated that up to a half of all mental health conditions could be prevented with the right interventions in childhood. Good mental health enables children to play and learn, develop a sense of right and wrong and make and maintain positive relationships.

Emotional Health and Wellbeing Service for 0 to 25 years

In May 2017, a new Emotional Health and Wellbeing Service for 0 to 25 year olds was commissioned by Shropshire CCG with supportive funding from Shropshire Council to build upon the previous Child and Adolescent Mental Health Services (CAMHS) for enhanced effective early help services. This service provides support 24 hours a day, 7 days a week in order to promote resilience, prevent mental health crisis and respond quickly to the presenting needs of children and young people in relation to mental health.

Services are delivered by the following organisations;

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

South Staffordshire and Shropshire Healthcare NHS FT are the lead provider of the service providing community services, specialist treatment and crisis resolution for young people with mental health problems.

Contacts:
Compass (for new enquiries)
Phone: 0345 678 9021
Email: earlyhelp@shropshire.gov.uk
Website: https://shropshire.gov.uk/early-help/practitioners/compass/

Referrals from professionals
Phone: 0300 124 0093
Secure Email: 025SPA@sssft.nhs.uk

Delivery of health promotion, prevention and early help support as well as working with young people to aid transition/sign posting to other services or resources.

Drop in services with no referral required are available;

Every Thursday 2pm – 6pm
Palmer's Coffee Shop, Belmont Church, Claremont Street, Shrewsbury, SY1 1QG
Every Monday 2pm – 6pm

Hollinswood Neighbourhood Centre, 7 Downemead, Hollinswood, Telford, TF3 2EW

For questions or if you would like to know more please contact BEAM at; AskBeam@childrenssociety.org.uk

A 24 hour available online support service which can be accessed anonymously via phone, tablet, laptop or PC and offers peer support, self-help material and gives children and young people access to live forums.

Professional councillors for live online chats without referral for anyone aged between 11 and 25 years.

Access is at www.kooth.com
Hours for live chats with professional councillors

Monday to Friday: 12pm to 10pm
Weekends/bank holidays: 6pm to 10pm

Following a face to face assessment with the NHS Practitioner, the practitioner will discuss options available to you which might include the offer of Healios if this is the right care to meet needs.

Online psychological therapy service delivered by qualified practitioners and is available between 8am and 9pm, 7 days a week

More information available at: www.healios.org.uk/

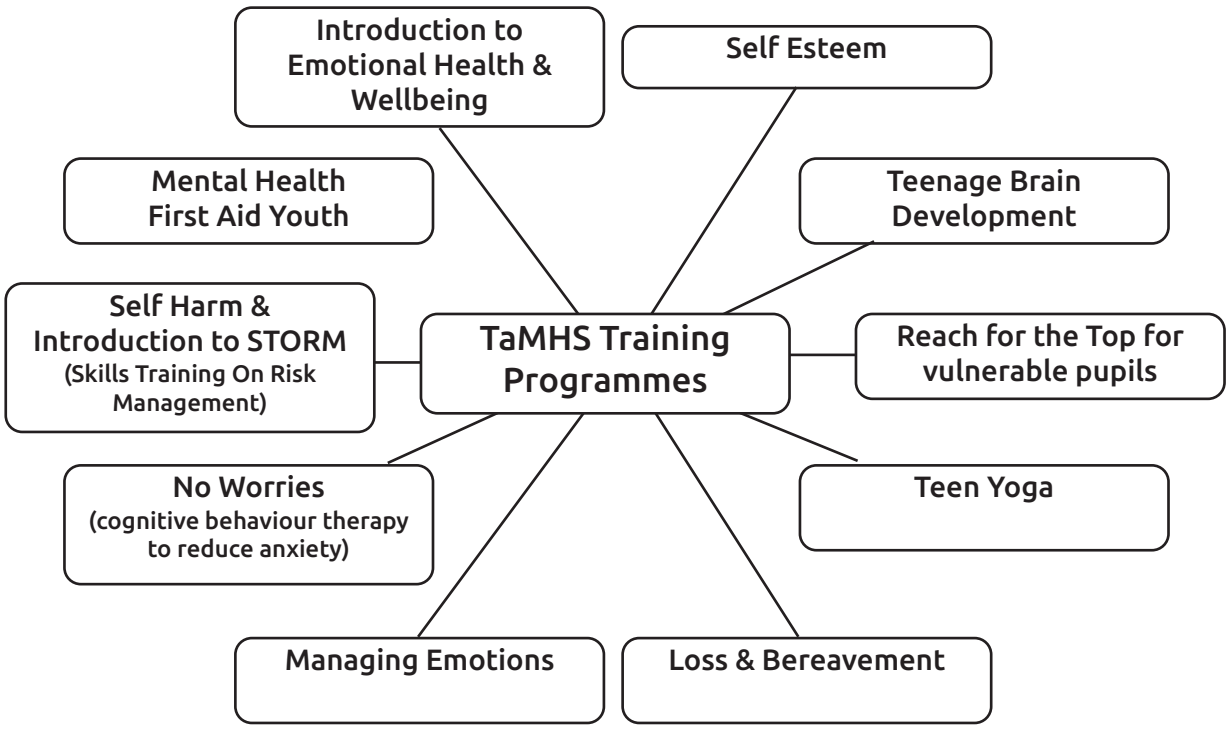
Targeted Mental Health Support (TaMHS)

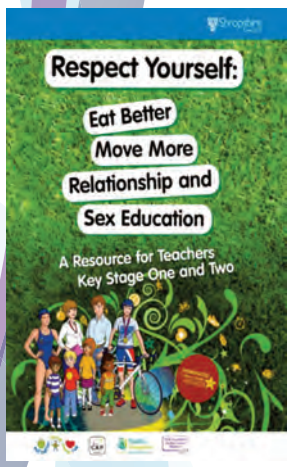
The TaMHS service provides support for schools and other organisations that provide services for young people (as well as professionals and volunteers) in order to promote emotional health and wellbeing and develop resilience in ages 0 to 19 years.

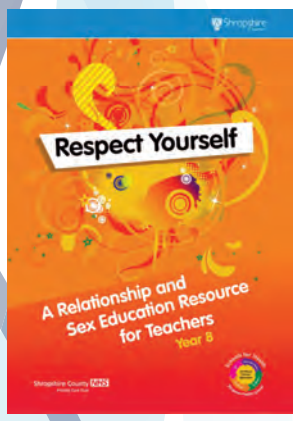
Shropshire was one of 25 sites across the country that ran a government funded targeted mental health programme for schools, which has subsequently been extended to include and support wider services that work with young people.

These services, professionals and volunteers across all settings are invited to attend training on issues such as self-harm, suicide prevention, loss and bereavement, anxiety, managing emotions, building self-esteem and relaxation. The purpose is to increase the local workforce knowledge base which enables professionals and volunteers working with children and young people to;

i. Recognise early signs and symptoms of need
ii. Provide practical examples of how to respond to the emotional needs of young people
iii. Provide tips and strategies on what to do and say following identification of need







Personal, Social and Health Education (PHSE) with Schools

PHSE is a planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives. It is the umbrella term under which schools deliver personal, social and health education issues including (but not limited to);

- Relationship and sex education
- Emotional and mental health
- Drugs and alcohol education
- Healthy eating
- E-safety

The work to support Shropshire schools is characterised by adopting a whole school approach. This work supports and complements TaMHS, is linked to schools' pastoral care system, school nurse CHAT service and Targeted Youth support. We support, advise and challenge our schools, heads and governors to adhere to key principles of effective practice and evidence based approaches.

The programme has supported the continuing low local teenage pregnancy rate as well as addressing key areas of safeguarding, discrimination and prejudice on LGBTQ issues, emotional and mental health and substance use.

PSHE young inspectors presenting on PSHE to FRESh (Fairness, Respect, Equality Shropshire) Ltd for Shropshire Equality Forum

Shropshire young people with Maria Miller MP who hosted a Parliamentary briefing on Relationship and Sex Education

Shropshire is recognised nationally for leading practice. The relationships and sex education work has won the national Children and Young People Now awards 2017, and is now being purchased by other authorities and schools, (including one in France).

This is the first year there has been an award for PSHE. The PSHE Education Award was one of 23 categories being showcased at the 'Children and Young People Now' awards. Shropshire's submission beat seven other contestants to win the PSHE Education Award category.

Healthy Outdoors for Schools

The Healthy Outdoors for Schools pilot project was launched during autumn 2016, to support schools to get children walking to increase their activity levels and aid a healthier lifestyle. Two schools: St. Leonard's School Bridgnorth (a large urban school) and St. George's School Clun (a small rural school), took part in the pilot. Both schools decided to start the Daily Mile with support from a funded Walking Co-ordinator from Walking for Health.

The schools embraced the initiative. Now running for a year, it is fully embedded into the school day and culture. Both schools adopted a whole school approach; meaning over 400 pupils are now walking or running a mile a day within the school day. Each school has given the Daily Mile their own individual stamp.

As part of the offer, links with schools and their local environment / community were encouraged, including promoting local walking opportunities for families to adopt in their leisure time.

Evaluation results from the pilot are very positive, with most staff saying they would recommend it to other schools, "Just try it!" a teacher commented.

> "Initially a lot of classes were going out at the same time, which caused problems. Now we stagger it and that is fine. More flexible now."
>
> "They really love doing it…all join in", they "do it every day. Great as refocuses them and they are ready to learn"
>
> "I've got one little girl who always spends her playtimes in the cloakroom area, so this is an opportunity to ensure she is outside and is walking"

Further information:

Helen Foxall Walking Coordinator
email: helen.foxall@shropshire.gov.uk
phone: 01743 255059

Clare Fildes Outdoor Partnerships Enterprise Manager
email: clare.fildes@shropshire.gov.uk
phone: 01743 255067

Outdoor Partnerships, Shropshire Council, Shirehall,
Abbey Foregate, Shrewsbury. SY2 6ND

Living Well

Working together to improve health

As we age the risk of developing high blood pressure, heart disease and type 2 diabetes increase. Spotting the early signs and helping preventing the onset of these conditions is key to staying healthy for longer.

NHS Health Check

The free NHS Health Check offers an opportunity to identify many hidden health risks and plan for action.

If you are between 40-74 years of age, and have not been diagnosed with an associated condition, you should expect to receive an invitation to attend from your GP or the local authority, once every 5 years, whilst remaining eligible.

The check involves:

- a face-to-face meeting with a trained professional who will carry out simple blood tests and basic measures, also asking questions relating to daily living activities
- a risk management element will allow personalised feedback of results, providing advice and support to reduce associated risk factors, and where appropriate onward referral to health improvement services or GP

More information on the NHS Health Check is available from the Healthy Shropshire website at:
http://www.healthyshropshire.co.uk/topics/nhshealthcheck/

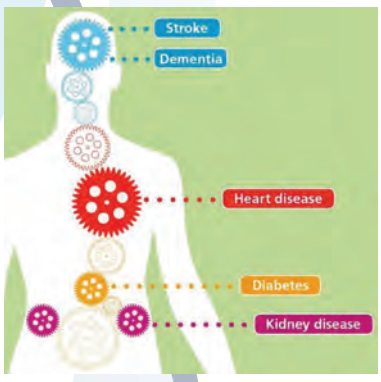
NHS Health Check within Shropshire

Shropshire Council and the Public Health Department have a responsibility to ensure the NHS Health Check is available for all eligible Shropshire residents. Consequently, collaborative working between General Practice and Shropshire Public Health to provide the service, has enabled both invites and take-up of the service to continue to rise year-on-year, with over 8500 Patients attending during 2016-17. The close working between organisations has also enabled essential follow-up lifestyle interventions based within General Practice and the community settings to be made available, addressing lifestyle risks such as Weight Management, Smoking and Physical inactivity.

Our Aim

- To ensure the total number of eligible individuals from 2013 have received a first invitation by April 2018
- To record a year on year increase in the take up of the NHS Health Check invite
- To increase opportunities to access NHS Health Checks

Current trends indicate a continued year on year increase in activity, with all Shropshire General Practice's now participating. The Public Health Help2change provider team are also supporting practices who may have limited capacity to offer appointments, often utilising the Help2change community mobile NHS Health Check Clinic.



help2change freehealthcheck

Each year over 500 people will have avoided a major cardiovascular incident, such as a heart attack or stroke, as a result of treatment following their NHS Health Check

'A new case of raised Blood pressure is found every three to four NHS Health Checks, with a new diagnosis of hypertension made every 30-40'

'A new diagnosis of diabetes is made for every 80-200 NHS Health Checks'

'A person with cardiovascular risk ≥20% is identified every six to ten checks'

Source: NHS Health Check Programme evidence synthesis January 2017 'University of Cambridge'

'For every 110 people having a check 1 person is diagnosed with type 2 diabetes'

Help2Slim is a weight management service for obese patients. Currently 1,000 people are treated per year.

Obesity is the main risk factor for type 2 diabetes and significantly increased risk of heart disease, stroke, dementia and cancer

Diabetes alone accounts for one tenth of the entire NHS spend

Diabetes in Shropshire costs the NHS £47m per year and Social Care £8.3m per year

For further information on weight management please call 0345 678 9025 or visit the Healthy Shropshire webpage for;

- **Weight management:** www.healthyshropshire.co.uk/topics/weight-management

  Topics include:

  Weight management & pregnancy | Free local weight management service | Fit families | BMI Check

- **Physical activity:** www.healthyshropshire.co.uk/topics/physical-activity

  Topics include:

  Help to become more active | Exercise on referral | Benefits of physical activity | Ideas for keeping active

help2quit

"Excellent service & practitioners, highly recommended"

"Being able to text is great"

"Very pleasant and caring, nothing was too much trouble. Wouldn't have done it without your support"

Help2Quit continues to provide the most effective method of quitting smoking, combining specialist behaviour change support along with a range of stop smoking medications. In 2016/17, over 2,000 quit attempts were made with the service.

During 2016/17 regulations that require picture warnings covering 65% of both sides of the pack were introduced. Other measures include: a ban on distinguishable flavours, including menthol; the regulation of e-cigarettes; and measures to reduce tobacco smuggling.

Smoking in Shropshire costs the NHS £11.1m per year and Social Care £7.4m per year

Cigarettes are to be sold in packs containing a minimum of 20 sticks. Regulations requiring standardised packaging also came into force.

For expert help and advice on quitting smoking call 0345 6789 025 or visit www.healthyshropshire.co.uk/topics/stop-smoking

Help2Quit are also on twitter @Help2QuitShrops

Adult Mental Health

Ensuring our population has good mental health is important as it impacts on all aspects of people's lives, including links with good physical health, social participation, developing personal relationships, education, training and ability to fulfil potential in employment opportunities as well as a key component in nurturing resilient communities.

A recent study commissioned by the West Midlands Combined Authority[5] (2017) identified that poor metal health has a financial cost in the West Midlands of over £12billion per year (equivalent to £3,000 per person living in the region) comprised of cost of health and social care, employment costs (through loss of output in the local economy, sickness absence and unemployment) and estimated adverse human costs from reduced wellbeing and quality of life. This has significant implications for the Shropshire economy given a 1 adult in 6 prevalence of having a common mental disorder in England (equating to 1 in 5 women and 1 in 8 men)[6].

Shropshire's GREAT OUTDOORS

Shropshire WILD TEAMS

The Shropshire Wild Teams are groups of conservation volunteers who are using mental health services, primarily secondary services, as well people with learning disabilities.

The Shropshire Wild Teams was originally set up with Public Health funding to engage with people leading sedentary and/ or isolated lives as a longer term preventative strategy to minimise future deteriorating health and the resulting increase in costs for further health care interventions.

[5]Mental Health in the West Midlands Combined Authority. A report for the West Midlands Health Commission. January 2017. K. Newbigging and M. Parsonage. Available at: http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/news-events/2017/mental-health-in-the-west-midlands-combined-authority.pdf
[6]Adult Psychiatric Morbidity Survey 2014. Available at: http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf

Many of these are the most marginalised and disadvantaged within our communities. The Wild Team initiative quickly evolved to focus on those using mental health services, primarily secondary services, as well people with learning disabilities. The public cost of caring and supporting individuals using these services can be expensive, regularly resource intensive and nearly always long term.

"Thank you, this year has been one of the most difficult I have had to face and your support and positive outlook has made a huge difference. I don't often get lost for words but the days I have spent out with you and the team have made a real difference and I don't quite know how to say thank you… I have started to reduce my meds and touch wood I seem to be returning to my old self bit by bit. I genuinely would have been lost without wild teams this year and I hope that it continues to be a success. The new job will hopefully get me back in the loop and leave me time to pursue what I really want to do. I feel like I often left the house on a Monday morning feeling utterly lost and hopeless only to return after a day with you with more than a flicker of hope!!"

Volunteer GF Tigers

Serious and chronic mental Illness commonly manifests in two main criteria; inactivity and isolation. Along with the added chaotic lifestyle many experience during periods of relapse or crisis, the longer term prognosis for many can be poor, resulting in deteriorating health issues and further complex interventions.

The Wild Team's approach to supporting people have been built on the growing evidence base that confirms the physiological and psychological benefits all of us experience from spending time within natural environments, from reducing heart rates and blood pressure to the release of serotonin and feelings of general well-being.

About Shropshire Wild Teams video

"The group is sometimes the only time I get to socialise so it is very important to me. I now look forward to Thursdays as it gives me a purpose. I have learned so many new skills and made a lot of new friends. I find the group very useful as it builds confidence and social skills. Way back in September I was a bit dubious about it but soon forgot most of my fears that I had. I am really enjoying the work we are doing and when get to work with groups like the National Trust. I find it so rewarding."

Volunteer Bridgnorth Zombies

Other benefits of the Wild Teams include;

- The opportunity to get out to meet others when previously they would stay at home throughout the week, maybe only leaving to shop for essential items.
- Feelings of belonging to part of a new unexpected social group, some for the first time in years.
- Gaining genuine new skills that have enabled an awakened confidence and realisation that personal agency and the ability to move on is a possibility open to them.
- Finding work is a goal may previously have been one kept private from others due to a lack of self-belief often from earlier "failures." However talk of the possibility of work in the future is one that is now heard within all of the Teams.

The Impact to the People

51 volunteers , 5 went on to find work

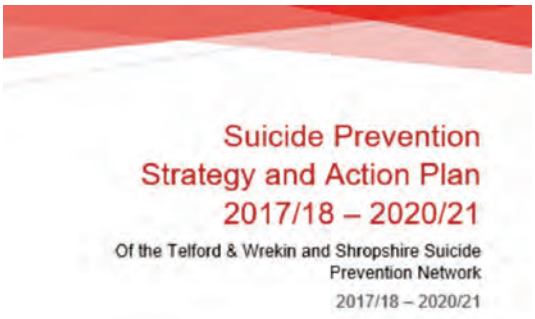
Benefits include:

- Increased personal and social confidence
- Overcoming depression, anxiety and agoraphobia
- Reduction in self harm incidents
- Skills development

The Impact on the environment

- Habitat management
- Footpath maintenance
- Hedge laying
- Gate installation
- Wildlife survey work

Self harm and suicide prevention



Suicide is preventable, and its risk factors can be screened for. Suicide is the leading cause of premature deaths in men younger than 50, which means that more men die of suicide in the UK than heart disease, cancer, heart attack or in road traffic accidents. People who are bereaved by suicide are at three times the risk of making a suicide attempt themselves. There is also growing evidence of the association between self-harm and increased risk of death by suicide, even though many people who self-harm do not intend to take their own life.

Between 2013 and 2015 there were 50 deaths recorded as suicide in Telford and Wrekin and 81 deaths recorded as suicide in Shropshire. These numbers are likely to be underestimated due to the legal necessities for categorising a suicide death.

It is clear that, although our region has a suicide rate that is similar to the national average, more work needs to be done to support those people who are at risk and those who are affected by suicide. Suicide affects all types of people and communities and is linked to a wide variety of factors including depression, alcohol and drug misuse, unemployment, family and relationship problems, social isolation and loneliness.

A Shropshire and Telford Wrekin Suicide Prevention Network was formed in September 2016 which invited a range of stakeholder organisations from across both Local Authority areas, NHS, voluntary and community sector, police, emergency services and more to work together to decide how we are going to reduce the number of suicides locally and how to best mobilise our resources to ensure vulnerable and at risk people are able to quickly and easily access the appropriate support they need.

As a result the Suicide Prevention Network has produced a Joint Suicide Prevention Strategy for Shropshire and Telford and Wrekin (available here) which aims to;

- Raise awareness of suicide risk, promote access to support services (including those bereaved by suicide) from a wide range of sources (not just health services).

- Encourage more people to talk about self-harm, suicide and the risk factors associated with suicide in order to destigmatise and encourage people to seek help when they feel it is needed.
- Provide those who have a public facing role to have confidence in signposting people affected by suicidal thoughts to the services that could best help them.

Delivery of the Strategy in Shropshire is managed by the Shropshire Suicide Prevention Action Group (a sub group of the Network).

For more information about Shropshire's Joint Suicide Prevention Strategy visit http://www.shropshiretogether.org.uk/mental-health/.

Anyone needing support should call the Samaritans 24-hour support service on **0116 123** or make an urgent appointment to see their GP.

To access mental health services, in Shropshire call 0300 124 0365 or visit http://mentalhealth.sssft.nhs.uk/.

Zero Suicide Alliance Free Suicide Awareness and Prevention Training

The Zero Suicide Alliance have produced a 20 minute training video to help everyone spot the signs in someone contemplating suicide and advice on how to intervene using a range of scenarios.

Access the Zero Suicide Alliance webpage for a wide range of resources and access to the training: http://zerosuicidealliance.com/

Could you spot the signs in someone contemplating suicide?
Even if you could, how confident would you be to intervene?
… read on to find out how YOU could prevent a tragic death by suicide, and it'll only take you 20-30 minutes!

Drugs and Alcohol Action Team (DAAT)

Shropshire DAAT along with SRP and in conjunction with the Shropshire Recovery Network, has formed a team in order to enter the Changes UK Five a Side Football Tournament.

Organised by Changes UK, a Birmingham based recovery charity, the tournament is in its second year and took place on the 3rd March at the Powerleague Football Centre in Yardley, Birmingham.

This is the first year that Shropshire have participated in the tournament. The team, made up of service users and individuals in recovery have been supported by Shrewsbury Town Football Club who have very kindly donated the kit.

Even before the first game, participation in the tournament has been a fantastic opportunity and experience for all involved. As well as an organised initial team building exercise at The Shrewsbury Sports Village the players themselves have also organised some extra football training. The tournament itself will be a great chance for the players to meet other Service users, peers and those in recovery from across the UK.

Picture of the team on the day

Details about the team's participation and progress in the tournament can be viewed on the DAAT's twitter feed @Shrop_DAAT.

It was a fantastic day even though the weather was very wet indeed. Shropshire won the very first game they played which was brilliant. There were unfortunately no further victories against some very good other teams. There were however a lot of very positive comments from other participants about the Shrewsbury Town kit and also the enthusiasm that the whole team showed, playing through injuries and exhaustion! A very positive experience for all involved and it is hoped that Shropshire can again send a team in 2019.

Willowdene Farm Women's Recovery Centre

"to stimulate, encourage and promote a purposeful offending and substance free lifestyle in a working society"

The Willowdene Farm site in Chorley near Bridgnorth is a purpose built women's only recovery centre and is available to women offenders who are over 21 years old and are at risk of custody.

The Women's Recovery Centre (WRC) provides support for women to engage in therapy, skills training, thinking skills development, work focused activity and to overcome alcohol and/or substance misuse dependence to achieve sustainable recovery. There is also opportunity to gain skills qualifications.

The purpose of the recovery programme is to remove the women from their offending lifestyles, giving them focused time to turn their lives around. The programme will consist of recovery-orientated treatment that helps women overcome their dependency issues and in turn reduces the harm that addiction causes to our communities. The programmes are designed with the individual and their families at the heart of their recovery plan, enabling them to take greater responsibility for rebuilding their lives and shaping their future.

Access to support is not reliant on housing benefit and, therefore, enables the women to retain their homes without further impact on any other household member. This should enable the offender to return to a stable environment when reintegrated.

Link to the Women's Residential Programme Leaflet for;

- Offenders: http://www.westmerciaprobation.org.uk/document/Page/womenresidentialoffender.pdf
- Professionals: http://www.westmerciaprobation.org.uk/document/Page/womenresidentialprofessional.pdf

The UK Recovery Walk 2018: Shrewsbury

The UK Recovery Walk celebrates the achievements of people in recovery from drug and alcohol dependency, alongside promoting the work of treatment services. The walk also gives the opportunity to demonstrate that recovery is possible and challenges the stigma often associated with drug and alcohol dependency.

Following a very successful campaign, Shrewsbury won a national public vote to host the UK Recovery Walk in 2018, the 10th anniversary of the walk. Each year around 5000 people travel from across the country to participate in the event

Service users and members of the recovery community are fully involved in the every aspect of the planning process. In addition to celebrating recovery, the recovery walk will give an opportunity to raise awareness of drug and alcohol dependency and challenge the stigma linked with substance misuse. The opportunity of hosting the walk will also create a lasting legacy for recovery in Shropshire, bringing together disparate recovery communities across the county, which can be isolated due to the rurality of the county.

Ageing Well

As we age it is NOT inevitable that we will have poor physical or mental health nor have to be considered "over the hill". There is a good proportion of older people who live life to the fullest and which can be enhanced through being actively, mentally and socially engaged within society, providing benefit both to themselves and to others.

Older people have a lifetime of experience to offer with many across Shropshire who make fantastic contributions within their communities providing informal carer services as well as providing key links with many of our voluntary and charitable organisations. This includes volunteers who deliver meals-on-wheels, staff community clubs, run shops and cafes in hospitals and do much more besides.

We do however, recognise that as some people age they will require additional support over and above that which is available through our Living Well programmes. Therefore, Shropshire Public Health's Ageing Well programmes focus on interventions to both reduce risk of avoidable injury and hospital admission as well as promoting resources to help people remain comfortable in their own homes and be safe and well for as long as possible.

Falls Prevention

One third of people aged over 65, and half of those aged over 80, fall at least once a year. In Shropshire, it's estimated that around 400 older people fall every week, with 1 in 5 of these falls resulting in significant injury.

Approximately 10 people aged over 65 years fracture their hip each week in Shropshire; 8 out of 10 of these fractures result from a fall.

Falls are very expensive; in a study in Torbay, health and social care costs in the first year following a fall amounted to 4% of the hospital budget and 4% of the adult social care budget.

Many older people are frightened of falling and are reluctant to talk about it. But falls are not an inevitable part of ageing. They can be resistant to messages about falls prevention and reluctant to talk about it because they:

- Are frightened of falling and don't believe anything can be done
- Believe the myth that falls are just a part of growing older
- Believe falling is just a matter of chance or will never happen to them
- Deny they are at risk because they see a fall is a sign of weakness or inability to manage.

But falls are NOT an inevitable part of ageing, and we know that while the causes of a fall may be complex, there is plenty that can be done to reduce their risk.

We've taken a new approach by helping those who have concerns, to help older people at vulnerable to falls. We've made available a range of national self-help resources to raise awareness of the action people can take to reduce their risk of falls, bringing them together for easy access into a single web-page. "Let's talk about the F-word" provides a range of practical suggestions, on-line interactive tools and resources to help someone stay safe and avoid falls. These include the NHS approved 'Falls Assistant, (an in-depth tool to self-assess the key falls risks relevant to an individual and act on the self-management advice and support provided), an interactive check for falls hazards in the home and practical exercises to help build strength and balance.

To let people know about 'Let's talk about the F-Word; we've worked with Age UK Shropshire, Telford and Wrekin to run a 6 month (June to December) social media campaign using Twitter and Social media, aimed in particular at adults of working age who may be concerned about a parent, grandparent or friend. Our "Let's talk about the F-Word campaign" is a call to action, encouraging people to use these resources to help prevent future falls. Health and social care professionals are also using the site to help people to look after themselves.

If you are concerned about yourself, an ageing parent, family member or friend go online to http://www.healthyshropshire.co.uk/topics/ageing-well/preventing-falls/

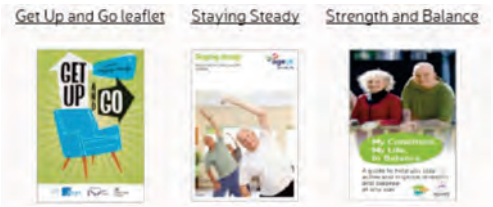
This includes information, advice and links for;

Falls Assistant: interactive tool to understand risk, how to reduce risk and exercises to improve mobility and balance

Strength and Balance exercises for healthy ageing: instructions and advice for information

Mobility and Balance: a simple test to indicate need to improve strength, gait and balance

Fall check home safety: an interactive check of the hazards in the home that might cause a fall



A selection of printed material and videos are also available online at http://www.healthyshropshire.co.uk/topics/ageing-well/preventing-falls/

For those who don't have access to the internet, you can visit your local library and ask for information on the Let's Talk about the F-word campaign.

Dementia

Dementia is a condition that has a significant detrimental impact on those who live alongside it, not just those who have the condition. Dementia is also considered to have the biggest financial impact of all of the long-term conditions, costing the economy nearly double that of cancer.

Recognising that age is the biggest risk indicator for developing dementia and projections show that by 2031, 45% of the south Shropshire population will be over 65 years of age (and will be among the three oldest populations across England and Wales), a Shropshire dementia strategy for 2017 to 2020 has been produced. This Strategy is for people who;

- Live with dementia
- Provide support for people with dementia
- Are affected by dementia and
- Anyone interested in learning about what we in Shropshire are planning to do to help improve the lived experience of the condition

Although full details of the Strategy can be found on the Shropshire Choices website (link to webpage and Strategy), in summary the key aims of the Strategy are to;

- Increase community-based options available for people with dementia to promote a better quality of life for people living with the condition.
- Reduce the number of people with dementia who experience unplanned admission to the acute hospitals.
- Reduce the amount of time that people with dementia spend in hospital once they are admitted.

In addition to the release of the dementia strategy, key dementia achievements for Shropshire during 2016/17 include;

- Commissioned dementia support service provided on a one-to-one basis or with family to promote independence and prevent hospital or care home admission where appropriate
- Dementia companion support worker services have been implemented in Ludlow and Oswestry where an assigned individual will help each person diagnosed with dementia (which may include their carer) through their journey. This includes the design of memory clinics within GP practices in Ludlow and Oswestry to create improved links with primary care and provide a familiar place to attend.
- The Dementia Action Alliance is continuing to work towards creating dementia friendly communities to improve the lives of people living with dementia and their carers.

For further details on the range of support available for dementia, please visit the Shropshire Choices website at https://www.shropshirechoices.org.uk/dementia.

Simple advice for keeping yourself healthy

The following Public Health 10 tip lifestyle messages are for people of all ages. For further information, ideas to help you achieve these tips and details of local programmes please visit the Healthy Shropshire website at www.healthyshropshire.co.uk.

1. **Stop Smoking:** If you smoke, quitting is probably the greatest single step you can take to improve your health. It doesn't matter how many times you have tried to quit - you CAN STOP smoking, and you are four times more likely to stop smoking successfully with a stop smoking service than you are alone. To find your local service call 0345 6789 025.
2. **Keep a healthy weight:** Maintaining a healthy weight is important for good health. Being overweight increases your risk of developing health problems including coronary heart disease, stroke, type 2 diabetes, osteoarthritis and some types of cancer. Your weight is determined by the balance between what you eat and drink and how active you are.
3. **Be physically active:** There are many forms of exercise and everyone can benefit from doing a little more, more often. Physical activity is everything from everyday activity, to playing sports or joining an exercise class. Increasing our everyday demanding activities such as gardening, climbing the stairs, mopping the floor or walking the children to school instead of driving, can be a good place to start to increase physical activity levels. You may, however, prefer to join a sports club, an exercise group, or a walking group and enjoy a more social element when exercising.
4. **Drink alcohol within sensible limits:** To keep health risks from alcohol at a low level (such as increased risk of cancer, diabetes, cirrhosis of the liver and heart disease which are linked to regular drinking to excess), you are safest not to regularly drink more than 14 units per week (around 7 pints of average strength beer or 7 175ml glasses of wine). This applies to both men and women. If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all, to keep risk to your baby to a minimum.
5. **Eat a healthy, balanced diet:** Eat at least 5 portions of a variety of fruit and vegetables each day. Fruit and vegetables are also usually low in fat and calories (provided you don't fry them or roast them in lots of oil). That's why

eating them can help you maintain a healthy weight and keep your heart healthy. Cut down on fat, salt and added sugar. For more guidance on eating well, please visit the Healthy Shropshire Eatwell page at http://www.healthyshropshire.co.uk/topics/healthy-eating/what-is-a-balanced-diet/eat-well-plate.

6. **Use NHS Screening services:** Take up opportunities for screening when you are invited to participate in NHS screening programmes including breast, bowel cancer, cervical, diabetic eye, abdominal aortic aneurysm and programmes during pregnancy and for babies. The NHS Health Check is also freely available for anyone aged 40 to 74 years to identify hidden health risks and plan for action.

7. **Look after your sexual health:** This means enjoying the sexual activity you want, without causing yourself or anyone else any suffering, or physical or mental harm. Sexual health is not just about avoiding unwanted pregnancy or Sexually Transmitted Diseases (STIs) – But using a condom will help with both. Sexual health services are free and available to everyone regardless of sex, age, ethnic origin and sexual orientation. In Shropshire clinics are provided in Shrewsbury, Ludlow, Whitchurch, Oswestry and Market Drayton, all providing methods of contraception, (including long acting methods) and screening, testing and treatments for sexually transmitted diseases and HIV.F or more information on Sexual Health Services in Shropshire please visit www.openclinic.org.uk.

8. **Manage your stress levels and emotional wellness:** Mental health and wellbeing is relevant to everyone, it's how we feel and how we cope which can change from day to day. You can have good wellbeing even if you have been diagnosed with a mental illness – it's all about having a good quality of life. Talking things through, relaxation, physical activity and maintaining a balanced diet can help, as well as ensuring a good work/life balance by developing interests outside of work can help reduce stress and improve productivity.

9. **Take up opportunities for flu immunisation:** If you are over 65, or if you are under 65 and are pregnant or have long term health condition, have your annual flu immunisation.

10. **Form relationships and connect with others:** Volunteering, joining an interest group or activity in something you enjoy or may like to learn and making time to speak to someone can be good ways of connecting with other people and making new friends. Being around people that we can talk, laugh and enjoy spending time with has many positive impacts on both physical and emotional health.

5 Ways to Wellbeing

There are 5 steps we can all take to improve our mental wellbeing which are presented below.

Health and Wellbeing Board
Thursday 24th May 2018

Children's Trust Briefing to the Health and Wellbeing Board

Responsible Officer **Karen Bradshaw**

Email: karen.bradshaw@shropshire.gov.uk Tel: 01743 254201

1.0 Summary

This regular update briefing commissioned by the Health and Wellbeing Board (H&WBB) from the Shropshire Children's Trust will focus on 0 – 25 Special Educational Needs and Disabilities (SEND) and preparation for the OFSTED & Care Quality Commission Joint Local Area Inspection; the SEND High Needs Review and Development Plan; the proposed changes to children's centre services and progress on the work being undertaken on 'school readiness'. This briefing provides assurance to the H&WBB on the work of the Trust and highlights areas for closer consideration by the H&WBB.

2.0 Recommendations

The Children's Trust recommends that the H&WB:

a) supports the work ongoing around preparation for SEND OFSTED & Care Quality Commission Joint Local Area Inspection and calls upon partners to engage with the revision of the 0 – 25 SEND self evaluation.

b) notes the development plan for SEND high needs provision

c) notes the consultation on the proposed changes to children centre services

d) encourages partners to promote and disseminate the leaflets on school readiness when available

REPORT

3.0 Risk Assessment and Opportunities Appraisal

The Children's Trust through its associated health and wellbeing outcomes supports the reduction of inequalities across Shropshire

4.0 Financial Implications

No financial decisions are explicitly required with this report, there may be associated resource implications to be considered for some actions.

5.0 Background

This update briefing provides the Health and Wellbeing Board with regular assurance from the Children's Trust concerning the partnership approach to promoting and supporting the health and wellbeing of children, young people and families in Shropshire.

1.0 SEND Preparation for the OFSTED Joint Local Area Inspection

6.1 The Joint Local Area Inspection involves inspectors speaking with children and young people who have SEN and/or disabilities, parents and carers, local authority and NHS officers. They visit a range of providers as well as speaking to leaders, staff and governors about how the SEN reforms are being implemented. Inspectors look at a range of information about the performance of the local area, including the local area's self -evaluation. Inspectors meet with leaders from the local area for health, social care and education. They review performance information, evidence about the local offer and joint commissioning.

6.2 The inspectors are looking for evidence that the local areas:

- effective in the identification of children and young people who have special educational needs and/or disabilities
- working in partnership across agencies to ensure adequate provision for children and young people with SEND.
- promoting and supporting positive outcomes for children and young people with SEND

6.3 In reaching their judgements, inspectors, in line with the requirements of the Code of Practice, will pay particular attention to:

- the accuracy and rigour of the local area's self-evaluation, the extent to which the local area knows its strengths and weaknesses, and what it needs to do further to improve the life chances of children and young people with special educational needs and/or disabilities
- to what extent the outcomes for children and young people are improving as a result of the collective actions and support of local agencies and bodies
- the efficiency of identification of special educational needs and disabilities
- the timeliness and usefulness of assessment
- how well local agencies and bodies plan and coordinate their work to assess need and provide necessary effective support
- how well the local area engages with children and young people, and their parents and carers, to inform decisions about the strategic commissioning of services (joint strategic needs assessment)
- how well the local area involves the individual child or young person, and their parents and carers, in the process of assessing their needs
- how well the local area communicates with children and young people, and their parents or carers, to ensure that these primary users are clear about the identification and assessment processes and the criteria used to make decisions
- the extent to which the local area gives due regard to its duties under the Equality Act 2010 to children and young people with special educational needs and/or disabilities.

6.4 In order to ensure that the 0 – 25 SEND Strategic Partnership Board understands the needs of children and young people with SEN and or Disabilities and their families and carers in Shropshire, work is being undertaken to revise the self evaluation. This requires all partners across Health, Education and Social Care both in adult and children's services to engage with this piece of work. This might entail a narrative that explains the services that they provide and feedback from those who they provide services for as well as identifying appropriate data that supports information on key performance indicators relevant to their service area.

6.5 This is a priority area of work as it is anticipated that Shropshire will be subject to a 0 – 25 SEND local area inspection by OFSTED & the Care Quality Commission in 2018.

2.0 SEND High Needs Review and Development Plan

7.1 Background

The Department for Education (DfE) released funding to all English Local Authorities for a strategic review of high needs provision. This has been backed up by the 'Special Provision Fund' to enable capital investment in provision for pupils with SEND. Shropshire commissioned FWL & Associates to carry out this review, which started in October 2017 and was completed (with the publication of a plan on the Local Offer) in March 2018.

7.2 What is the funding for?

Local authorities can invest in mainstream and special schools, nurseries, colleges and other provision. Shropshire has an allocation of **£500k Special Provision Fund** between 2018-21 (£167k p.a. for 3 years). The funds will be used to create new (additional) places or improve existing facilities at good or outstanding provision for pupils with EHC Plans.

7.3 Findings of the review

The key findings of the review were:

- Growing demand for specialist provision being driven by increasing learner complexity and pressure on mainstream
- proportionally low level of specialist / high needs provision

- Significant journey distances faced by some of Shropshire's most vulnerable learners
- Services have evolved to address this through development of Specialist Hubs BUT this has been patchy and intermittent
- Priority gaps in school age provision:
    - Specialist provision attached to mainstream schools for learners with communication & interaction difficulties (including Autism Spectrum Conditions) and those with Moderate Learning Difficulties (MLD)
    - Provision for pupils with Social Emotional and Mental Health (SEMH) difficulties / Autism Spectrum Conditions
    - Provision for learners with Mental Health difficulties – although this need could arguably be better served through investment in universal and targeted support in mainstream – e.g. Nurture Bases

7.4 Considerations following the review include looking at opportunities for development of specialist provision in mainstream primary and secondary schools and/or partnership models.

Going forward, provision needs to:
- Be cost effective (given resources available) and relatively quick to implement
- Address access and inclusion issues – particularly in relation to geographical reach
- Maximise respective strengths of mainstream and specialist providers

7.5 Next Steps

In order to take the work forward:
- A working group is being established that will report back to the 0 – 25 SEND Strategic Partnership Board
- A programme action plan is being developed that outlines key stages, milestones and consultation requirements
- Preparatory work is being undertaken in advance of a bid for a new Free School

7.6 This exciting piece of work will build capacity and skills across Shropshire and have a significant positive impact on a range of learners. We look forward to reporting back to the H&WB as the programme progresses.

3.0 Consultation on proposed changes to children's centre services

Plans to deliver Children's Centre services from six Early Help Family Hubs across Shropshire will go out to public consultation from 29 May to 12 July 2018, and people are being urged to have their say.

Under the proposals, services would be delivered from six key buildings instead of the existing 26 buildings, namely: The Centre – Oswestry; Richmond House – Shrewsbury; Crowmoor Centre – Shrewsbury; Rockspring Centre – Ludlow; and buildings in Whitchurch and Bridgnorth that are yet to be decided.

Children's centre services would continue to be provided from the six new hubs, and through local community venues and home visits. Services provided by Shropshire Council's partners will also continue, including midwifery services, health visitor services and services for vulnerable and disadvantaged children, especially those with special needs.

In phase 1 consultation on the new Early Help Delivery Model the public expressed broad agreement about the benefits of integrated multi agency, multi disciplinary teams working together in Early Help Family Hubs and geographic areas. The Early Help Partnership Board is focussed on further strengthening its relationship with schools, health, housing, police, the voluntary and community sector and its commissioned services to ensure partnership working and collaboration is at the forefront of driving change to improve outcomes for children and young people who most need help. The Early Help Partnership Board reports directly to the Children's Trust, to update on progress and address challenges.

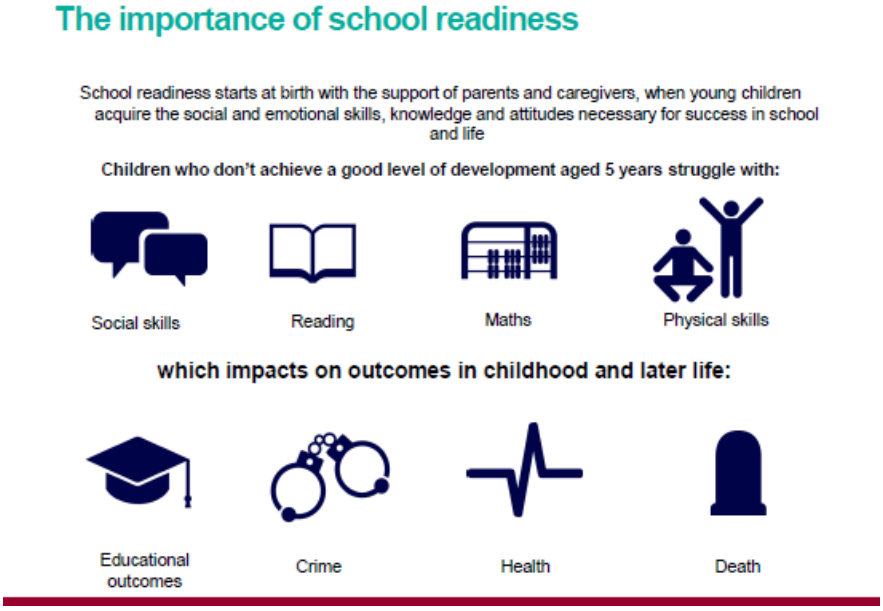
Shropshire Council does not intend to close the 20 unneeded buildings but anticipates that they would be used by other organisations providing services for children and families.

The proposals – which were considered by Shropshire Council's Cabinet on the 2 May 2018 – have been drawn up following a previous consultation held in February and March 2018 in which families, stakeholders and staff were asked for their views on the idea of family hubs. Their views and opinions have helped to shape the proposals that will now go to further consultation.

The consultation will begin on 29 May and run for six weeks and some 25 public meetings will be held from 4 June to 12 July (see list attached as Appendix A). People will also be able to complete an online version of the consultation questionnaire via the Shropshire Council website, or complete and return a hard copy.

9.0 School Readiness

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. The good level of development (GLD) is used to assess school readiness. Children are defined as having reached a GLD at the end of the Early Years Foundation Stage if they have achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in specific areas of mathematics and literacy



As part of its programme of 'deep dives' in 2017 the Children's Trust focussed on school readiness. A Public Health England Report had identified that although in 2014/15; 68.3% of children in Shropshire were ready for school at reception this still meant that 31.7% of children were not ready for school at this stage. Anecdotal reports from primary schools supported this with schools reporting that some children are starting school having not reached the appropriate developmental milestones in order for them to learn effectively. These may include under developed cognitive fine and gross motor skills.

The Ages and Stages questionnaire (ASQ-3) undertaken at age 2 is designed to highlight those children who may require extra support however the completion of the questionnaire by parents is not compulsory. The Children's Trust wanted to raise awareness with parents so that they understand the importance of their child being 'school ready'. Not only to give them the best start at school but to also ensure those children with additional development needs are identified as early as possible and receive the extra support they require.

The work that the Task and Finish Group has undertaken in consultation with schools and parents has led to the development of easy to understand information leaflets. The leaflets **How I grow and learn – my journey to school** include:

Pregnancy key messages

- When you talk to me, I can hear you and I get to know your voice.
- When you sing to me, I feel settled and safe and that helps me grow and develop.
- When you eat, I grow.

- When you stroke your tummy, I feel safe.
- If you take care of yourself, you are taking care of me

0-2 key messages

- Hold me close and let me see your face, this makes me feel safe and I learn about faces and recognise emotions.
- When you talk to me, I learn new words.
- When you talk to me, I know I am important to you.
- When you talk to me, I will try and copy.
- I like it when we look at picture books together. I learn new words and start to recognise objects.
- Let me explore my world so that I can learn about it. Let me play on my tummy, on my back and let me touch and feel things.
- When you sing to me, I start to recognise words, patterns and rhythms, so please sing to me or tell me a story or a nursery rhyme.
- When you feed me healthy food, I will grow and develop. Look out for my cues, I will tell you when I am hungry and when I am full.
- When I am ready let me try new foods.
- I like to explore my food, how it feels, looks and tastes. I might be messy but I learn a lot. When I am cuddled, I feel safe and loved.
- It's fun when we play together and I learn from you.
- I like to play outside.

2- 4 years key messages

- I like it when we look at, read books together, and make up our own stories.
- I like it when we talk about my day.
- I like to have some routines and boundaries as this helps me to feel safe and understand my world.
- Help me to have a healthy diet so I can continue to grow and develop.
- I like to play with others but I also like to play on my own at times.
- I like to play outside.
- I would like to be able to do things for myself like go to the toilet, get dressed, wash my hands, brush my teeth but you may need to help at times.

All ages key messages

- To help me to continue to grow, develop and learn, I need….
- You to take care of yourself to take care of me
- To eat healthy food
- To see the dentist to make sure my teeth are healthy.
- Have my immunisations to protect me from infection and serious diseases.
- To have my health checks to make sure I am growing and developing well and to help me if I need additional support.
- When I am not well, I need you to seek advice.
- I might have some additional challenges that require some specialist support or equipment to help me to achieve my personal aspirations. Please speak to my GP or Health Visitor if you think this might be the case

The information will be disseminated in a number of ways and H&WB partners are encouraged to support this going forward.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) https://www.gov.uk/government/publications/local-area-send-inspections-one-year-on
Cabinet Member (Portfolio Holder) Nick Bardsley
Local Member
Appendices APPENDIX A Consultation events timetable – children's centre service proposals

Consultation on proposed changes to children's centre services

June/July 2018 - public consultation events

Monday 4 June
1.30pm – 2.30pm Ellesmere Children's Centre

Tuesday 5 June
10.00am – 11.00am Meole Children's Centre, Shrewsbury
10.30am – 11.30pm Cleobury Mortimer, Country Centre

Wednesday 6 June
1.30pm – 2.30pm Woodside Children's Centre, Oswestry
2.00pm – 3.00pm Trinity Methodist Hall, Shifnal

Monday 11 June
10.00 am – 11.00am Sunflower House, Shrewsbury
2.00pm – 3.00pm St Mary's Children's Centre, Bridgnorth
7.00pm – 8.00pm Church Stretton, Mayfair Centre

Tuesday 12 June
10.00 am – 11.00am Honeysuckle Lodge, Martin Wilson School, Shrewsbury

Wednesday 13 June
2.00pm – 3.00pm Mereside School, Shrewsbury

Thursday 14 June
10.00am – 11.00am Buttercup Lodge, Sundorne Infant School, Shrewsbury

Monday 18 June
7.00pm – 8.00pm Whitchurch, Civic Centre

Tuesday 19 June
10.30am – 11.30am Highley, Severn Centre
6.30pm – 7.30pm Bishop's Castle Children's Centre

Wednesday 20 June
2.00pm – 3.00pm Albrighton Children's Centre

Tuesday 26 June
1.30pm – 2.30pm Broseley, Birch Meadow Centre

Thursday 21 June
10.00am – 11.00am Baschurch Children's Centre

Thursday 28 June
10.00am – 11.00am Bayston Hill, Library

Monday 2 July
10.00am – 11.00am Wem Children's Centre

Tuesday 3 July
2.00pm – 3.00pm Minsterley, Parish Rooms

Wednesday 4 July
10.00am – 11.00am Craven Arms Children's Centre
1.30pm – 2.30pm Children's Centre, Market Drayton Infant School

Thursday 12 July
(Childminders' network)
6.30pm – 7.30pm Shrewsbury, Riversway / Shawbury / Much Wenlock, Primary School

Shropshire Council

NHS Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
Meeting Date

Item Title Adult Mental Health Needs Assessment

Responsible Officer
Andy.begley @shropshire.gov.uk Tel: Fax:
Gordon.kochane @shropshire.gov.uk

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1. Summary

The Shropshire Mental Health Needs Assessment seeks to identify and describe the patterns of mental health problems for adults within Shropshire, identify inequalities in mental health (including access to services) and to determine the priorities for the most effective use of resources to inform whether the content and configuration of existing services is appropriate for our population.

Ensuring our population has good mental and emotional health is important as it impacts on all aspects of people's lives, including links with good physical health, social participation, ability to cope with the normal stresses of life, developing personal relationships, education, training and ability to fulfil potential in employment opportunities.

Managing a positive state of mental wellbeing is associated with a range of positive social outcomes such as educational success, wealth, employment, self-awareness and acceptance of others. There is however, no evidence that these social outcomes alone can improve mental wellbeing. Conversely, there is evidence that negative social factors such as educational failure, poverty, unemployment and fear of others can be both a cause and an outcome of a mental health problem.

Programmes to promote good emotion health and address mental ill health can be targeted throughout the course of life, from pregnancy and maternity (supporting conditions such as antenatal/postnatal depression), childhood and teenage years (where the majority of mental health problems are first identified) through to adulthood (which otherwise could impact on a person's social circumstances) and older age.

The findings of this Health Needs Assessment suggest that in general, the population mental health of people within Shropshire is better that the averages reported in the West Midlands and England. There are however, still many people across our communities where inequality creates different abilities to access appropriate support and engage within their community as a result of their social, physical and economic environment, which can make them more susceptible to mental health problems.

2. Recommendations

1. **Develop and implement a Mental Health Strategy**: Using the findings of this Health Needs Assessment and ensuring clear links with supporting existing strategies including for dementia, suicide prevention, children and young people and carers.

2. **Better identification and recording of mental ill health**: Data collection across services on issues, characteristics and demographics of clients (particularly with emerging ethnic or migrant populations)

3. **Data sharing between organisations to improve client experience**: Essential information for analysis of risks, understanding needs, service review and promoting equity for clients across different services and for better targeting of care and prevention programmes

4. **Timely access to mental health services based on need**: Feedback from service users indicators identified access to services can be slow and complicated

5. **Raised awareness of and access to support networks that signpost services**: Improved communication to communities and between health & social care services of the range of mental health services and support organisations and how to access them (which may also include links with primary care via Social Prescribing Advisors & Community Care Co-Ordinators)

6. **Frequent service user consultation**: Providers to seek feedback from clients who contact or use mental health service and support networks to review, learn & better respond to changes in community mental health needs

Consistent professional training of frontline staff: For those working across health, social care, the voluntary sector and other services that are most likely to work with people with mental health needs to promote mental wellbeing to the public and among themselves. This would include upskilling of volunteers & support for carers to empower them to have conversations to support mental health & wellbeing.

REPORT

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

4. Financial Implications

Mental Health is one of the most financially demanding conditions for the Health and Social Care economy with common mental disorders costing the local authority on average of £135 per person per year and the NHS £1,219 per person per year and dementia costing the local authority £14,338 per person per year and the NHS £2,048 per person per year (Unit Cost Database - New Economy Manchester). Mental health problems can also increase the risk of a range of other physical health conditions and therefore create further demand on the Care system if not addressed, prevented and/or better managed to ensure people can remain independent for longer.

5. Background

The Health Needs Assessment was produced by a sub group of the Mental Health Partnership Board and included representation from Shropshire Public Health, Shropshire CCG, SSSFT, Commissioning Support Unit and a VCO representative.

The purpose has been to identify where the greatest mental health need may be across our community to help inform where resources could be targeted to ensure greatest impact and to help support the development of a mental health commissioning strategy.

There has been much work within the Shropshire in developing services and formal workplans such as with the recent commissioning of the 0 to 25 years Emotional Health and Wellbeing service, the dementia strategy, the suicide prevention strategy and the carers strategy. There had not however, been a formal assessment of adult mental health across Shropshire in recent times.

6. Additional Information

None

7. Conclusions

The Health Needs Assessment is currently in draft form and still open to comment.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices

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Draft Shropshire Mental Health Needs Assessment

February 2018

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Executive Summary

The Shropshire Mental Health Needs Assessment seeks to identify and describe the patterns of mental health problems for adults within Shropshire, identify inequalities in mental health (including access to services) and to determine the priorities for the most effective use of resources to inform whether the content and configuration of existing services is appropriate for our population.

Ensuring our population has good mental and emotional health is important as it impacts on all aspects of people's lives, including links with good physical health, social participation, ability to cope with the normal stresses of life, developing personal relationships, education, training and ability to fulfil potential in employment opportunities.

Managing a positive state of mental wellbeing is associated with a range of positive social outcomes such as educational success, wealth, employment, self-awareness and acceptance of others. There is however, no evidence that these social outcomes alone can improve mental wellbeing. Conversely, there is evidence that negative social factors such as educational failure, poverty, unemployment and fear of others can be both a cause and an outcome of a mental health problem.

Programmes to promote good emotion health and address mental ill health can be targeted throughout the course of life, from pregnancy and maternity (supporting conditions such as antenatal/postnatal depression), childhood and teenage years (where the majority of mental health problems are first identified) through to adulthood (which otherwise could impact on a person's social circumstances) and older age.

The findings of this Health Needs Assessment suggest that in general, the population mental health of people within Shropshire is better that the averages reported in the West Midlands and England. There are however, still many people across our communities where inequality creates different abilities to access appropriate support and engage within their community as a result of their social, physical and economic environment, which can make them more susceptible to mental health problems.

The following recommendations have been produced based on a combination of epidemiological analysis of mental health quantitative service data and from qualitative feedback from the experiences of service users and service providers.

Recommendations

1. **Develop and implement a Mental Health Strategy**: Using the findings of this Health Needs Assessment and ensuring clear links with supporting existing strategies including for dementia, suicide prevention, children and young people and carers.

2. **Better identification and recording of mental ill health**: Data collection across services on issues, characteristics and demographics of clients (particularly with emerging ethnic or migrant populations)

3. **Data sharing between organisations to improve client experience**: Essential information for analysis of risks, understanding needs, service review and promoting equity for clients across different services and for better targeting of care and prevention programmes

4. **Timely access to mental health services based on need**: Feedback from service users indicators identified access to services can be slow and complicated

5. **Raised awareness of and access to support networks that signpost services**: Improved communication to communities and between health & social care services of the range of mental health services and support organisations and how to access them (which may also include links with primary care via Social Prescribing Advisors & Community Care Co-Ordinators)

6. **Frequent service user consultation**: Providers to seek feedback from clients who contact or use mental health service and support networks to review, learn & better respond to changes in community mental health needs

7. **Consistent professional training of frontline staff**: For those working across health, social care, the voluntary sector and other services that are most likely to work with people with mental health needs to promote mental wellbeing to the public and among themselves. This would include upskilling of volunteers & support for carers to empower them to have conversations to support mental health & wellbeing.

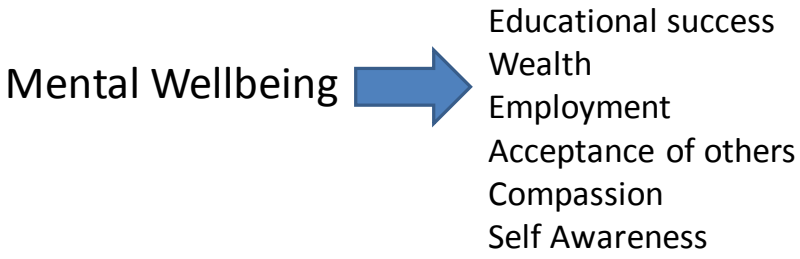
Preface: What is Mental Health?

The term mental health is used to describe a spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health[1].

Mental or emotional wellbeing is used to define positive mental health and although is currently not diagnosable, includes the key components of;

- *Feeling good*: a subjective measure such as happiness and life satisfaction and;
- *Functioning well*: including a wide range of psychological wellbeing factors such as self-acceptance, personal growth, positive relations with others, autonomy, purpose in life and ability to ascertain control over one's environment

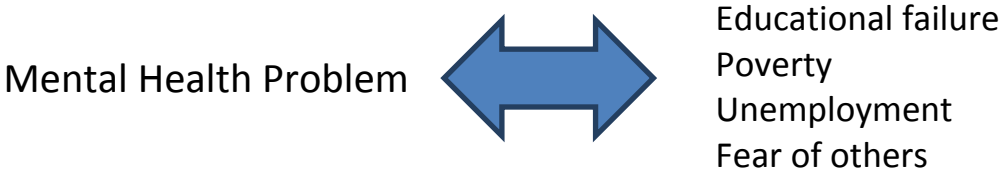
Managing a state of mental wellbeing is associated with a number of positive social outcomes as summarised in the diagram below. It is noted however, there is no evidence to suggest these positive social outcomes have a reciprocal impact on developing mental wellbeing.



Conversely the term mental health problem is used to define poor mental health and negative mental health states which includes the components of;

- *Mental disorder*: an identified mental health problem which can either meet the criteria for psychiatric diagnosis or is recognised but falls short of the diagnostic criteria threshold
- *Common mental health problems*: such as anxiety and depression
- *Severe mental health problems*: which include schizophrenia, bipolar disorder and various behavioural disorders

Having a mental health problem can lead to a number of negative social outcomes. There is evidence that these negative social or environmental factors can also lead to mental health problems, as summarised in the diagram below.



[1] Faculty of Public Health (2016). Better mental health for all: a public health approach to mental health improvement. Available at: http://www.fph.org.uk/better_mental_health_for_all

Introduction

Ensuring our population has good mental and emotional health is important as it impacts on all aspects of people's lives, including links with good physical health, social participation, ability to cope with the normal stresses of life, developing personal relationships, education, training and ability to fulfil potential in employment opportunities. It is also a key component in nurturing resilient communities and can therefore be seen as the responsibility of individuals, families, friends, employers and the wider community to enable people to develop and maintain good mental health.

Mental Health care practice has been in a state of change for the past 30 years. It has moved from a system of long term care and hospitalisation to one predominantly of integration and community care. Care is provided by multidisciplinary teams in people's homes and in the community with access to specialist hospitals for acute admissions and residential units for longer term care. Attitudes, diagnoses, treatment and care have all changed and improved.

Despite this, the majority of mental ill health problems still go unrecognised and untreated (McManus et al, 2009[2]). People with mental health problems are more likely to experience physical health problems, smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty and be over-represented in the criminal justice system. Mental health is the cause of 40% of new disability benefit claims each year in the UK[3] and 70% of people with severe mental health problems are economically inactive and on disability benefit (compared to 30% of the general population).

A recent study commissioned by the West Midlands Combined Authority[4] (2017) identified that poor mental health has a financial cost in the West Midlands of over £12billion per year (equivalent to £3,000 per person living in the region) comprised of cost of health and social care, employment costs (through loss of output in the local economy, sickness absence and unemployment) and estimated adverse human costs from reduced wellbeing and quality of life. This has significant implications for the Shropshire economy given that at least one if four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time (equating to one in five women and one in eight men)[5].

There is much evidence of inequality for the development of mental health problems, particular between people from different socio-economic groups, genders, ages and ethnicities. Although in recent times there has been greater awareness to address these inequalities across society, it is recognised that there are still many groups who have different abilities to access support and to engage within their community as a result of their social, physical and economic environment. This can make some people more susceptible to mental health problems.

[2] McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins, R. (eds.) (2009) Adult psychiatric morbidity in England, 2007. Leeds: NHS Information Centre for health and social care.

[3] Singh, S. (February 2014). Mental Health and Work: United Kingdom Paris: Organisation for Economic Co-operation and Development. Available at: http://www.oecd.org/els/mental-health-and-work-united-kingdom-9789264204997-en.htm

[4] Mental Health in the West Midlands Combined Authority. A report for the West Midlands Health Commission. January 2017. K. Newbigging and M. Parsonage. Available at: http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/news-events/2017/mental-health-in-the-west-midlands-combined-authority.pdf

[5] Adult Psychiatric Morbidity Survey 2014. Available at: http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf

Mental Health during the course of Life

Starting Well

- Mental health problems often begin early in life with over half of these problems being established by age 14 and 75% by age 24 years[6]. Therefore, there is a crucial role that family relationships can play during formative years to mould the infant's brain in a way which affects health throughout their life.
- Perinatal mental health illness during pregnancy and during the first year after birth affects up to 20% of women and covers a wide range of conditions (including antenatal depression, anxiety, perinatal obsessive compulsive disorder, postpartum psychosis and post-traumatic stress disorder). If left untreated it can have a significant and long lasting effects on the women and her family.

Living Well

- During adulthood, mental health problems can impact upon an individual's ability to maintain employment, housing and secure family relationships.

Ageing Well

- Depression in older people affects up to 25% of the population and up to 40% of people in Care Homes.
- Dementia affects 1 in 5 of people over the age of 80 years, which is of even greater risk in an ageing population.

Risk Factors for Children and Young People

The risk factors for poorer mental health outcomes for children and young people include having a learning disability, being a looked after child, being homeless or sleeping rough, parental unemployment and lone parenthood[7]. An additional predictor of adult mental (and physical) health relates to adverse childhood experiences, which includes abusive or neglectful parenting, drug or alcohol misuse, parental mental illness, divorce, bereavement and bullying[8].

Within Shropshire, there is an estimated 4,000 children and young people with a mental health problem with the most common being conduct disorders, emotional disorders and hyperkinetic (ADHD) disorders.

A large proportion of children and young people with mental health needs are usually seen in universal services provided by practitioners who are not mental health specialists (such as GPs, health visitors or school nurses). For specialist support, Shropshire children can be referred to CAMHS (Child and Adolescent Mental Health Services) or to the range of services provided by the recently commissioned 0 to 25 year Emotional Health and Wellbeing Service (see Section 9 for further details).

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[6] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62 (6) pp. 593-602. doi:10.1001/archpsyc.62.6.593.

[7] H. Green, A. McGinnity, H. Meltzer, T. Ford and R. Goodman, "Mental Health of Children and Young People in Great Britain 2004," Office for National Statistics, London, 2005.

[8] Bell, M.A., Ashton, K., Hughe.s, K., Ford, K., Bishop, J. and Paranjothy. (2015). Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population. Wales: Public Health Wales.

Risk Factors for Adults

There are a wide range of risk factors in adulthood of mental ill health, which can include individual, social and cultural factors. These are presented in the table below.

Table a1: Additional risk factors associated with mental ill health

Individual factors	▪ Grief and bereavement ▪ Loneliness and isolation ▪ Anxiety and stress ▪ Relationship difficulties ▪ Carer responsibilities ▪ Alcohol and substance misuse
Social factors	▪ Low socio-economic status ▪ Lack of support networks ▪ Homelessness ▪ Stigma and discrimination
Community and cultural factors	▪ Language barriers ▪ Refugee status

Evidence has also identified that people with long term chronic conditions (such as cardiovascular disease and diabetes) are two to three times more likely than the general population to experience mental health problems such as depression or anxiety[9]. In addition, women are more likely than men to be treated for mental health problems (29% vs 17%)[10].

When considering specific types of mental disorder, the following risk factors were identified from the most recent Adult Psychiatric Morbidity Survey (2014).

Table a2: Risk factors identified from responses to the Adult Psychiatric Morbidity Survey (2014) by type of mental disorder

Common Mental Health Disorder	▪ Aged between 16 to 24 years and between 45 to 54 years (females) ▪ Living alone and aged under 60 years ▪ Separated of divorced ▪ Economically inactive (receipt of employment and support allowance), unemployed or financial difficulties ▪ Smoker ▪ Female gender ▪ Comorbidity with chronic physical conditions
Probable Psychotic Disorder	▪ Economically inactive (receipt of employment and support allowance) or Unemployed ▪ Aged between 35 and 44 years ▪ Black ethnicity and male ▪ Living alone *Risk factors identified in previous APMS surveys (2000/2007)* ▪ Low educational attainment ▪ Living in rental accommodation ▪ Living in an urban area ▪ Living as a single person family unit or lone parent ▪ Separated or divorced

[9] C. Naylor, M. Parsonage, D. McDaid, M. Knapp, M. Fossey and A. Galea, "Long-term conditions and mental health: The cost of co-morbidities," The Kings Fund, London, 2012.

[10] Office for National Statistics, "Better Or Worse: A Follow-Up Study Of The Mental Health Of Adults In Great Britain," The Stationary Office, London, 2003.

National Policy Context

In 2011, the Government released its mental health strategy No Health without Mental Health[11], a cross-government all age mental health outcomes strategy. The strategy set out clear, shared objectives for mental health including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. In January 2014, the Government launched Closing the Gap: Priorities for Essential Change in Mental Health[12], which identified 25 aspects of mental health provision where the Government, health and social care commissioners and providers and other organisations can work together to improve outcomes for people living with mental ill health.

Commissioners for mental health services have been working towards Payment by Results since 2011 (where providers of treatment are paid for each patient seen or treated, taking into account the complexity of care needs). The currency in which it will achieve this is through Clusters. A cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the mental health clustering tool (MHCT). Within the clustering tool there is a decision tree which shows there are three main trunks of clusters, Non-psychotic, psychotic and organic, from which the cluster sit underneath.

Whilst Mental Health may be ahead of game in respect of moving away from acute and long term based care and improvements have been made in mental health provision and follow-up, inequalities persist in access to good quality services. In addition there has not been the same level of infrastructure to develop data collection and payment by results as physical health care. Although government policy prioritises parity of esteem between physical and mental health, there is a general lack of progress and on some levels a misunderstanding of what will work towards achieving parity of esteem. Physical health targets have been applied to mental health which on paper would support parity of esteem but on the contrary perpetuate the lack of parity.

For example, crisis care has a four hour target to match the A&E 4 hour wait target; this grossly misses the prioritisation process that occurs in an A&E department, so if a person requires immediate attention and resuscitation they don't have to wait 4 hours, they are treated immediately. The question this raises is whether a mental health crisis can ever be considered life threatening? To which the answer is yes, but is a 4 hour response acceptable?

There is no equivalent prioritisation for urgent care in mental health. Another misunderstanding leading to maintaining a lack of parity is the IAPT (Improving Access to Psychological Therapies) target of 6 and 18 weeks to treatment, the latter of which is a secondary care waiting time target although IAPT is a primary care service. It also important that a broader supporting focus is able to support mental health need to take into consideration the links with individual, social, community and economic factors which may not always be associated with physical health issues.

In March 2015, NHS England established an Independent Mental Health Taskforce to develop a five year strategy for mental health (*The Five Year Forward View for Mental Health*[13]) which was published in February 2016. The strategy includes 57 recommendations which require cross government action and multi sector collaboration with themes of;

- Commissioning for prevention and quality

[11] Department of Health, "No health without mental health: a cross-government mental health outcomes strategy for people of all ages," Stationary Office, London, 2011.
[12] Department of Health, "Closing the Gap: Priorities for essential change in mental health," Stationary Office, London, 2014.
[13] The Five Year Forward View for Mental Health. NHS England (Feb 2016). Available at: www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

- Good quality care for all, seven days a week
- Innovation and research to drive change
- Strengthening the workforce
- Transparency and data revolution
- Incentives, levers and payments
- Fair regulation and inspection

The Five Year Forward View for Mental Health also sets a target to reduce suicides by 10% nationally by 2020, with every local area to have a multi-agency suicide prevention plan in place. Shropshire established a Suicide Prevention Partnership Network of stakeholders who work, support or are interested in supporting the reduction and prevention of self-harm and suicide across the Local Authority areas of Shropshire and Telford & Wrekin. During 2016/17, the Network produced a Joint Suicide Prevention Strategy which referenced local data and guidance from the Department of Health's national suicide prevention strategy *Preventing Suicide in England*[14]. In addition, guidance from the Local Government Association[15] suggested a number of questions we should be asking to help inform the development of a local Action Plan

It is recognised that these policy developments must be set within a wide context of changes across public services, the impact of austerity measures on Local Authority budgets and alterations to eligibility criteria which are likely to impact on access to services and the range of support available.

Purpose of the Shropshire Adult Mental Health Needs Assessment

The purpose of this health needs assessment is to describe the patterns of mental health problems for adults within Shropshire, identify inequalities in mental health (including access to services) and to determine the priorities for the most effective use of resources to inform whether the content and configuration of existing services is appropriate for our population.

It is intended that the findings from the health needs assessment will serve as the building blocks in assisting the Shropshire Mental Health Partnership Board to produce a Shropshire Mental Health Strategy.

Adult mental health has been selected as the primary focus for the needs assessment as there has already been a great deal of work locally to establish the mental health needs of children and young people, undertaken for the commissioning of a 0 to 25 Emotional Health and Wellbeing service which was established in 2017. It is however, recognised that there may be some overlap in service provision for those accessing mental health services and are aged between 18 and 25 years.

Methodology

A combination of literature reviews, desk based research, epidemiology, service user and provider perspectives have been used to collate evidence for this assessment. It is produced under guidance from a dedicated steering group comprised of representatives from Shropshire Public Health, Shropshire CCG, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, the charity and voluntary sector and the Commissioning Support Unit. Progress has been reported to and overseen by the Shropshire Mental Health Partnership Board.

The scoping criteria to be assessed within the needs assessment are outlined as follows;

Inclusion:

[14] Preventing suicide in England. A cross government outcomes strategy to save lives (2012). Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
[15] Suicide prevention: a guide for local authorities. (2016). Available at: www.local.gov.uk/sites/default/files/documents/1.37_Suicide%20prevention%20WEB.pdf

- Analysis of the epidemiology of adult mental health problems in Shropshire
- Use of local and national qualitative information related to diagnosis and access to mental health services
- Use of quantitative information from adult service users who currently access or who have accessed mental health services in Shropshire
- Consideration of co-morbidity of mental and physical health issues
- Mental health illness due to psychoactive substance misuse

Exclusion:

- Children and young people aged under 18 years
- People with learning disabilities
- Adults where the primary diagnosis is related to autism and conditions such as ADHD
- Alzheimer's and dementia as a dementia strategy was developed in 2017[16]
- Carers as an All Age Carers Strategy for Shropshire was developed in 2017[17]

It is recommended that any outcomes as a result of this Needs Assessment make reference to the work area Strategies mentioned above to ensure appropriate links and consistency between pathways (including links to community sector provision, other public sector organisations and wider economic considerations).

It is acknowledged there is a cross over in age ranges, for example the Early Interventions in Psychosis team work with children from aged 14, in addition there has been a separate piece of work regarding commissioning an Emotional and Wellbeing service for 0-25 year olds. To avoid duplication, this document will focus on adult mental health and make reference where appropriate to the findings and evidence already collated on mental health services with children and young people services rather than attempt to 'reinvent the wheel'.

Service user and provider perspectives

Service user and provider insight for adult mental health services was undertaken between June and August 2017 in partnership with Shropshire Council's Business Design Team. The approach taken involved the use of qualitative, contextual, semi-structured/unstructured one-to-one interviews and a separate topic guide for users of mental health services and for providers of these services.

A request was sent out via the Shropshire Mental Health Forum for any providers that would be interested in taking part in the project, both to be interviewed and to assist in recruiting service users. Nine providers were recruited who subsequently identified 19 service users.

Interviews with service users were conducted at the organisation/group they were attending. All were fully informed about the project and all were required to sign a Consent Form for their story to be included in this research. Assurances were given that their contributions would remain anonymous. Conversations lasted approximately 45-60 minutes. All information was then synthesised thematically in order to analyse. Full details of the final report *An Insight into Mental Health Needs in Shropshire for Shropshire Council's Mental Health Needs Assessment* can be seen in Appendix 1 of this Needs Assessment.

[16] Shropshire CCG and Shropshire Council: Dementia Strategy 2017 - 2020
[17] Shropshire Together All Age Carers Strategy for Shropshire 2017 - 2021. Available at: https://shropshire.gov.uk/committee-services/documents/s14383/7%20Appendix%20A%20All%20ages%20Carers%20strategy%20final%20version%202017-21.pdf

Section 1: Shropshire Profile Demographics

This section provides a summary of the populations and people within Shropshire, including the community and environmental factors which influence mental health outcomes.

Population

Shropshire is a large county in the West Midlands, with a population of around 313,400 people (ONS, 2016[18]). It consists of mainly white British ethnicity. The population pyramids in Figures 1.1 and 1.2 highlight the fact that the county has an aging population, with a large proportion of the population being aged between 40 and 69 years. More than 40% people are aged over 50 years and like many rural areas, Shropshire is expecting to experience an increase in the proportion of population of people who are aged 65 and over. Based on mid-year estimates from 2013, slightly more than a fifth of the county's population is under the age of 19 years.

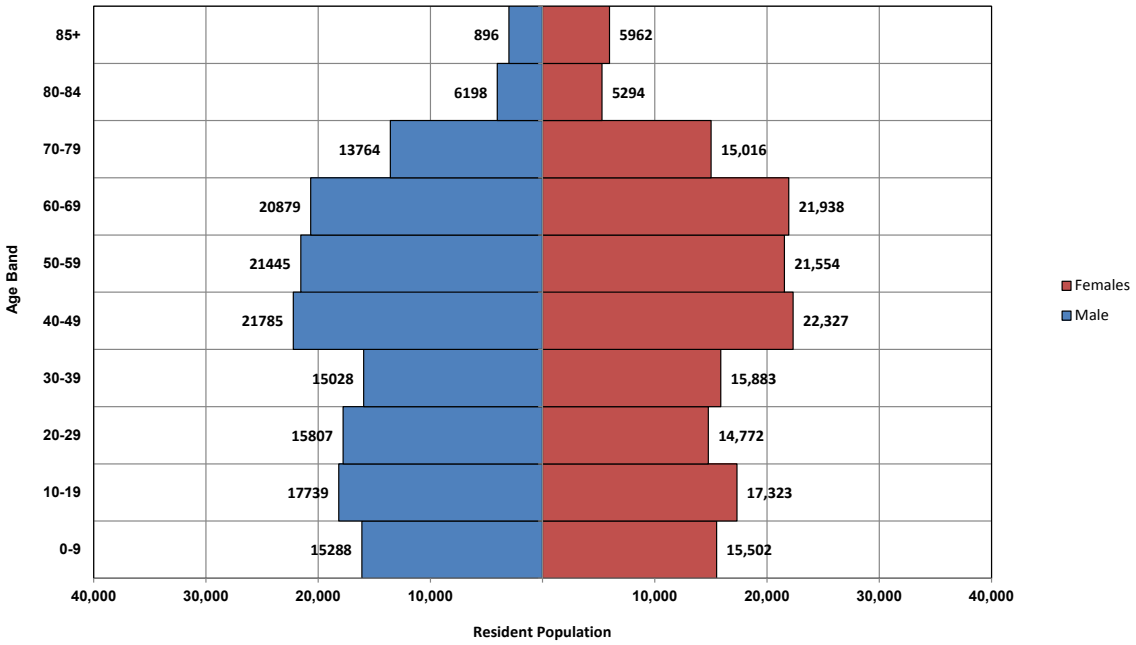
Overall the county is fairly affluent – however there are areas of deprivation and factors of rural sparsity which create issues with access to services. Shropshire supports a low wage economy with reliance on jobs in low paid sectors such as agriculture, tourism, and food and drink. More than 80% of jobs are in the private sector.

Shropshire's geography is an important consideration - it covers a large area of 1,235 square miles, of which only approximately 6% comprises suburban and rural development and continuous urban land. The geography of Shropshire is diverse. The southern and western parts of the county are generally more remote and self-contained.

The landscape provides the backdrop for the market towns as key focal points for communities, businesses, leisure and tourism. Shropshire is entirely inland and its borders also have importance for the people living at the edges of the county – as people may have historic, family or work connections with the bordering areas of Mid Wales, Cheshire, Staffordshire, Telford and Wrekin and onto the West Midlands, Worcestershire and Herefordshire. Shropshire's rural geography and many borders with neighbouring authorities have been highlighted in previous stakeholder consultations as key challenges for accessing services and treatment.

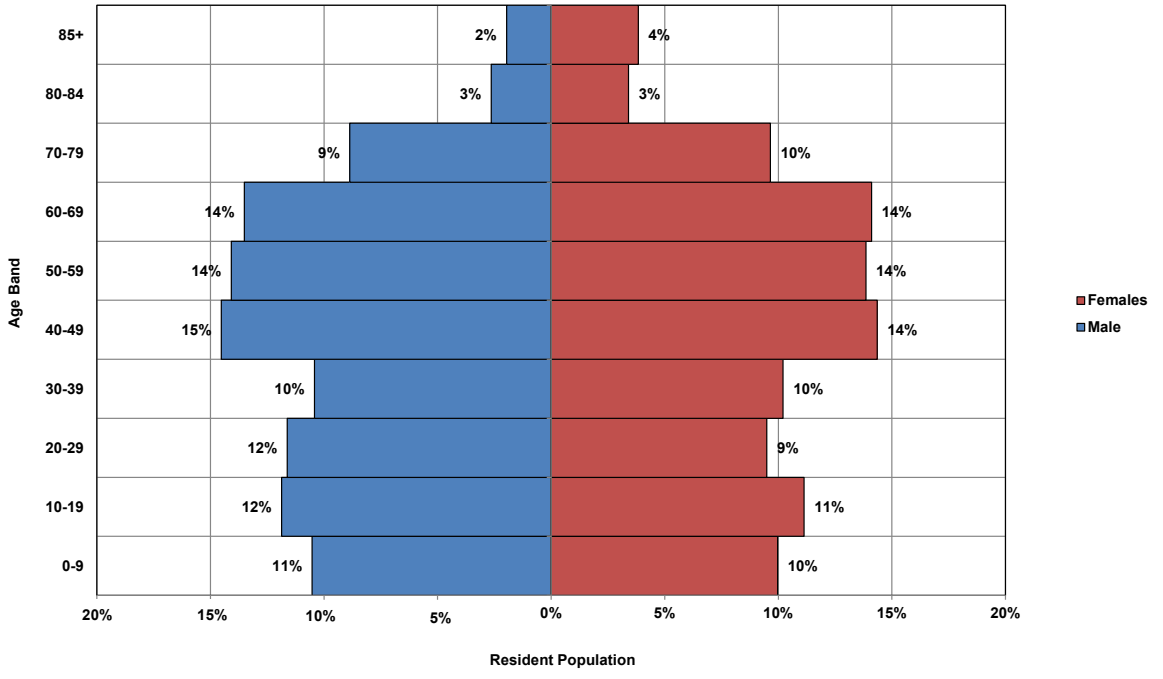
[18] Labour Market Profile – Shropshire. NOMIS Official labour market statistics 2016. Available at: https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabrespop

Figure 1.1. Population pyramid showing estimated population of males and females in Shropshire by age group



Source: Revised Mid-Year Population Estimates, ONS, 2013

Figure 1.2. Population pyramid showing proportion of population of males and females in Shropshire by age group



Source: Revised Mid-Year Population Estimates, ONS, 2013

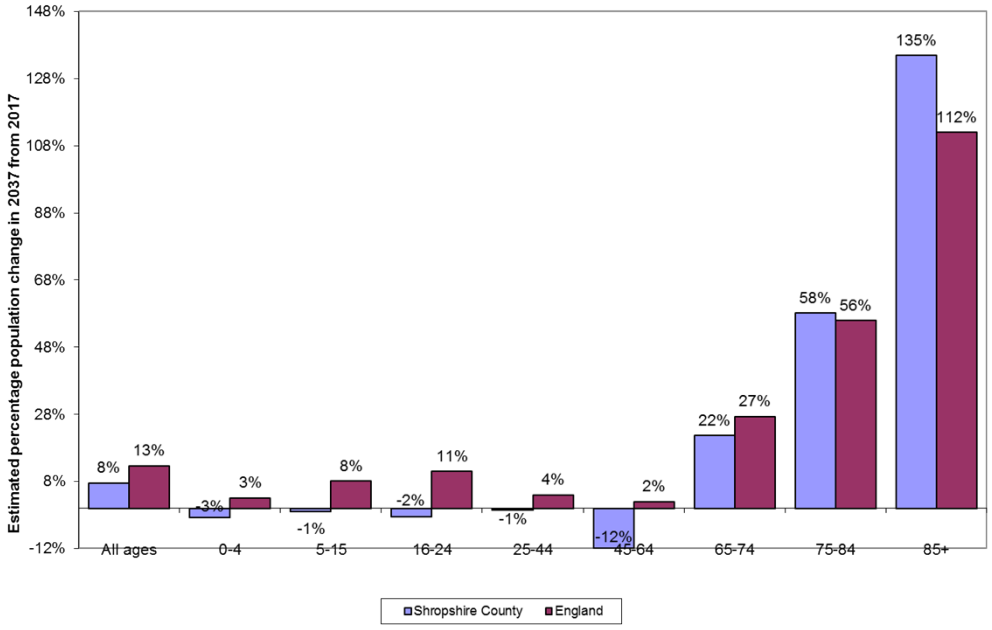
Population Projections (2017 to 2037)

Long-term subnational population projections are an indication of the future trends in population by age and sex over the next 25 years. They are trend-based projections, which mean assumptions for future levels of births, deaths and migration are based on observed levels mainly over the previous five years. They show what the population will be if recent trends continue.

Figure 1.3 shows the projected populations for Shropshire County and England in 2037 compared to populations in 2017. It demonstrates a considerable increase in projected populations for people aged 65 years and above for both Shropshire and England. It can be seen however, that Shropshire is projected to have surpassed growth of those aged 75 years and above compared to England, including 135% additional residents aged over 85 years in 2037 compared to 2017. This has significant implications on the future planning of care and preventative measures related to older age (such as increased risk of frailty and cognitive decline).

In contrast, the projections indicate a decrease in the Shropshire population aged under 64 years with lower growth compared to England.

Figure 1.3: Projected Shropshire County populations by age 2017-2037



Source: Population Projections Unit, ONS. Crown copyright 2014.

Ethnicity

Shropshire has a small ethnic minority population compared to the national average, with a relatively even distribution residing between urban and rural areas.

Table 1.1 identifies that white British residents represent 95.4% of the Shropshire population. It is noted that "other Western European" and "other Eastern European" make up a third of the "Other" ethnicity category.

Table 1.1: Ethnicity profile in Shropshire

	White British	White Other	Mixed/Multiple Ethnic Group	Asian/Asian British	Black/African/ Caribbean/ Black British	Other
Number	292,119	3,892	2,595	1,183	735	5,605
%	95.4%	1.3%	0.8%	0.4%	0.2%	1.8%

Source: NOMIS official labour market statistics - CT0010 - Ethnic group (write-in responses). ONS 2011 Census

Economy and Employment

Shropshire has a high economic activity rate amongst the 16-64 population, and given comparatively low levels of unemployment as well, employment levels are high for this age group. However, given the high proportion of the population past retirement age, the economic activity rate of those aged 16 years and over population is much closer to the national rate.

Between July 2016 and June 2017, 80.5% of working age people in Shropshire were economically active (n= 155,900 people) in employment or self-employed. This is higher than the West Midlands average of 76% and for Great Britain at 78%[19]. There were a greater proportion of economically active males during this time period in Shropshire (85%) compared to females (76%).

The Shropshire labour force is comparatively well qualified, at least compared to the West Midlands, but supports fewer professionals, whilst more work in elementary occupations or as process, plant and machine operatives. Shropshire also supports an above average number of people working in skilled trades occupations.

Shropshire supports a primarily small-business economy, with more than nine out of ten enterprises employing fewer than ten people. Self-employment is high, and significant numbers work from home/run businesses from home. There are comparatively few large employers, and employment is largely concentrated in the county town of Shrewsbury, and the main market towns of Oswestry, Market Drayton, Whitchurch, Bridgnorth and Ludlow.

Key sectors include health, education, retail and manufacturing. Shropshire is under-represented in private sector services such as professional, scientific and technical, and finance and insurance. The mix of sectors in Shropshire contributes to comparatively low workplace wages and to low levels of productivity (GVA generation).

Despite comparatively low workplace wages, resident wages are closer to the national average, with many high earners commuting out of the county for work. Generally, Shropshire is an affluent location, with low levels of deprivation and minimal unemployment. However, like other places, there are pockets of deprivation in Shropshire, where unemployment is higher and incomes lower.

Deprivation

The Index of Multiple Deprivation 2015 (IMD 2015) is a nationally recognised measure of deprivation at the small area level. The IMD 2015 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation. It is an important tool for identifying the most disadvantaged areas in England and can be used locally to help prioritise services and resources to help tackle health inequalities and social exclusion.

The IMD 2015 is based on small geographic areas known as Lower Super Output Areas (LSOAs). The Office for National Statistics defines a LSOA as a small geographic area containing between 1000 and 3000 people and between 400 to 1200 households. There are 32,844 LSOAs in England.

The IMD 2015 combines all seven broad domains:

- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services

[19] Labour Market Profile. NOMIS (2018). Available at: https://www.nomisweb.co.uk/reports/lmp/la/1946157170/report.aspx?town=shropshire#tabrespop

- Living environment deprivation
- Crime

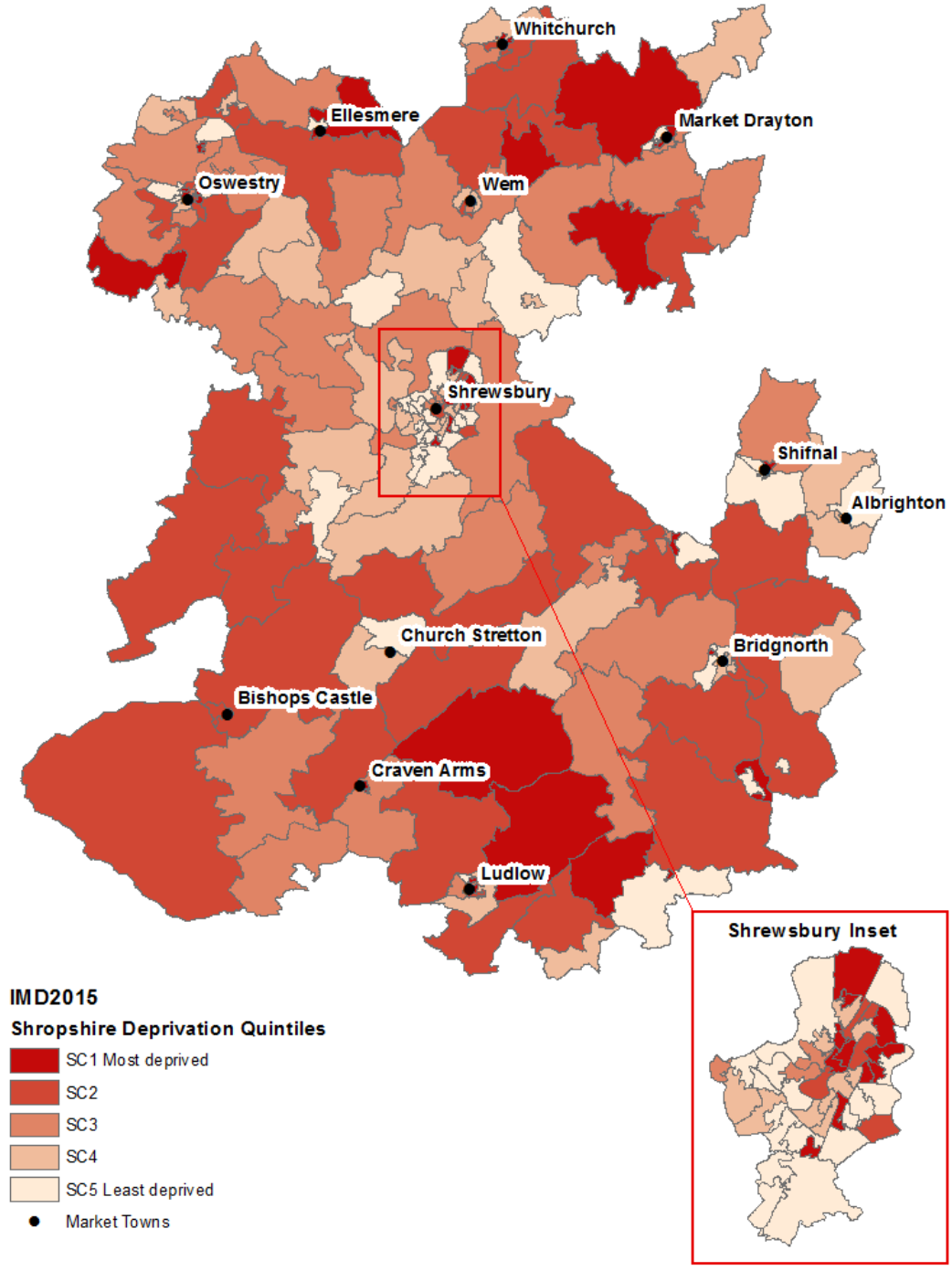
Overall, Shropshire is a relatively affluent area and is ranked the 107th most deprived county out of 152 upper-tier local authorities in England.

There are 193 LSOAs in Shropshire which are based on the boundaries from the most recent 2011 Census. There are nine LSOAs in Shropshire which fall within the 20% most deprived in England and these are located with urban areas of the county. The five most deprived areas are located within the electoral divisions of Harlescott (Shrewsbury), Monkmoor (Shrewsbury), Ludlow East (Ludlow), Oswestry South (Oswestry) and Meole/Bayston Hill, Column and Sutton (the LSOA crosses two electoral divisions in the wider Shrewsbury area).

To get a more accurate picture of local deprivation, Shropshire has been split into five quintiles. This has been done by ranking the IMD score for all LSOAs in Shropshire from one (most deprived) to 193 (least deprived) and then equally dividing the number of LSOAs to provide five categories.

Figure 1.4 shows deprivation as distributed in local quintiles in Shropshire. The LSOAs displayed in the darkest shade are the areas with the highest deprivation rank and those displayed in the lightest shade are the least deprived. The most deprived areas are generally situated around the major settlements in Shropshire, including Shrewsbury and Market Drayton.

Figure 1.4. Index of Multiple Deprivation 2015 in Shropshire County: Local Quintiles



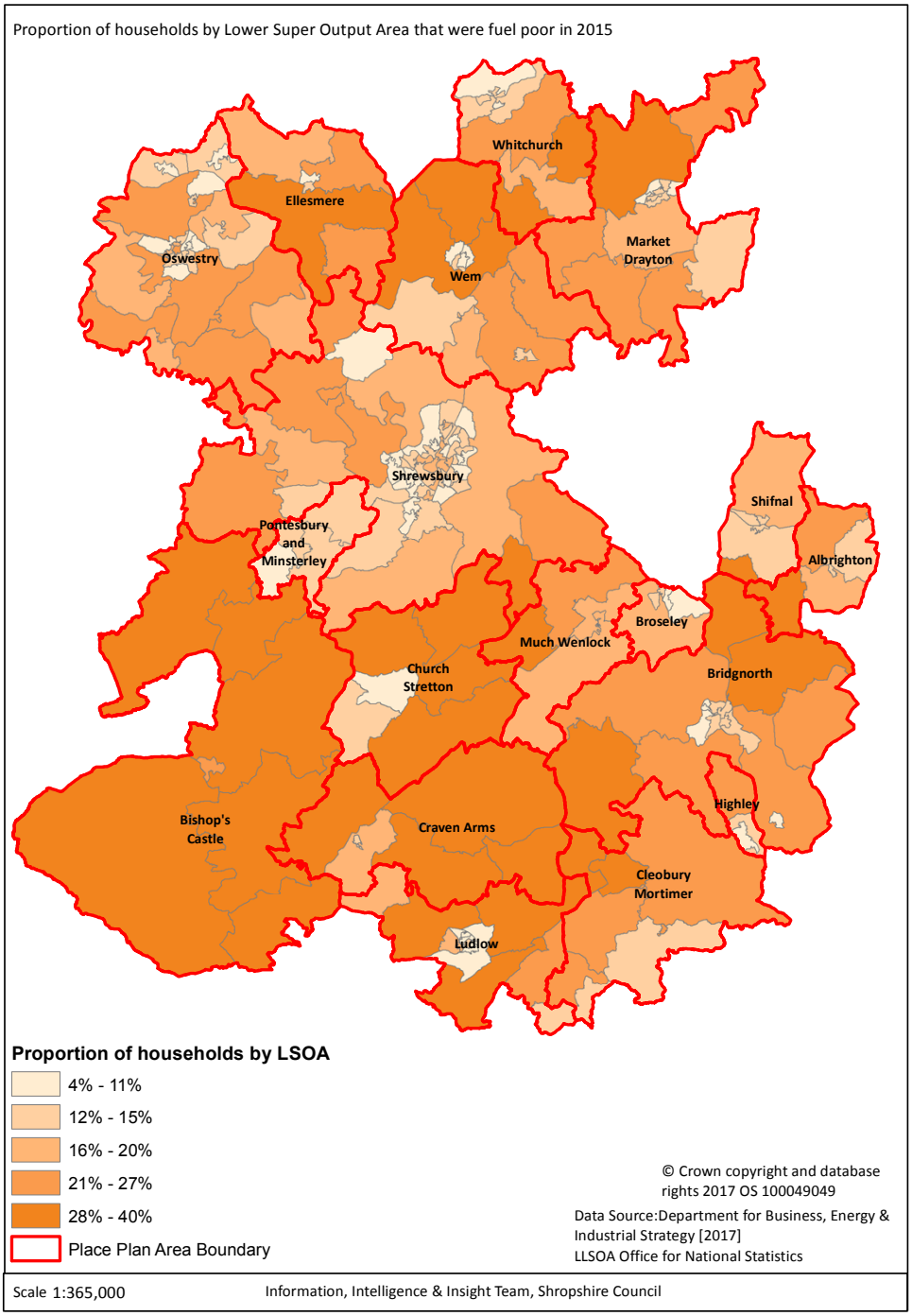
Source: IMD 2015, Community & Local Government and SOA Boundaries, Office of National Statistics 2011

Another factor associated with deprivation is that of fuel poverty where a household is defined as unable to afford to keep the home adequately heated due to;

- required fuel costs above the national average and;
- if they to spend that amount, the household would be left with a residual income below the poverty line

The following geographic place plan map identifies that the areas with the greatest proportion of reported fuel poverty in 2015 were Bishops Castle, Ellesmere, Whitchurch, Craven Arms and Church Stretton.

Figure 1.5. Proportion of households in fuel poverty (2015) in Shropshire County



Office for National Statistics: Measuring Wellbeing and Life Satisfaction

The ONS statistical bulletin Personal well-being in the UK: July 2016 to June 2017[20] provides estimates of personal wellbeing in the UK, based on findings from the April 2012 to March 2015, Annual Population Survey Personal Wellbeing 3-year National Statistics dataset.

ONS uses four survey questions to measure personal well-being. People are asked to respond to the questions on a scale from 0 to 10 where 0 is 'not at all' and 10 is 'completely'. The four questions are:

1. "Overall, how satisfied are you with your life nowadays?"
2. "Overall, to what extent do you feel the things you do in your life are worthwhile?"
3. "Overall, how happy did you feel yesterday?"
4. "Overall, how anxious did you feel yesterday?"

ONS first added these questions to the Annual Population Survey (APS), in April 2011 and more recently within a range of other population surveys[21].

Table 1.2 identifies that although people in the West Midlands felt less satisfied with their lives in England overall, Shropshire people reported greater life satisfaction than both regional and national averages.

Table 1.2: Results of question "How satisfied are you with your life nowadays?" April 2012 to March 2015

	Per cent in each category on 11 point scale:		
	Lower Satisfaction	Higher Satisfaction	Average (mean) rating
Area names	Scale: 0-6	Scale: 7-10	
England	21.53	78.48	7.52
West Midlands	22.37	77.63	7.48
Shropshire	19.65	80.35	7.67

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

A similar pattern is show in table 1.3 for the answers to the question around how worthwhile people felt the things they did in their lives were as with overall life satisfaction. Overall in the West Midlands a lower proportion of people felt the things they did in their lives were worthwhile, compared to Shropshire which had a higher reported worthwhile average compared to both regional and national responses.

Table 1.3: Results of question "Overall, to what extent do you feel the things you do in your life are worthwhile?" April 2012 to March 2015

Per cent in each category on 11 point scale:	Average (mean) rating

[20] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/july2016tojune2017

[21] Surveys using the 4 ONS personal wellbeing questions as of Feb 2015 (ONS, 2016). Available at: http://webarchive.nationalarchives.gov.uk/20160105170340/http://www.ons.gov.uk/ons/guide-method/method-quality/specific/social-and-welfare-methodology/subjective-wellbeing-survey-user-guide/index.html

Area names	Lower Worthwhile 0-6	Higher Worthwhile 7-10	
England	18.23	81.77	7.75
West Midlands	19.23	80.77	7.68
Shropshire	15.18	84.82	7.88

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

A higher proportion of people in Shropshire rated their feeling of happiness higher than in England and the West Midlands overall.

Table 1.4: Results of question "Overall, how happy did you feel yesterday?" April 2012 to March 2015

	Per cent in each category on 11 point scale:		
Area names	Lower Happiness 0-6	Higher Happiness 7-10	Average (mean) rating
England	27.15	72.85	7.37
West Midlands	27.66	72.35	7.35
Shropshire	24.18	75.81	7.54

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

The fourth question identifies a more positive response to have a lower point on the scale, with a lower proportion having experience anxiety. Again Shropshire shows a better overall average scale score of 2.79 compared to 2.93 average for England.

Table 1.5: Results of question "Overall, how anxious did you feel yesterday?" April 2012 to March 2015

	Per cent in each category on 11 point scale:		
Area names	Lower Anxiety 0-5	Higher Anxiety 6-10	Average (mean) rating
England	79.93	20.08	2.93
West Midlands	81.84	18.17	2.70
Shropshire	82.66	17.34	2.79

Source: April 2012 to March 2015, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS. For more information on the 3-year

Wider Determinants of Health and Wellbeing

As identified within the Adult Psychiatric Morbidity Survey, there are a number of wider factors associated with increased risk of mental ill health. In addition to the factors already discussed above, these include;

Social housing/rented accommodation....20
Living alone....23
Single Parent Family Households....25
Education (all age)....26
Access to Services....27

It is useful to consider these wider determinants which can be used as proxies to identify the "hidden population" of poor mental health (i.e. those who are currently not in contact with health services for a mental health condition). The place plan maps over the next few pages highlight the density of locations where each of these factors are most prevalent across Shropshire.

Summary of Wider Determinant Mapping

When the various risk maps are overlaid, there are 7 locations which commonly display the highest proportions of risk factors. As such it may be assumed these locations may be at a greater risk of *hidden* mental health problems;

- Highley
- Ludlow
- Market Drayton
- Shrewsbury
- Oswestry
- Wem
- Whitchurch

It is noted however, as proxy measures are being considered it does not necessarily mean that living in these locations increases risk of developing a mental health problem nor can it be established if the social circumstance/wider determinant risk factors are experienced as a result of a mental health condition.

Social housing/rented accommodation

The following maps (figures 1.6 and 1.7) identify that the greatest proportion of social housing with registered social landlord properties are located in Shifnal, Broseley, Highley, Ludlow and Oswestry. The highest proportion of rental properties are within Shifnal, Albrighton, Broseley, Much Wenlock and Craven Arms.

Figure 1.6. Registered social landlord properties per 1,000 dwelling by Place Plan Area in Shropshire County

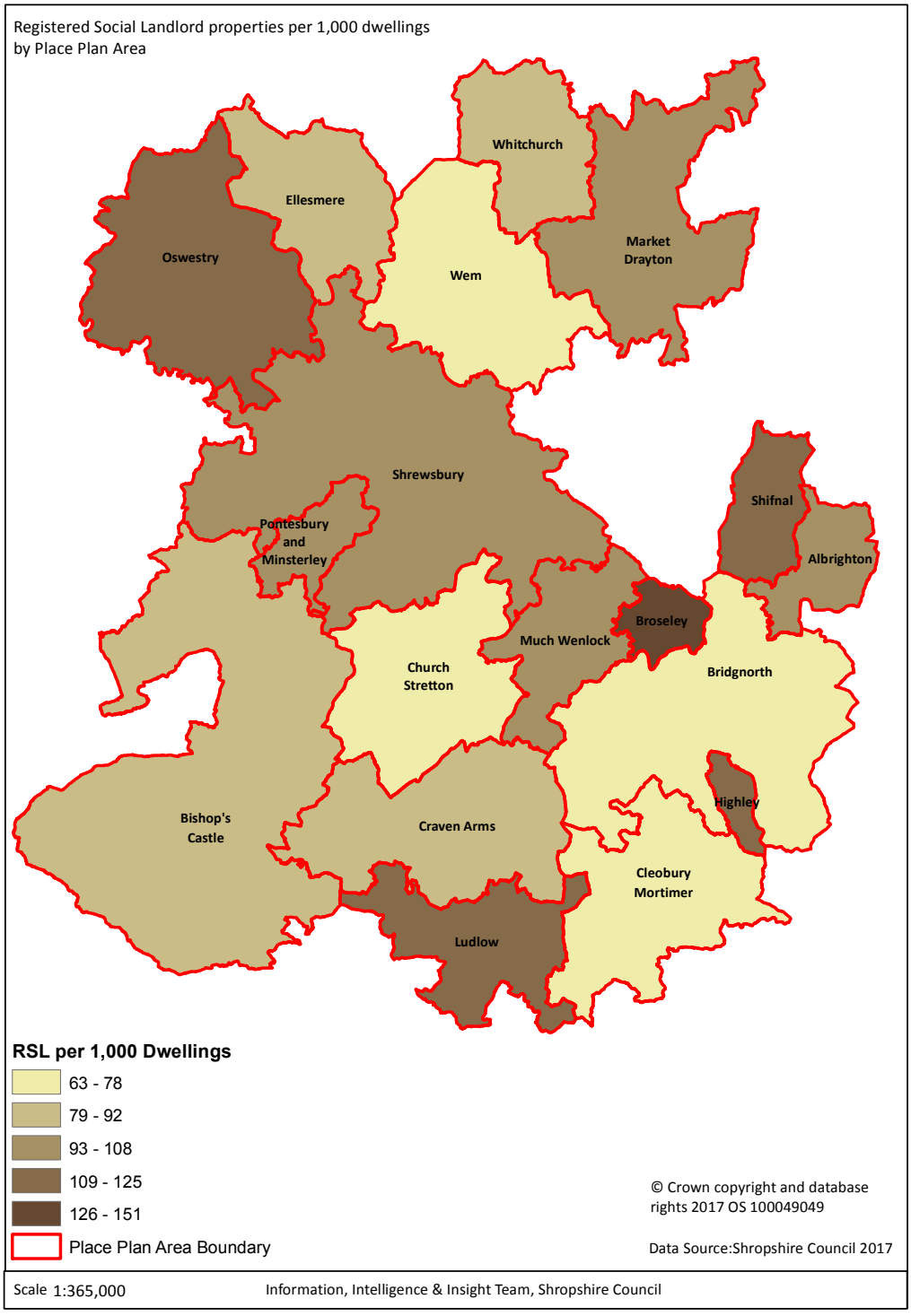
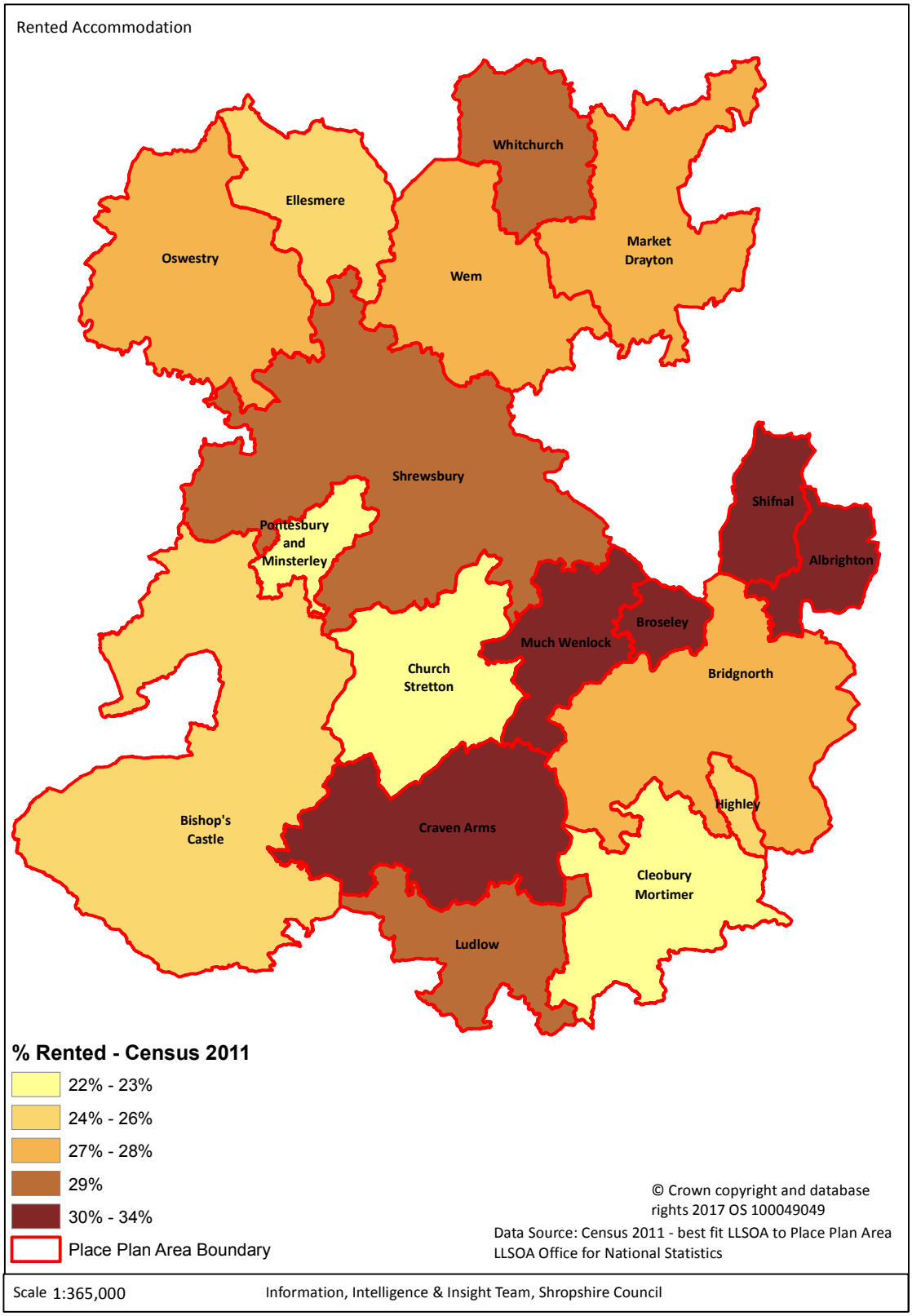


Figure 1.7. Proportion of rented accommodation in Shropshire County based on 2011 Census findings



Living alone

The locations with the highest densities of people aged over 65 years living alone are Albrighton, Much Wenlock, Church Stretton, Ludlow, Ellesmere and Wem. For people aged under 65 years, the greatest density of people living alone are in Sherwsbury, Ludlow and Whitchurch.

Figure 1.9. Proportion of one person households with a person aged 65+ years in Shropshire County based on 2011 Census findings

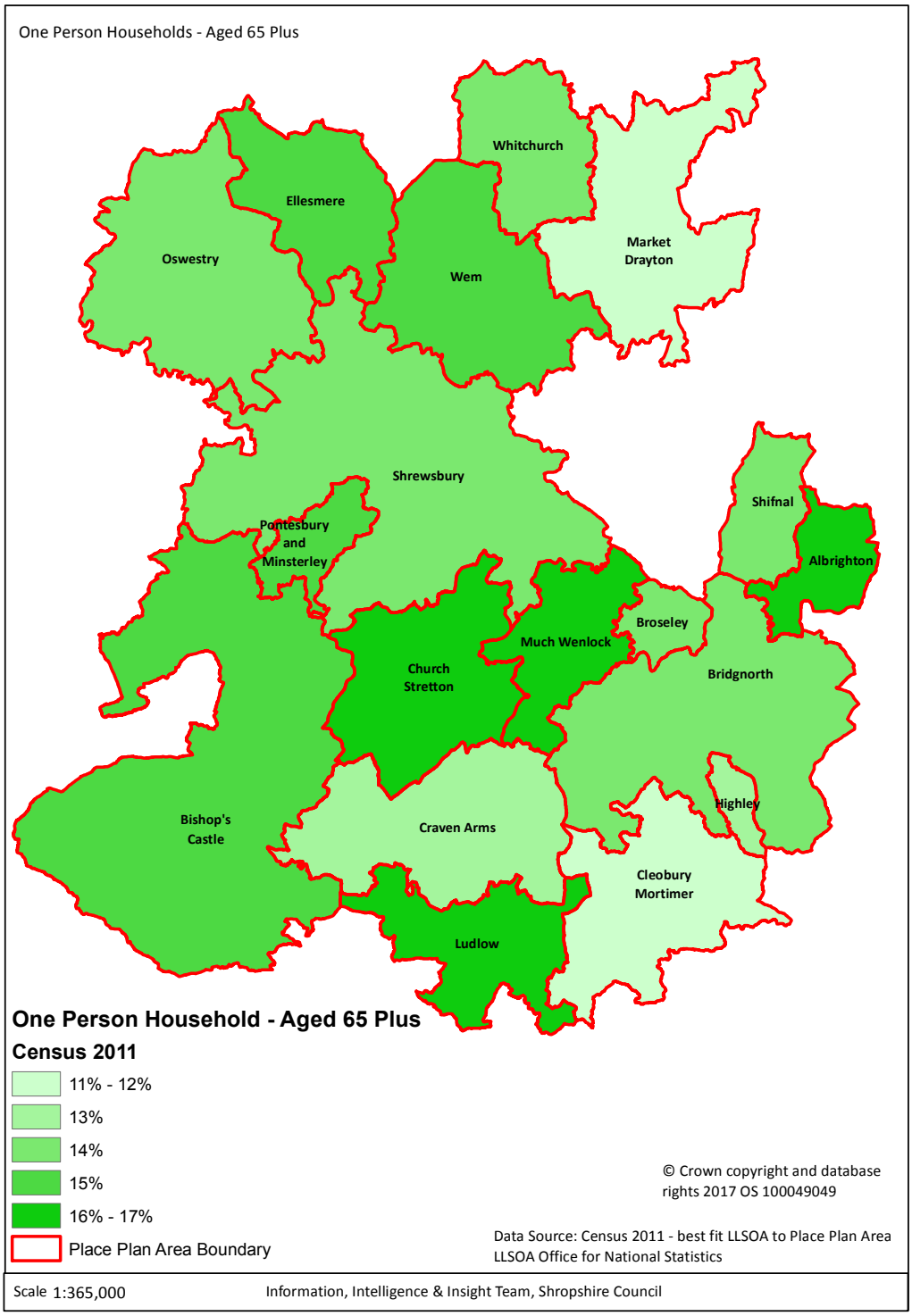
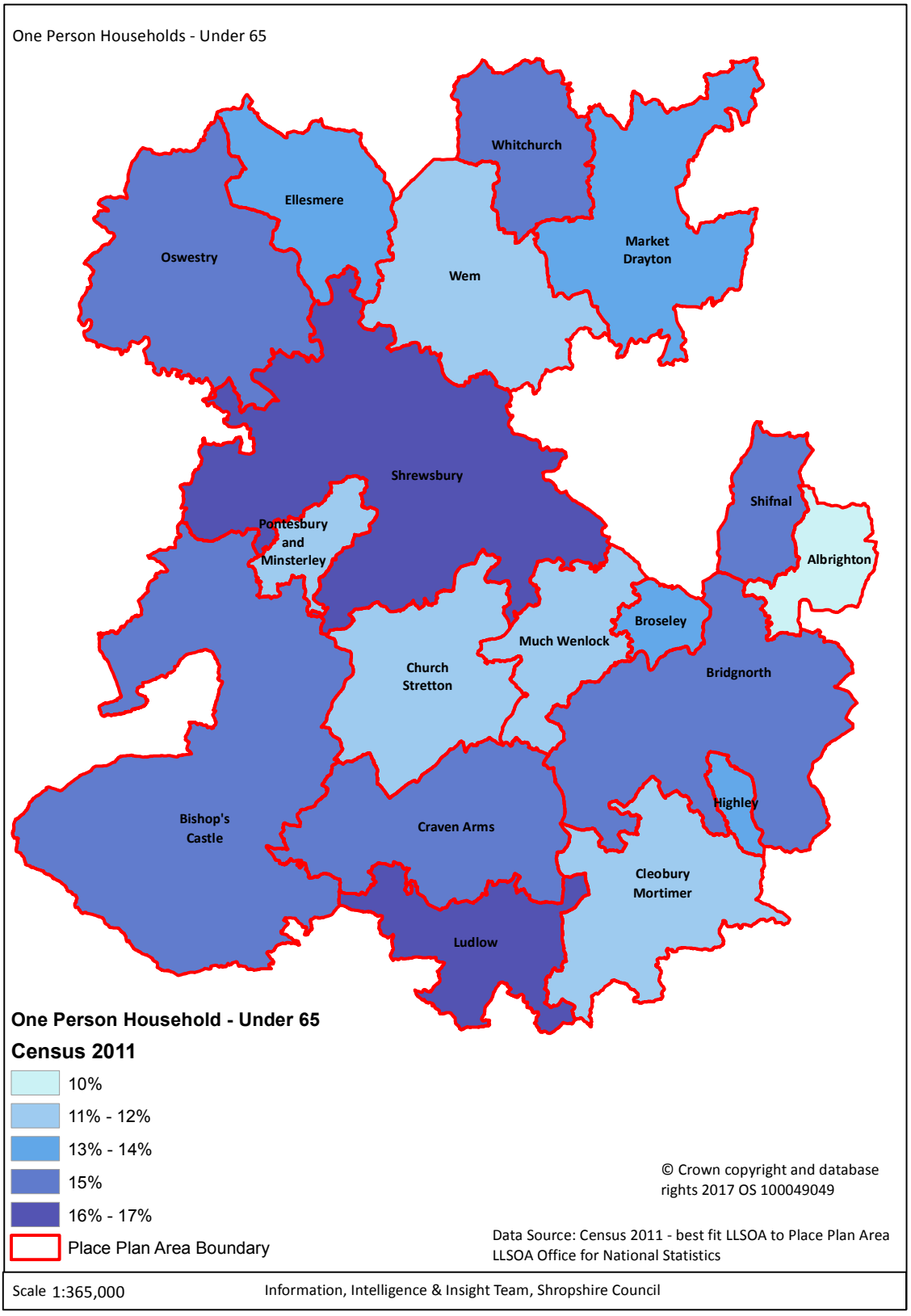


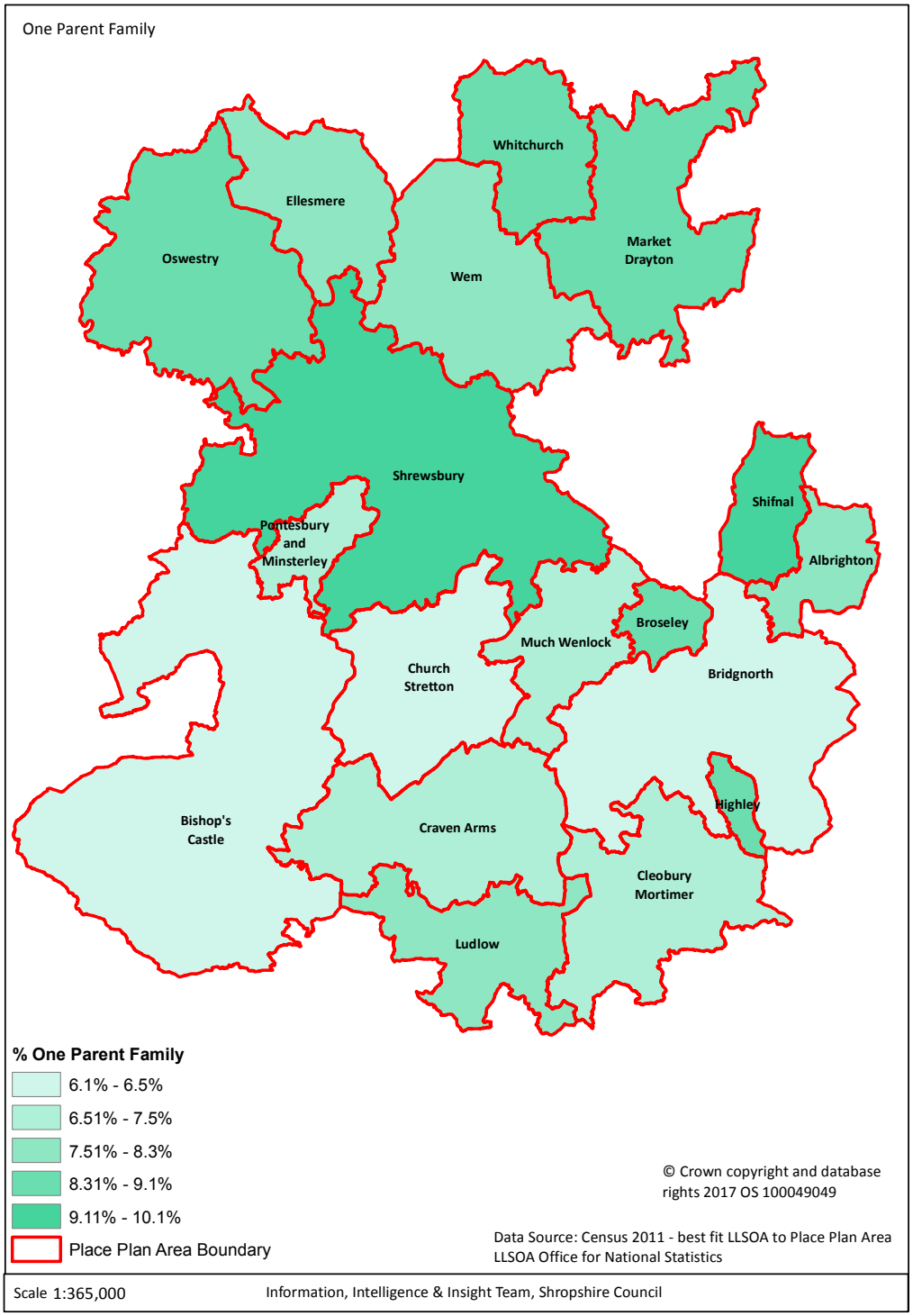
Figure 1.10 Proportion of one person households with a person aged less than 65 years in Shropshire County based on 2011 Census findings



Single Parent Family Households

The highest density of single parent family households are located in Shrewsbury, Shifnal, Market Drayton, Whitchurch and Highley.

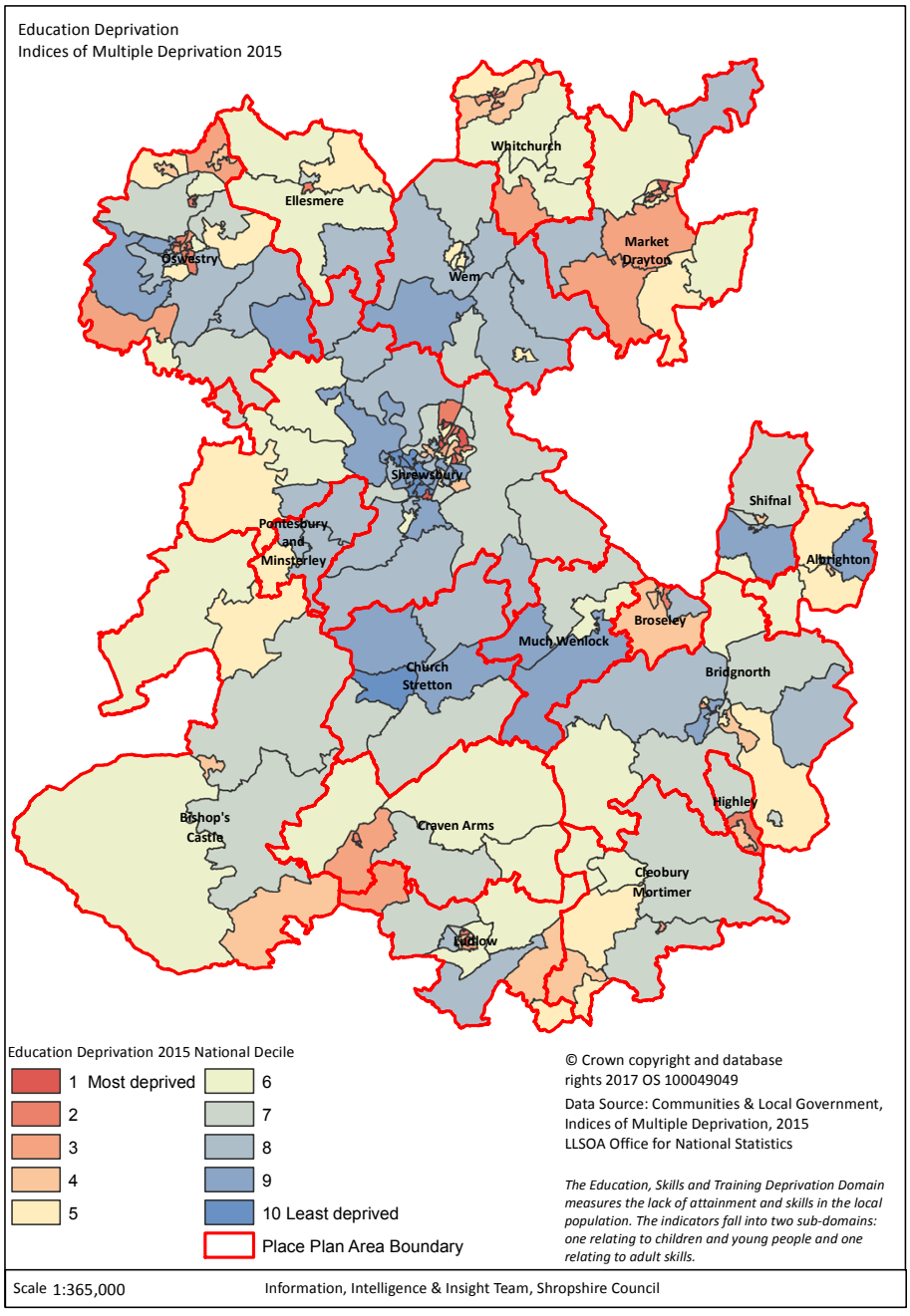
Figure 1.11. Proportion of one parent family households in Shropshire County based on 2011 Census findings



Education (all age)

The following map identifies the locations where the greatest deprivation of education attainment is recorded (based on key stages 2 and 4 outcomes, secondary school absence, post 16 years in education, entry to further education, adult skills and English language proficiency. It is seen that Market Drayton and Highley have the greatest density of poorer education outcomes although there are smaller level ward level localities also.

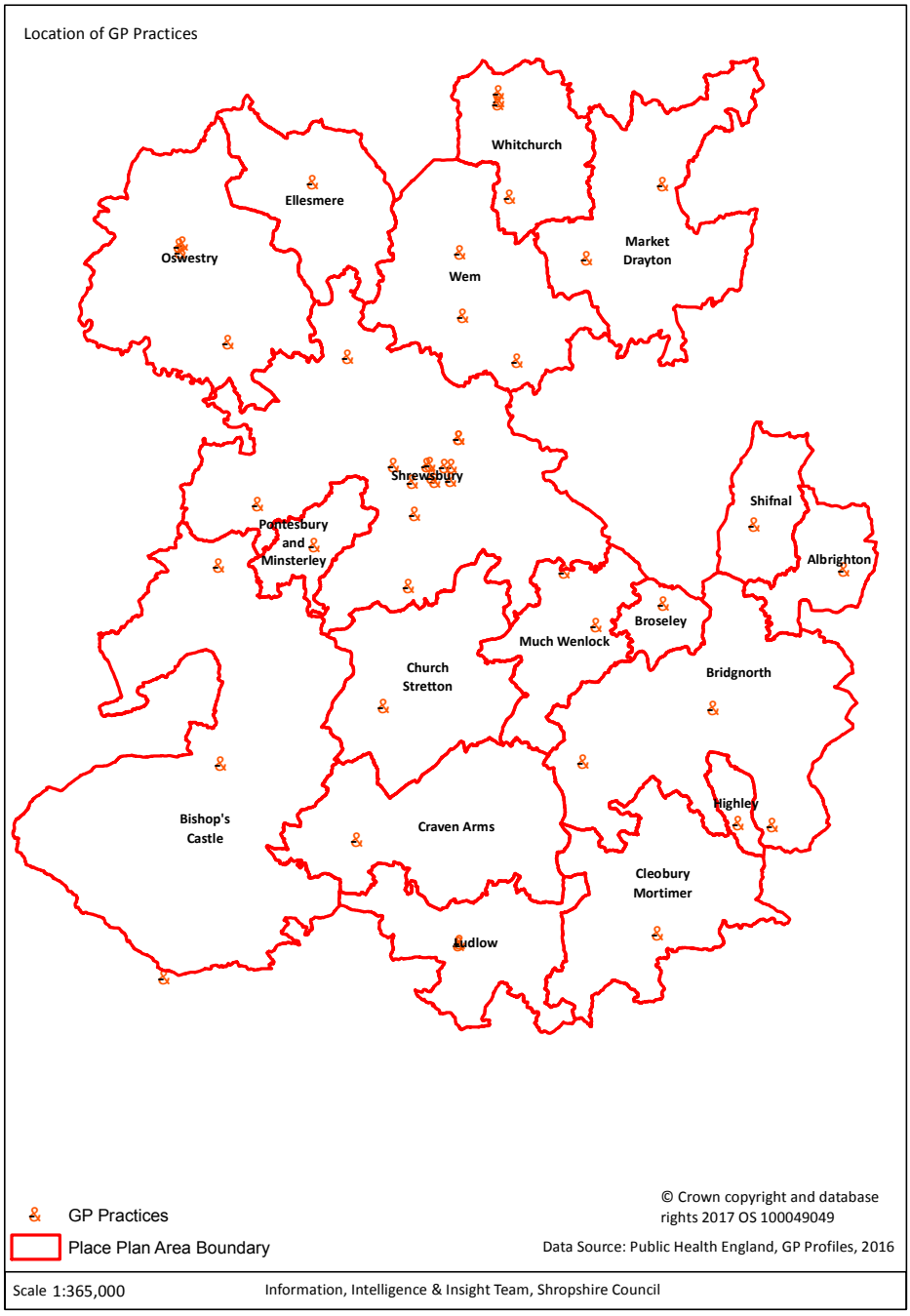
Figure 1.12. Education deprivation based on Indices of Multiple Deprivation (2015) in Shropshire County



Access to Services

Although currently it has not been possible to produce a single map with all health and social care services plotted, the following map provides an overview of GP locations across Shropshire. This is important (particularly in larger rural areas) as demonstrates a combination of population size against need but also highlights where some of the rural challenges of accessing primary care services will be.

Figure 1.13. Location of GP practices in Shropshire County



Section 2: Common mental health disorders

Common mental health problems relate to care clusters 1 to 7

Common mental health conditions (CMDs) comprise of different types of depression, anxiety and specific phobias which cause emotional distress, interfere with daily function and are often associated with physical and social problems (Goldberg and Huxley, 1992) but do not usually affect insight or cognition.

- Depressive Episodes: low mood and loss of interest and enjoyment in ordinary things and experiences
- Anxiety disorder: panic disorders, phobias, obsessive compulsive disorder and generalised anxiety disorder (GAD)

CMDs can result in physical impairment and both anxiety and depression often remain undiagnosed (Kessler et al, 2002) where individuals may not seek nor receive treatment. If left untreated, CMDs are more likely to lead to longer term physical, social and occupational disability and premature mortality (Zivin et al, 2015). Although, CMDs are less disabling compared to major psychiatric disorders, there is a higher prevalence of CMDs which in turn leads to a greater cumulative cost to society.

Chapter Summary

Generally, the mental health of people in Shropshire is better than the England average in terms of comparable rates of anxiety, depression, phobias, obsessive compulsive disorder and eating disorders.

The rates of CMD in Shropshire are significantly higher for women in comparison to men with a peak rate in the 25 to 44 year old range. This is in contrast to the younger peak age for CMD in men of 15 to 24 years. Deprivation in a common association with the localities with highest prevalence of CMDs (however, it cannot be ascertained if this directly cause or effect of a mental health problem).

It is often challenging to identify the true rate of mental health problems in the wider population and as such the findings of the latest Adult Psychiatric Morbidity Survey (2014) have been applied to the Shropshire population demographics (by age and gender). When this is applied, the highest rates of Common Mental Disorder (CMD's) in Shropshire relate to mixed anxiety and depression diagnosis.

Referral rates and the rate of people who enter into the Shropshire IAPT service are consistently lower compared to the England average which potentially could cause a gap between the numbers of those requiring an intervention and those receiving treatment. Once people have accessed the IAPT service however, a higher proportion of people complete treatment and move onto recovery compared to the England average and a similar proportion as to the national average achieve reliable improvement.

Findings from the Adult Psychiatric Morbidity Survey (2014)

National surveys of adult psychiatric morbidity were carried out in 1993, 2000, 2007 and 2014[22] to monitor mental illness and treatment with a large representative sample of the household population interviewed (including 7,500 aged 16 years or more and those who do not access services). Evidence from the Adult Psychiatric Morbidity Survey 2014 identifies a range of known associations with CMDs including;

[22] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England. Available at: http://content.digital.nhs.uk/catalogue/PUB21748

- Poverty
- Unemployment
- Being female
- Social isolation (adults under 60 years who live alone)
- Ethnicity (particularly black women)
- People in receipt of benefits
- People who smoke cigarettes

Key messages from the survey;

- Nationally there has been a slight but steady increase in the proportion of women with CMD symptoms since 2000, however this proportion has been stable amongst men. The increase in prevalence has been mostly seen at the more severe end of the CMD scale.
- There have been increases in CMD amongst late midlife mid-life men and women aged 55 to 64 years since the previous survey in 2007 and increases in young women aged 16 to 24 years.
- CMD symptoms are about three times more common in women aged 16 to 24 years (26.0%) compared to men (9.1%).
- Most people with an identified CMD reported by the Clinical Interview Schedule Revised (CIS-R) also perceived themselves to have a CMD. This is different to most of the other disorders assessed by the Adult Psychiatric Morbidity Survey.

CMD prevalence in Shropshire

Chart 2.1 displays the England rates for common mental disorders as identified within the Adult Psychiatric Morbidity Survey (2014) for males and females by age group. Chart 2.2 applies these rates to the mid year population estimates in Shropshire to provide estimated local prevalence.

Chart 2.2 suggests that prevalence of aggregated CMDs is consistently higher across all age groups for females compared to males. The greatest prevalence of CMD's are women aged 45 to 54 years and 55 to 54 years. Shropshire male prevalence remains at a similar number between the ages of 25 to 64 years where it is almost double that of males aged 16 to 24 years and males aged over 65 years. It estimated that in total there are 42,673 people with a common mental disorder in Shropshire (26,324 females and 16,348 males).

Chart 2.1: CMD reported in the past week by age and sex (APMS, 2014)

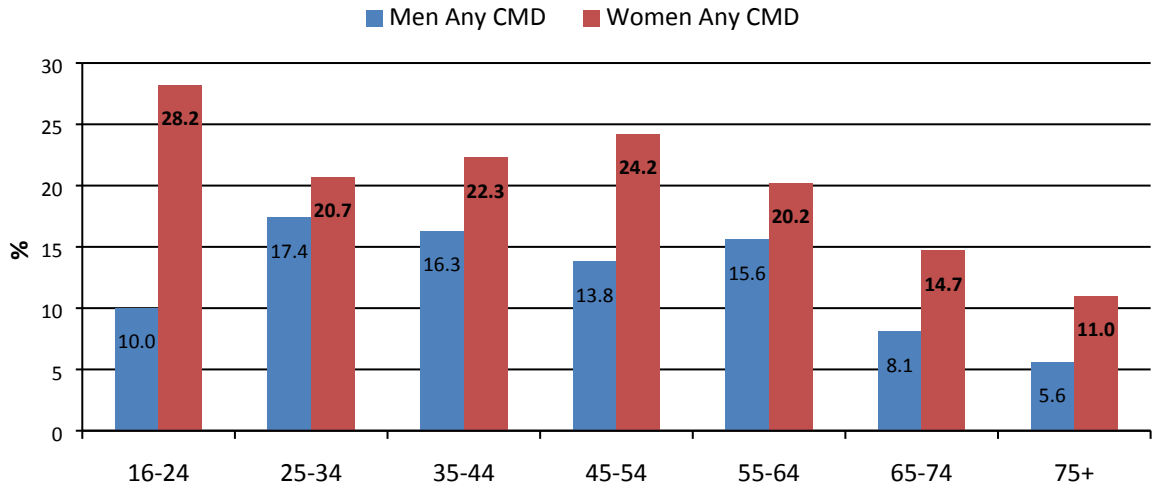


Chart 2.2: Estimated number of Common Mental Disorders for Shropshire males and females by age band, based on 2016 mid year population and rates identified in the APMS Survey

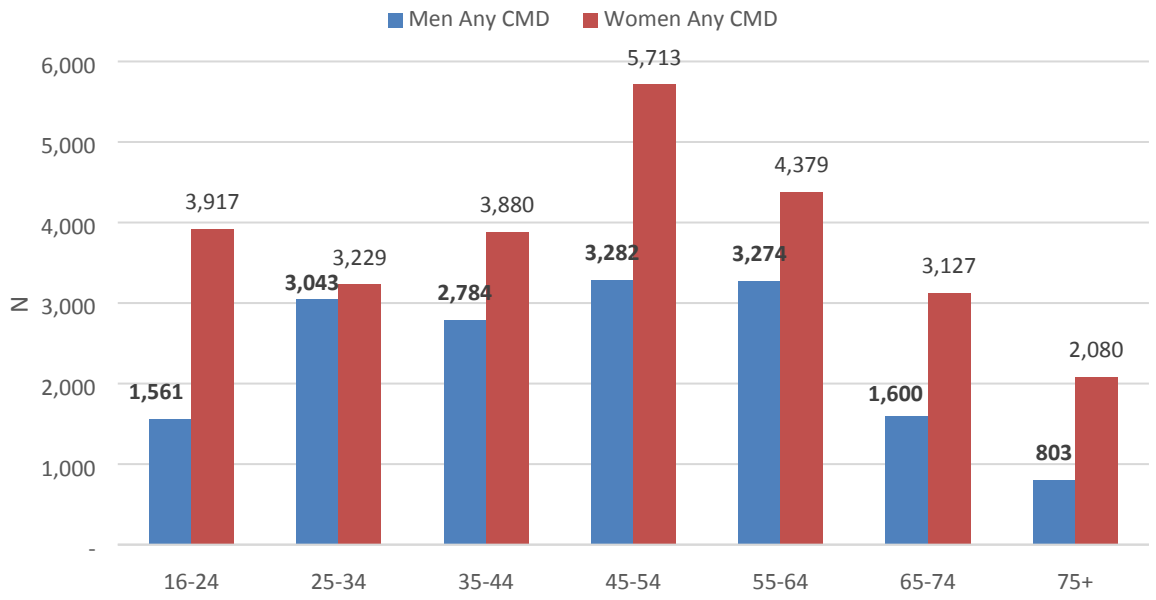


Chart 2.3 outlines the rates of specific CMDs for females as identified in the APMS (2014), where mixed anxiety/depression and general anxiety disorders are the most reported. When applied to the Shropshire 2016 mid year population (Chart 2.4), it can be seen that mixed anxiety and depression have the greatest reported prevalence across each group, with the highest seen in women aged 45 to 54 years.

Chart 2.3: CMD reported by Women the past week by age (APMS, 2014)

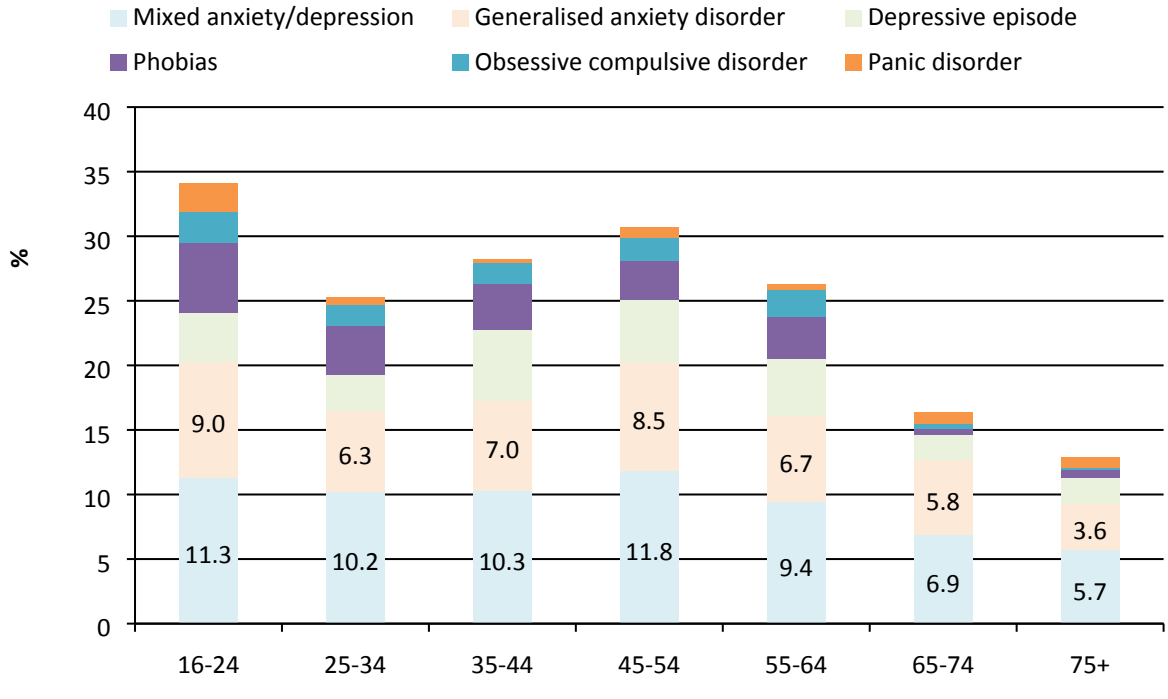
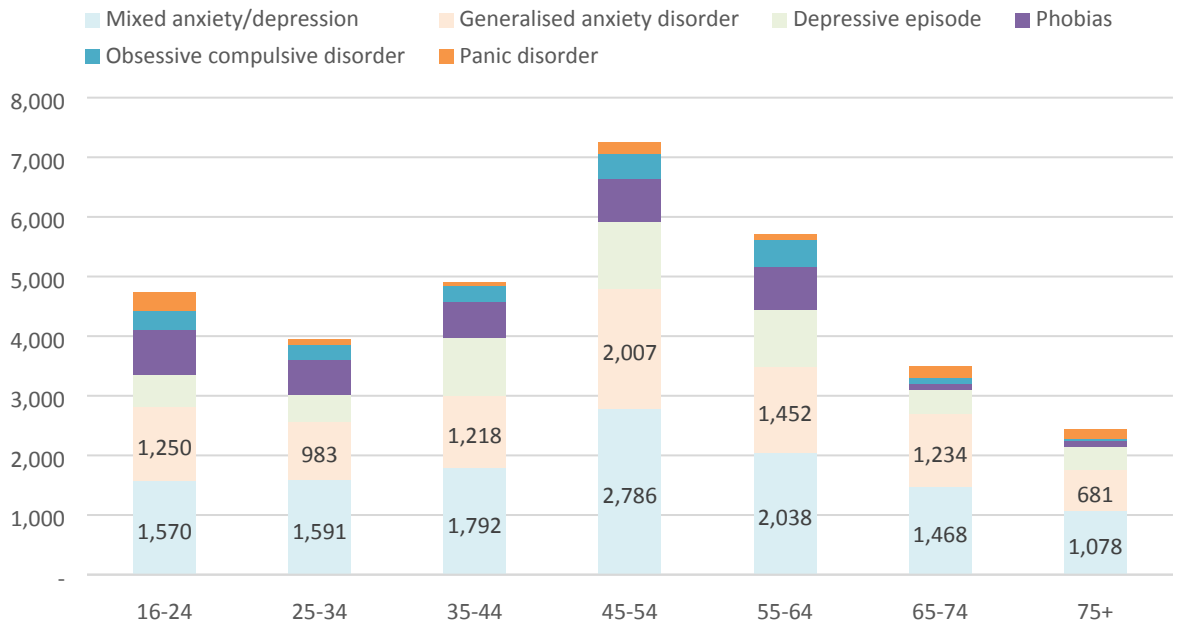


Chart 2.4: Estimated number of CMDs reported by Females the past week by age, based on mid year population rates (2016)



When the same process is applied to males, Chart 2.5 suggests the rates of mixed anxiety and depression are relatively consistent for those aged under 65 years. Chart 2.6 shows the estimated numbers of Shropshire males with specific CMDs and identifies confirms that mixed anxiety and depression are the most prevalent conditions.

Chart 2.5: CMD reported by Males the past week by age (APMS, 2014)

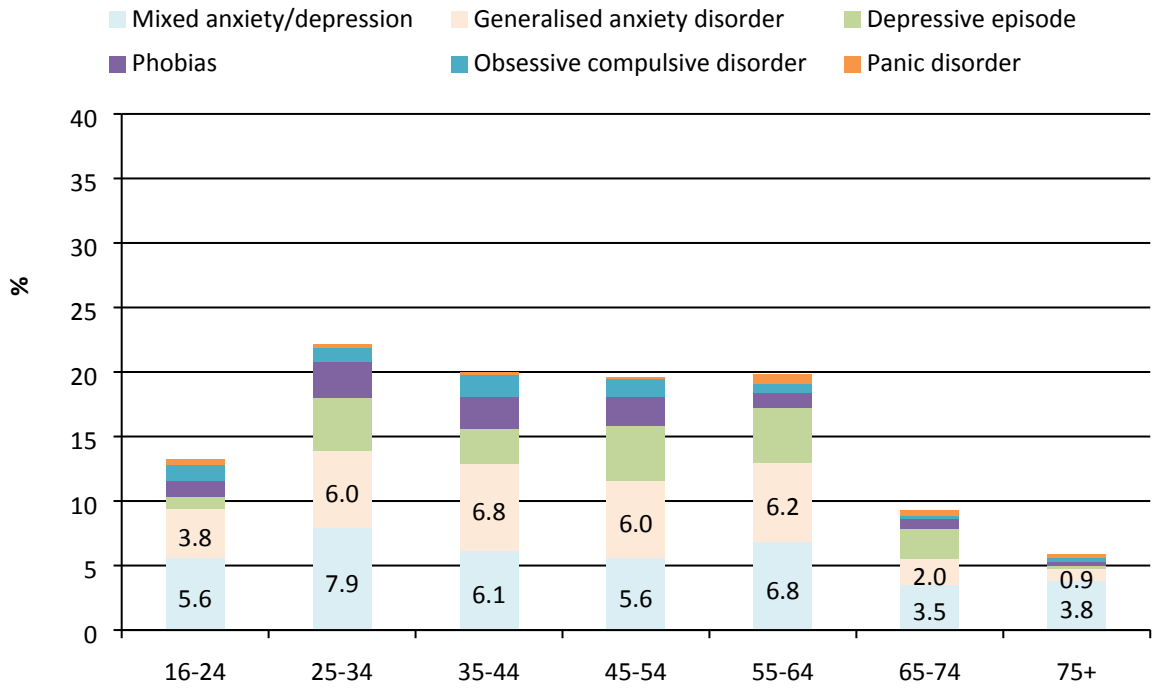
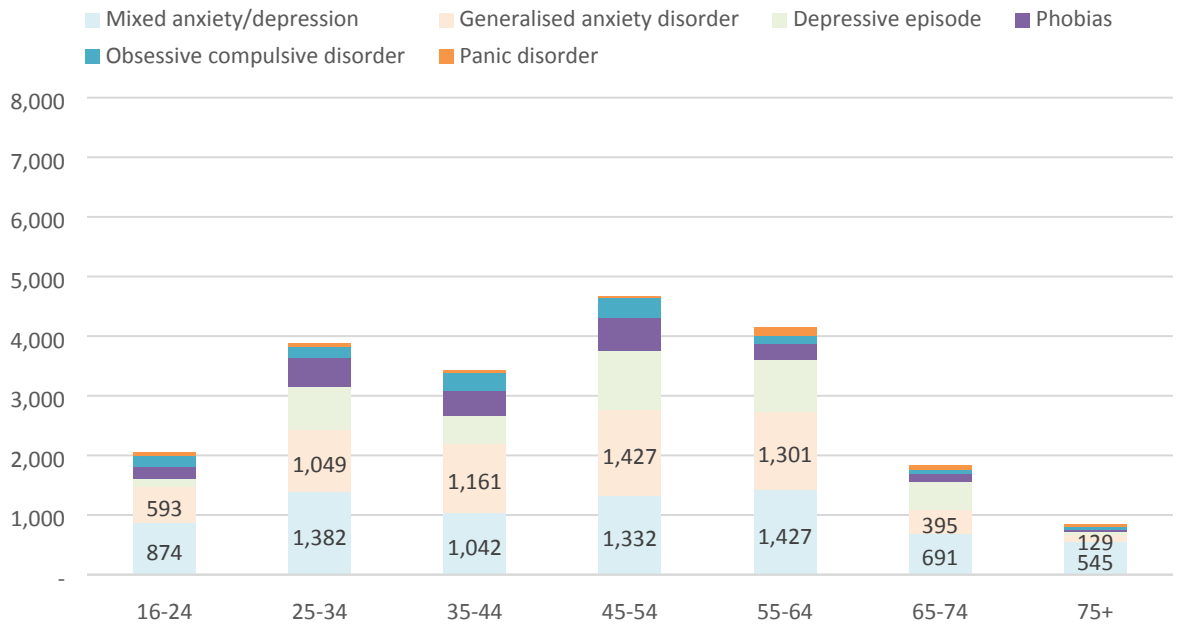


Chart 2.6: Estimated number of CMDs reported by Males the past week by age, based on mid year population rates (2016)



Comparison of Shropshire male and female CMD prevalence

When comparing the male and female prevalence in the following Charts (Charts 2.7a to f), it can also be seen that across all conditions there is a difference in prevalence across the ages and gender. For anxiety and depressive conditions, the greatest prevalence for both males and females is for those aged between 45 and 54 years, however males aged 25 to 34 years and 55 to 64 years have a higher prevalence of mixed anxiety/depression compared to the other male age groups for this condition.

Females aged 16 to 24 years have the highest prevalence of panic disorders with a secondary peak at 45 to 54 years and over 65 years. In comparison males have a peak of panic disorders at 55 to 64 years.

Female obsessive compulsive disorders peak between 45 and 64 years wheras males peak at 45 to 54 years.

Chart 2.7a: Mixed anxiety/depression

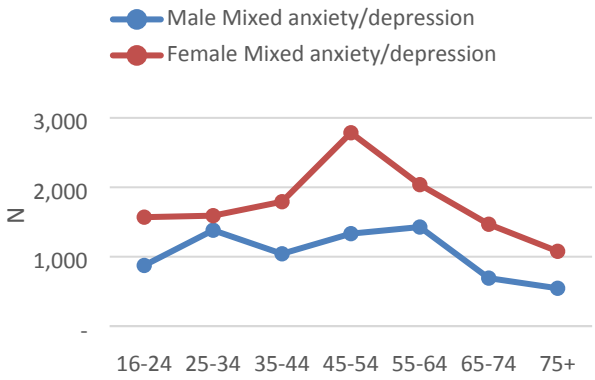
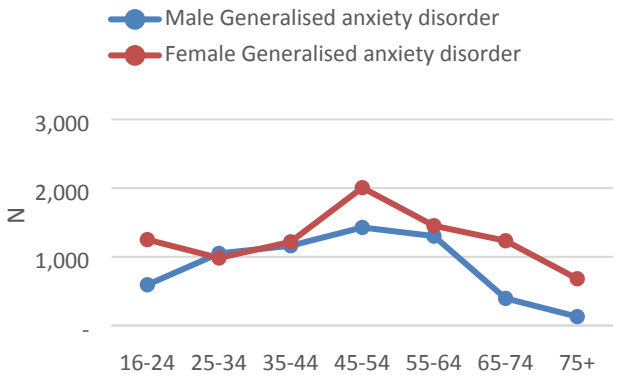
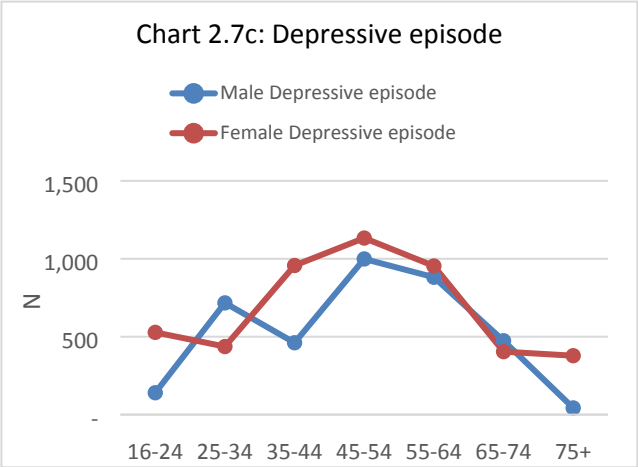
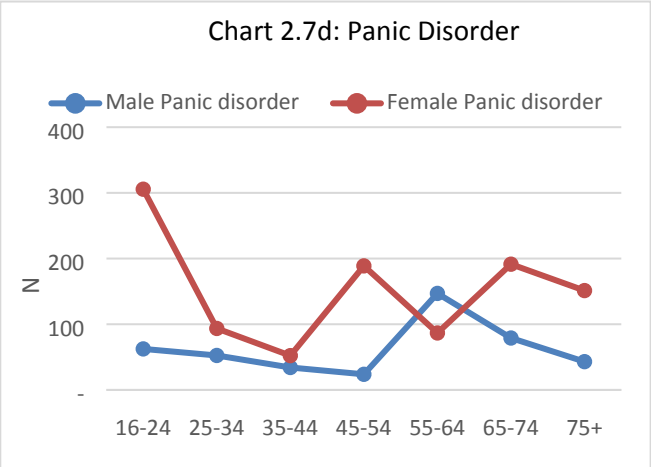
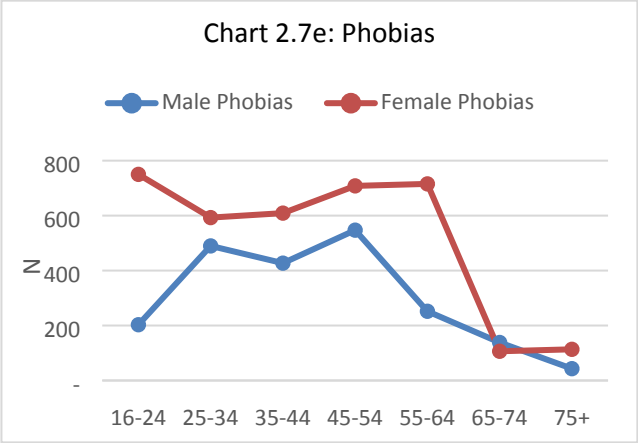


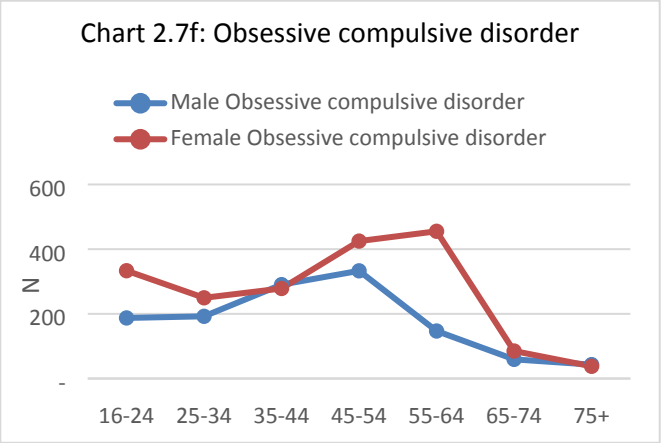
Chart 2.7b: Generalised anxiety disorder











Public Health England Fingertips Data

The Public Health England (PHE) health profiles utilise data provided from across health and social care services in England to provide summary indicators on a wide range of themes to support commissioining, production of Joint Strategic Needs Assessments, improve health and wellbeing and reduce inequalities. The profiles provide ability to browse indicators at different geographical levels and benchmark against the England average.

The table on the following page provides a summary of the key themes relevant to Mental Health taken from the PHE Fingertips data and compares how Shropshire is performing in comparison to the West Midlands and England averages (based on latest data available).

The PHE Fingertips data can be accessed via: https://fingertips.phe.org.uk

CMD outcomes for Shropshire (Public Health England Fingertips Data)

The following table outlines how Shropshire compares to the England average benchmarks for a number of factors related to common mental disorders.

Table 2.1:

Shropshire performing better than the England average	Shropshire performing worse than the England average	Shropshire performing similar to the England average
1. Mixed anxiety and depressive disorder: estimated % of population aged 16-74 • 2012: Shropshire at 6.6% (n= 14,809) was below the England (8.9%) and West Midlands averages (8.8%) 2. Generalised anxiety disorder: estimated % of population aged 16-74 • 2012: Shropshire at 2.8% (n=6,242) was below the England (4.5%) and West Midlands (3.6%) averages 3. Depressive episode: estimated % of population aged 16-74 • 2012: Shropshire at 1.28% (n=2,894) was below the England (2.5%) and West Midlands (1.7%) averages 4. All phobias: estimated % of population aged 16-74 • 2012: Shropshire at 1.08% (n=2,437) was below the England (1.8%) and West Midlands averages (1.5%) 5. Obsessive compulsive disorder: estimated % of population aged 16-74	1. Depression recorded prevalence (QOF): % of practice register aged 18+ • Increasing prevalence of depression in those aged 18+ between 2012/13 (6.0%) to 2016/17 (9.9%, n=24,470) • Shropshire was significantly higher than both the England average of 9.1% and similar to the West Midlands at 9.8% 2. Depression recorded incidence (QOF): % of practice register aged 18+ • Shropshire has an increasing incidence of depression in those aged 18+ each year from 2012/13 (1.1%) to 2016/17 (1.6%, n=3,965), this is above the England average however, follows a similar time trend line • An overall increasing trend indicating a growing local issue	1. Self-reported well-being: % of people with a low happiness score • 2015-16 the Shropshire percentage was similar to both the England and West Midlands averages with an overall decreasing trend 2. Self-reported well-being: % of people with a high anxiety score • 2015-16 the Shropshire percentage was similar to both the England and West Midlands averages • There was a significant increase in the Shropshire percentage between 2014-15 to 2015-16 indicating an improving trend 3. Estimated prevalence of common mental health disorders % of population aged 16-74 • Shropshire estimated percentage was 10.3% and below the estimated England average of 15.6%. 4. Depression and anxiety among social care users: % of social care users • 2013/14 the Shropshire percentage

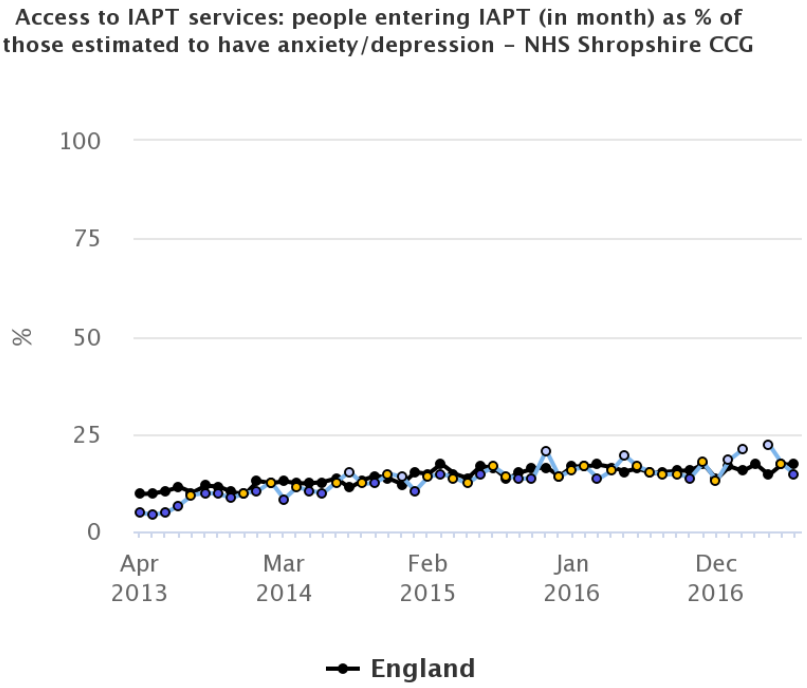
• 2012: Shropshire was below the England and West Midlands averages at 0.12% (n=263) 6. Panic disorder: estimated % of population aged 16-74 • 2012: Shropshire at 0.65% (n=1,454) was below the England (1.1%) and West Midlands averages (0.9%) 7. Eating disorder: estimated % of population aged 16 or more • 2012: Shropshire at 6.5% (n=14,755) was below the England (6.7%) and West Midlands averages (6.5%) 8. Admissions for depression: directly standardised rate per 100,000 population aged 15+ • 2009-10 and 2011-12 indicate that Shropshire was significantly lower (20.9%) than either the England average of 32.1% or the West Midland average of 32.5%. 9. Long-term mental health problems (GP patient survey): % of respondents aged 18+ • Shropshire CCG respondents aged 18+ was significantly lower (4.1%) than the England average of 5.2% or the West Midlands average of 5.4% • An overall increasing trend indicating a growing local issue		was higher than England 59.7% compared to 52.8%

Improving Access to Psychological Therapies (IAPT)

Improving Access to Psychological Therapies (IAPT) is an NHS programme that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression and anxiety disorders. Patients can either self-refer to the depression and anxiety service or can be referred via their GP/other services.

Chart 2.8 below plots the proportion of people estimated to have anxiety/depression who entered IAPT services in the recorded month. It can be seen there is variation around the national average however, there has been an increasing trend of access between April 2013 and June 2017 which is similar to the national trend.

Chart 2.8



Referrals into the IAPT service for adults over 18 years have been consistently lower in Shropshire compared to the national average since 2013/14 Q2 (latest local rate of 484 per 100,000 population compared to 807 per 100,000 in England).

It is recognised that not everyone who is referred to IAPT enters treatment however, since 2013/14 Q2, the Shropshire rate of people entering treatment has been consistently lower than the England average (as per Chart 2.9 below).

Chart 2.9

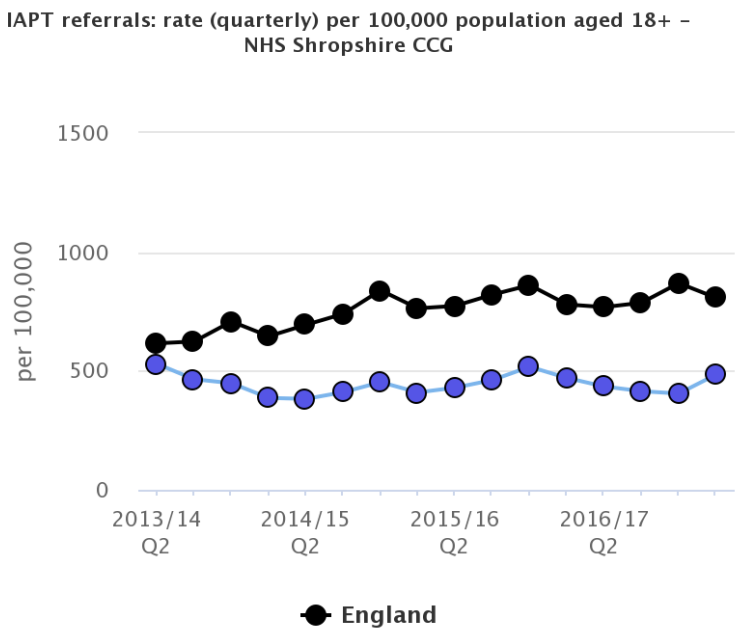


Chart 2.10 plots the proportion of referrals that have finished a course of treatment that waited less than 6 weeks for their first treatment (a standard measure of waiting time). It can be seen that since May 2015, there has been a higher proportion of people who waited less than 6 weeks for treatment compared to the national average (indicating less waiting time on average in Shropshire compared to the national average).

Chart 2.10

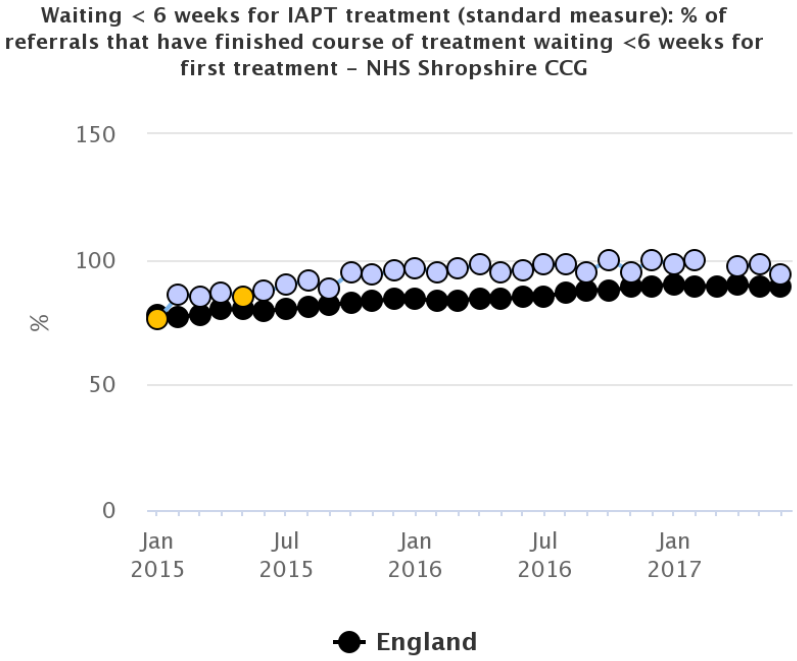
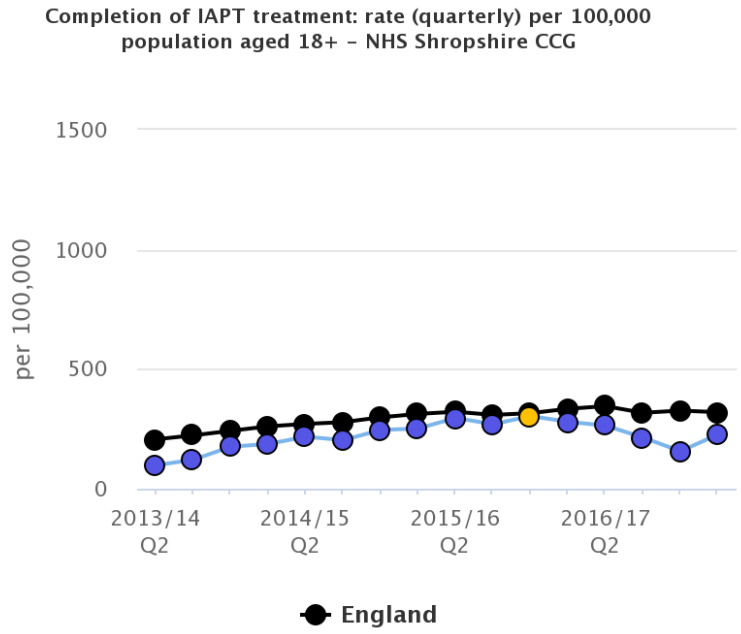


Chart 2.11 identifies that 226 per 100,000 population over 18 years (n=575) completed IAPT treatment during 2017/18 Q1. This is lower than the national average rate of 320 per 100,000 population and has been consistently below the England average for each quarter between 2013/14 to 2017/18 (with the exception of 2015/16 Q4 where a similar rate was recorded).

Chart 2.11



Since June 2015 the proportion of people who have completed their treatment and are moving to recovery has been similar or higher compared to the national average (see chart 2.12 below).

Chart 2.12

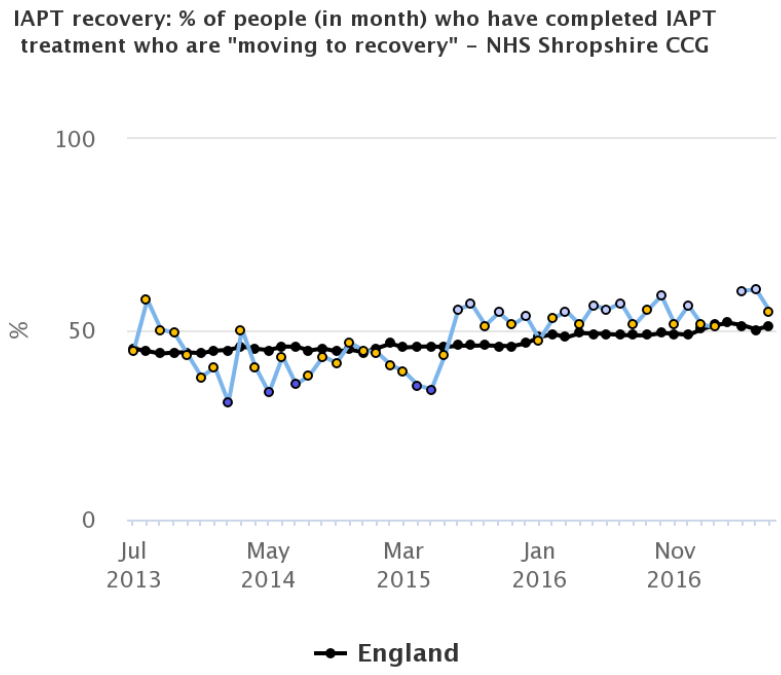
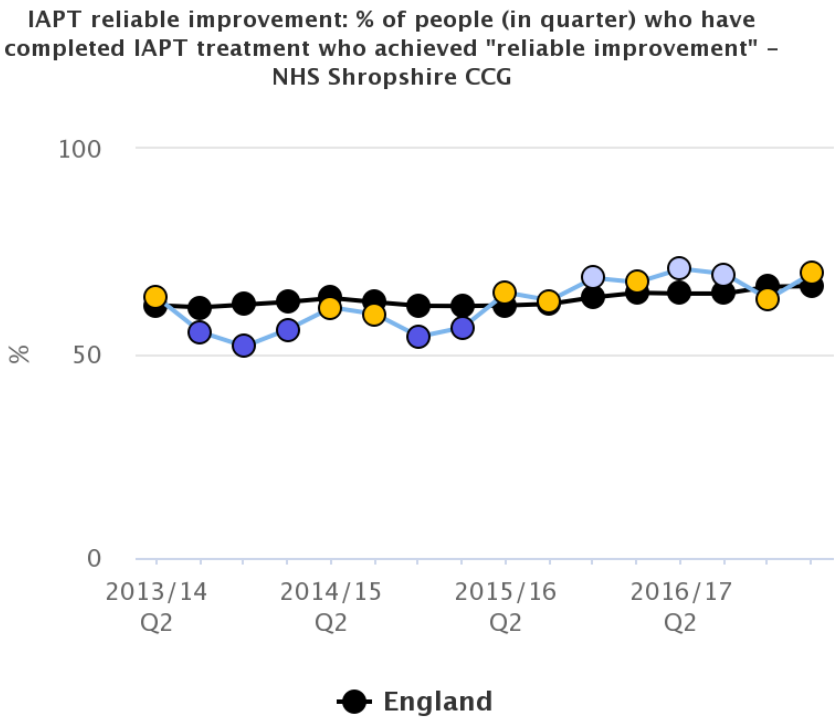


Chart 2.13 shows that 69.6% (n=400) of people who have completed their course of treatment and achieved “reliable improvement” in 2017/18, which is similar to the England average of 66.4%. It can also be seen that since 2015/16 Q2, this proportion has been similar or higher than the national average.

Chart 2.13


IAPT reliable improvement: % of people (in quarter) who have completed IAPT treatment who achieved "reliable improvement" – NHS Shropshire CCG
100
%
50
0
2013/14 Q2
2014/15 Q2
2015/16 Q2
2016/17 Q2
England

Demographics by Cluster

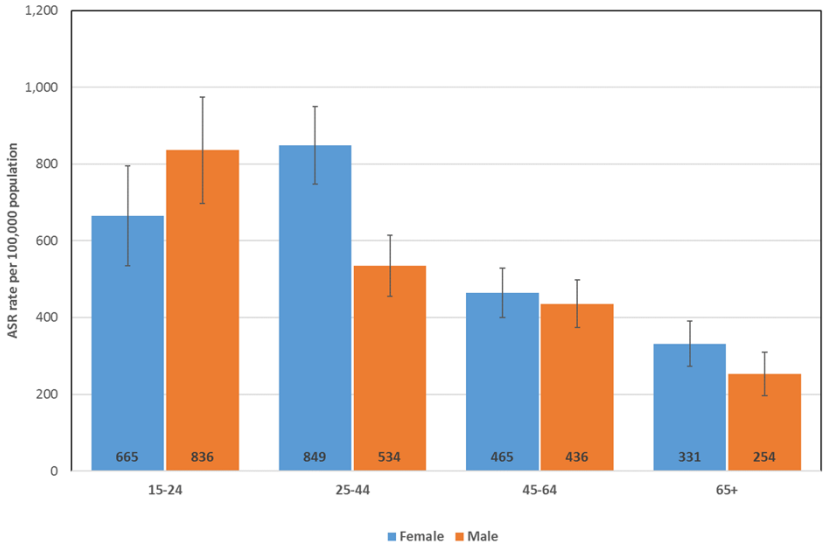
The following section provides a summary of CMD themes for Shropshire based on data from the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (February 2016 to February 2017).

Non Psychotic illness - mild, moderate, severe

Age and Gender:

- There were significantly higher rates for women compared to men in this group.
- Between the genders, there were significantly higher rates for females in the age band 25-44 but no significant difference across all the other age bands.
- Although there were higher rates for females aged 25-44, this was similar to age band 15-24 but significantly higher than age bands 45+.
- There were significantly higher rates of males in the 15-24 age band compared to all the other age bands.

Chart 2.14: Non-psychotic – mild, moderate, severe: by age and gender
Age standardised rates per 100,000 population

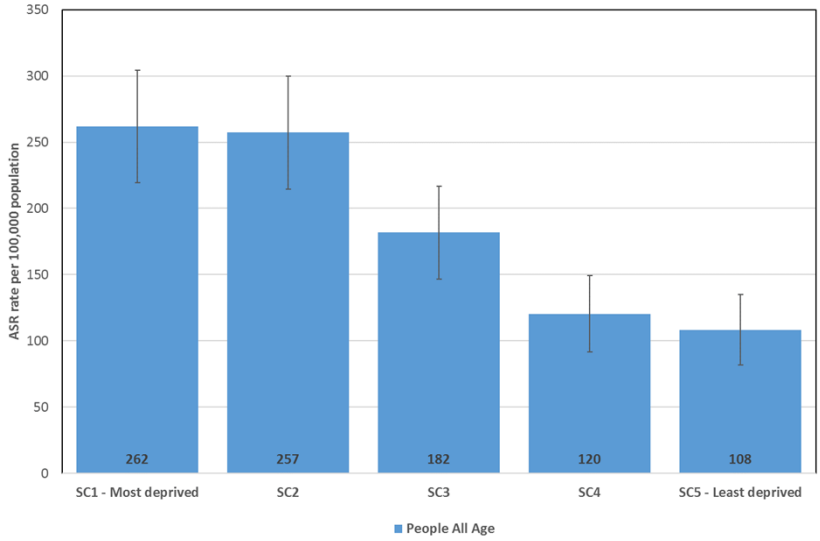


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

- Chart 2.15 overleaf shows that for all age, all gender there were significantly higher rates of people from the most deprived areas; quintile 1 and 2, compared to all the other quintiles
- The most deprived quintile is significantly higher than the least.

Chart 2.15: Non-psychotic – mild, moderate, severe: all age, all gender by deprivation
Age standardised rates per 100,000 population

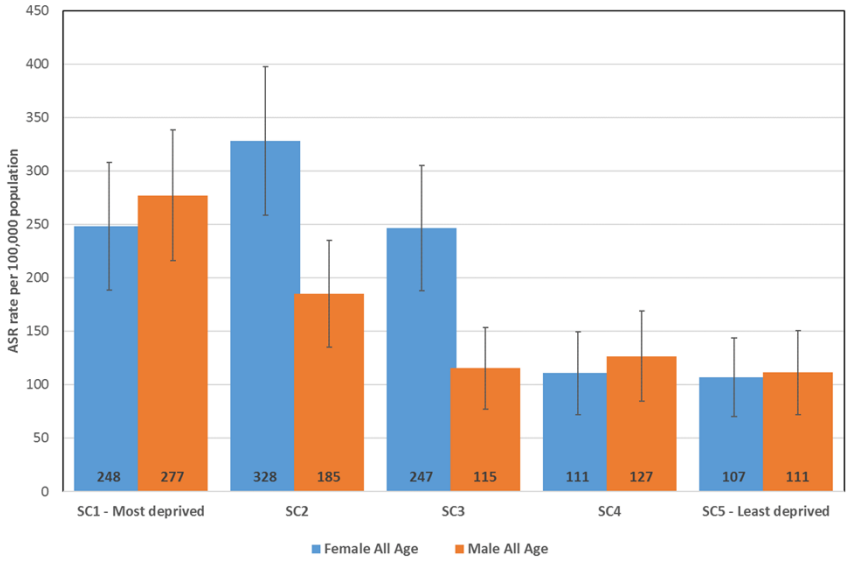


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 2.16 shows the comparison between the genders across all the deprivation quintiles.

- There were significantly higher rates of females compared to males in the more deprived quintiles SC2 and SC3, but the remaining quintiles were similar.
- Female rates were similar between the most deprived quintiles SC1-SC3; with the highest rate in SC2 but were significantly higher than the least deprived quintiles SC4-SC5.
- The pattern was similar for males with the highest rates from SC1 and SC2 being similar but SC1 being significantly higher than the least deprived quintiles SC3-SC5.

Chart 2.16: Non-psychotic – mild, moderate, severe: all age by gender by deprivation
Age standardised rates per 100,000 population

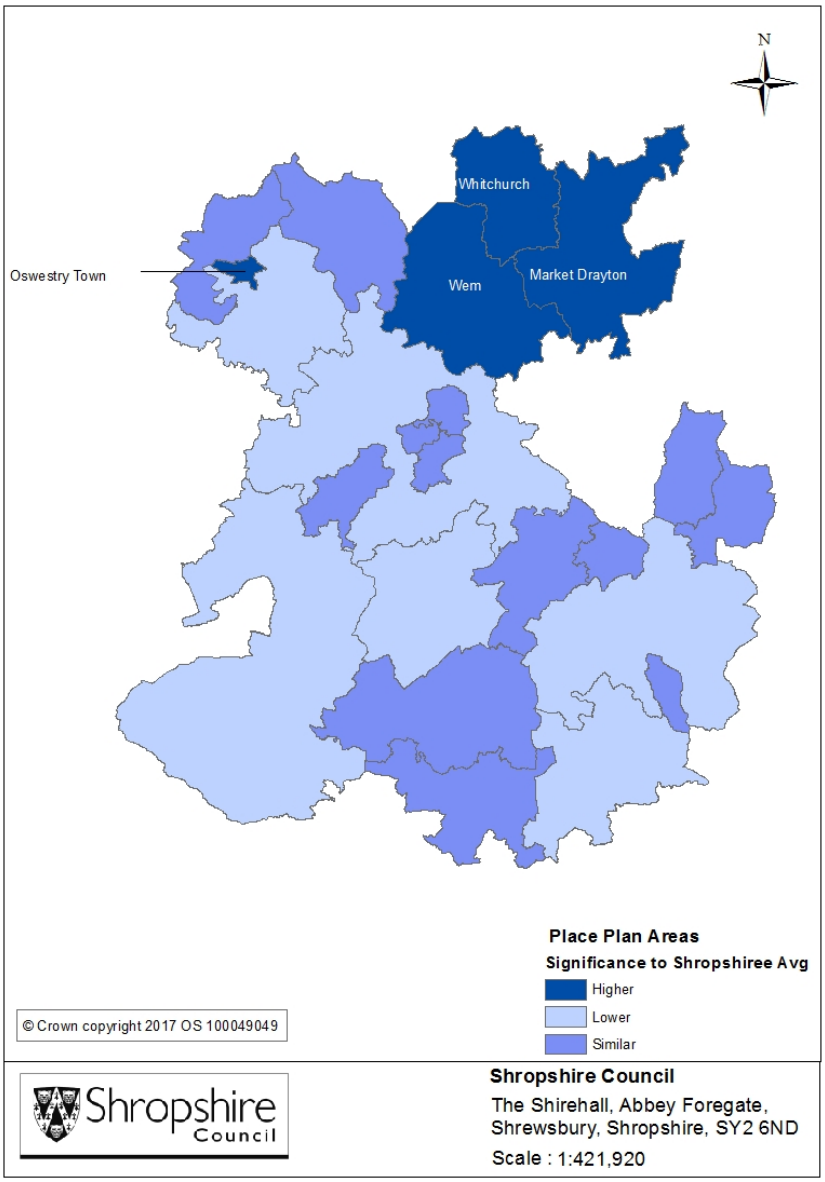


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Rurality:
There were similar rate of people from rural and town areas but significantly lower rates of people from urban areas for all age all gender.

Place Plan:
Highlighted in dark blue are the place plan areas that were significantly higher than the Shropshire average for non-psychotic – mild, moderate and severe cases and these were: Oswestry Town, Wem, Whitchurch and Market Drayton.

Map 1: Non-psychotic – mild, moderate, severe: all age all gender by place plan
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT)

Section 3: Severe and enduring mental illness

A mental health crisis often means an individual feels unable to cope or be in control of a situation. There may be feelings of emotional distress and high levels of anxiety where some individuals cannot cope with day-to-day life or work and could include thoughts about suicide, self-harm or hallucinations and hearing voices.

Chapter Summary

Rates of severe mental illness are lower compared to Common Mental Disorders however, the impact can be more complex. This chapter focuses on the themes of severe but non psychotic mental ill health, psychotic mental illness and psychotic crisis.

In Shropshire there are significantly higher rates of women with non psychotic but severe and complex mental ill health, with a peak identified in the 15 to 24 year group. Shropshire GP registers have a lower prevalence of recorded severe mental illness compared to the England average.

There are similar rates of men and women with ongoing psychotic episodes, however, the peak female rate is for those aged 45 to 64 years compared to males with a younger range between 15 to 44 years. The incidence of new cases of psychosis is significantly lower than the England average.

Men have a higher rate of psychotic crisis with no significant differences between the age bands.

There are strong associations between the areas with the highest rates of severe mental illness and living in the most deprived locations (except for those who had experienced a first episode of psychosis where the least deprived areas had a higher association).

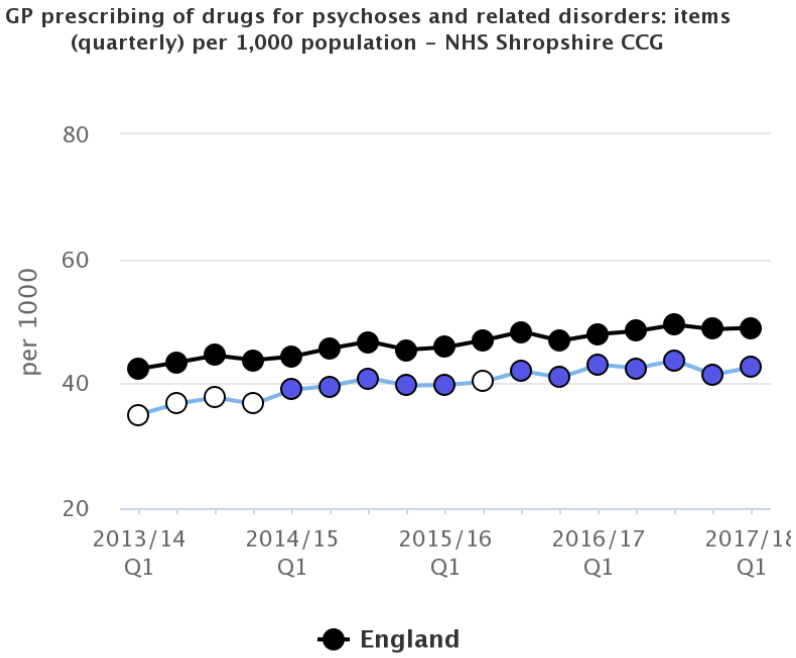
3.1 Severe and complex mental illness

The PHE Health Profiles identify the following trends for people with severe mental illness.

1. The estimated prevalence of psychotic disorder in people aged over 16 years in Shropshire is 0.36% (n=1,409) based on 2012 data

2. The rate of GP prescriptions of drugs for psychoses and related disorders has been consistently lower in Shropshire compared to the national average between 2014/15 Q1 and 2017/18 Q1 (as seen in Chart 3.1.1 below). Latest data (2017/18 Q1) indicates 42.6 per 1,000 population (n=12,931) in Shropshire have been prescribed psychoses drugs compared to 48.9 per 1,000 in England.

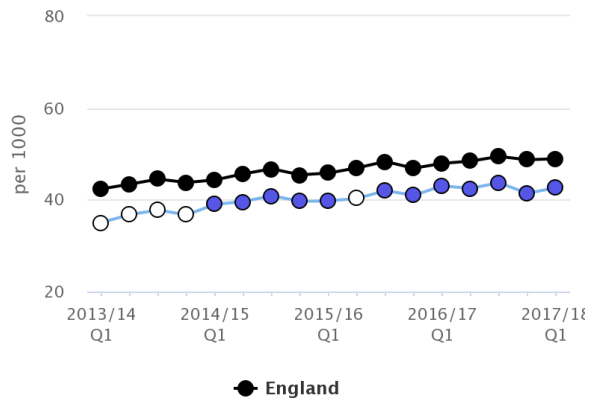
Chart 3.1.1



Severe and complex mental health outcomes for Shropshire (PHE Fingertips Data)

The following table outlines how Shropshire compares to the England average benchmarks for a number of factors related to severe and complex mental health outcomes.

Table 3.1.1: Severe and complex mental health outcomes

Shropshire performing better than the England average	Shropshire performing worse than the England average	Shropshire performing similar to the England average
1. The proportion of practice registers with recorded severe mental illness prevalence (QoF) for all ages, is consistently lower in Shropshire compared to the England average (shown in Chart 3.1.2 below). **Chart 3.1.2** GP prescribing of drugs for psychoses and related disorders: items (quarterly) per 1,000 population – NHS Shropshire CCG  2. Shropshire has a significantly higher proportion of people with long term conditions who feel they have had enough support from local services in the last 6 months (65.5%) compared to the England average of 63.1% and the West Midlands average of 63.8%. 3. Since 2016/17 Q4, the rate of people in Shropshire subject to the Mental Health Act has been lower than the national average. In 2017/18 Q1 the local rate was 9.8 per 100,000 (n=25) population compared 38.4 per 100,000 for England.	1. Latest data from 2011 identifies that Shropshire had a significantly higher percentage of the population (18.6%) with a long-term health problem or disability compared to the England average of 17.6%. Shropshire is however, lower than the West Midlands average of 19%	1. 16.3 per 100,000 population (n=911) estimated incidence for new cases of psychosis in Shropshire which is statistically similar to the England average of 18.1 per 100,000 population 2. The proportion of mental health service users who were inpatients in a psychiatric hospital in Shropshire has been consistently similar to the national average between 2016/17 Q2 and 2017/18 Q1. The latest reporting period indicates 1.7% (n=25) of mental health service users are in hospital in Shropshire compared to 1.8 nationally

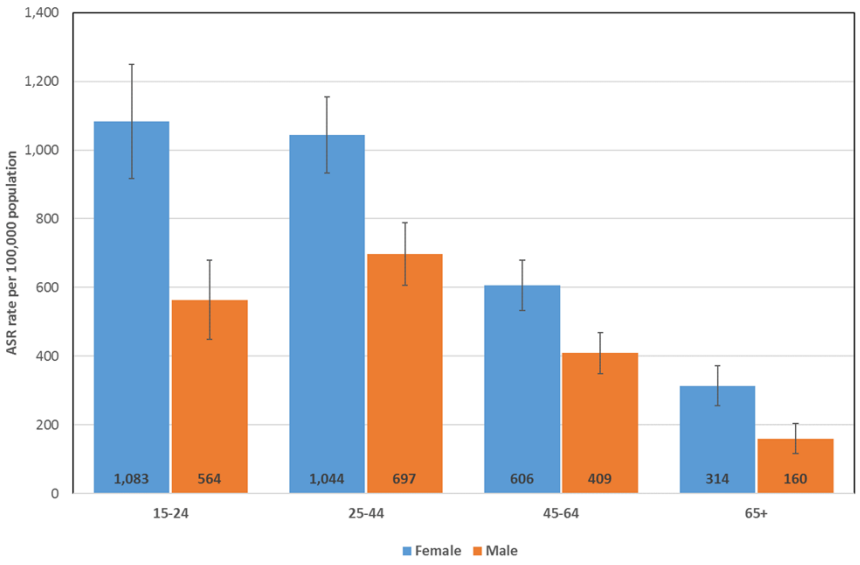
Findings from South Staffordshire and Shropshire Healthcare NHS Foundation Trust Intelligence Report (2017):

Non psychotic – very severe and complex disorders

Age and Gender:

- There were significantly higher rates of women compared to men with non-psychotic but severe and complex mental health illness.
- Between the genders, there were significantly higher rates of females compared to males across all the age bands with the highest rate in the 15-24 age band, which was similar to the 25-44 age band but was significantly higher than the 45+ age bands.
- The highest rates of males was in the 25-44 age band which was similar to the 15-24 age band but significantly higher than those in the 45+ age bands.

Chart 3.2.1: Non-psychotic – very severe and complex: by age and gender: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

Chart 3.2.2 shows the rate of deprivation for all age all gender is significantly higher for those from the most deprived quintile compared to all the other quintiles.

- The rates were similar between the genders across all the quintiles except SC3, which had a significantly higher rate of females to males.
- Female rates were highest from the most deprived area but similar to quintile 3 and significantly higher than those from the least deprived areas.
- Male rates were significantly higher for those from the most deprived quintile compared to all the other quintiles (Chart 3.2.3).

Chart 3.2.2: Non-psychotic – very severe and complex: all age all gender by deprivation: Age standardised rates per 100,000 population

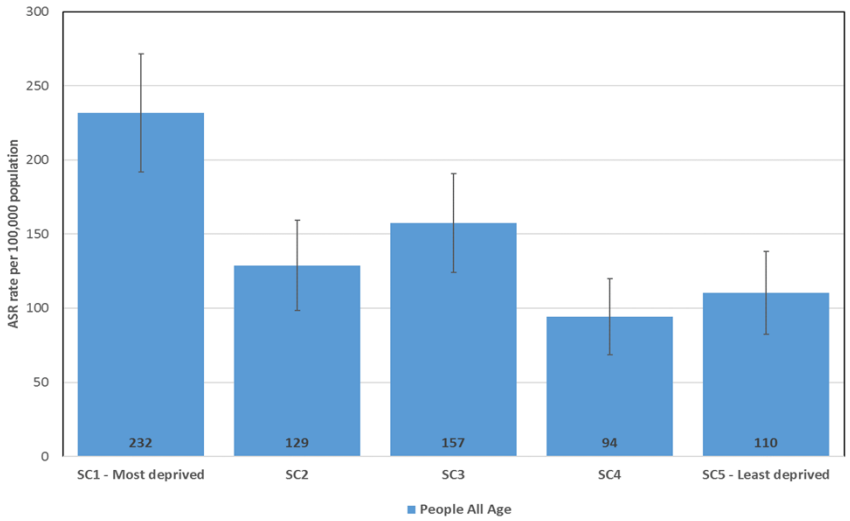
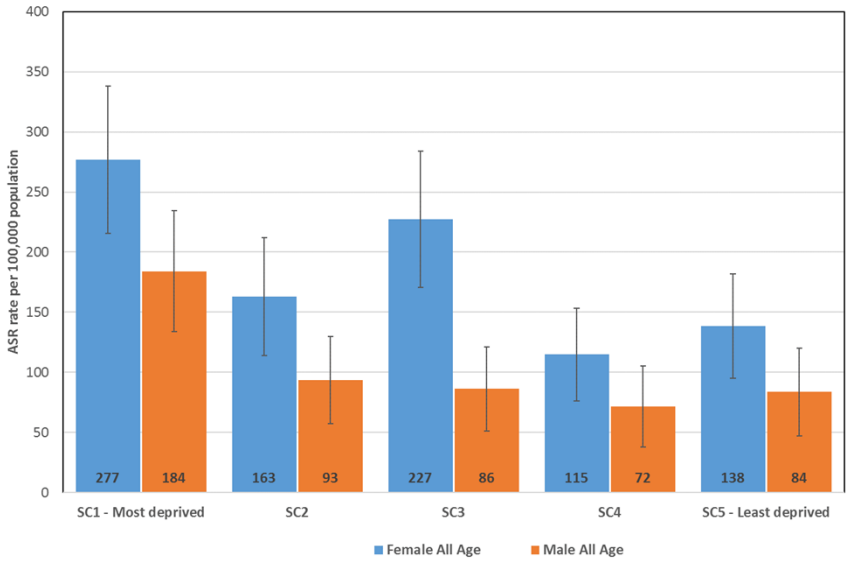


Chart 3.2.3: Non-psychotic – very severe and complex: all age and gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

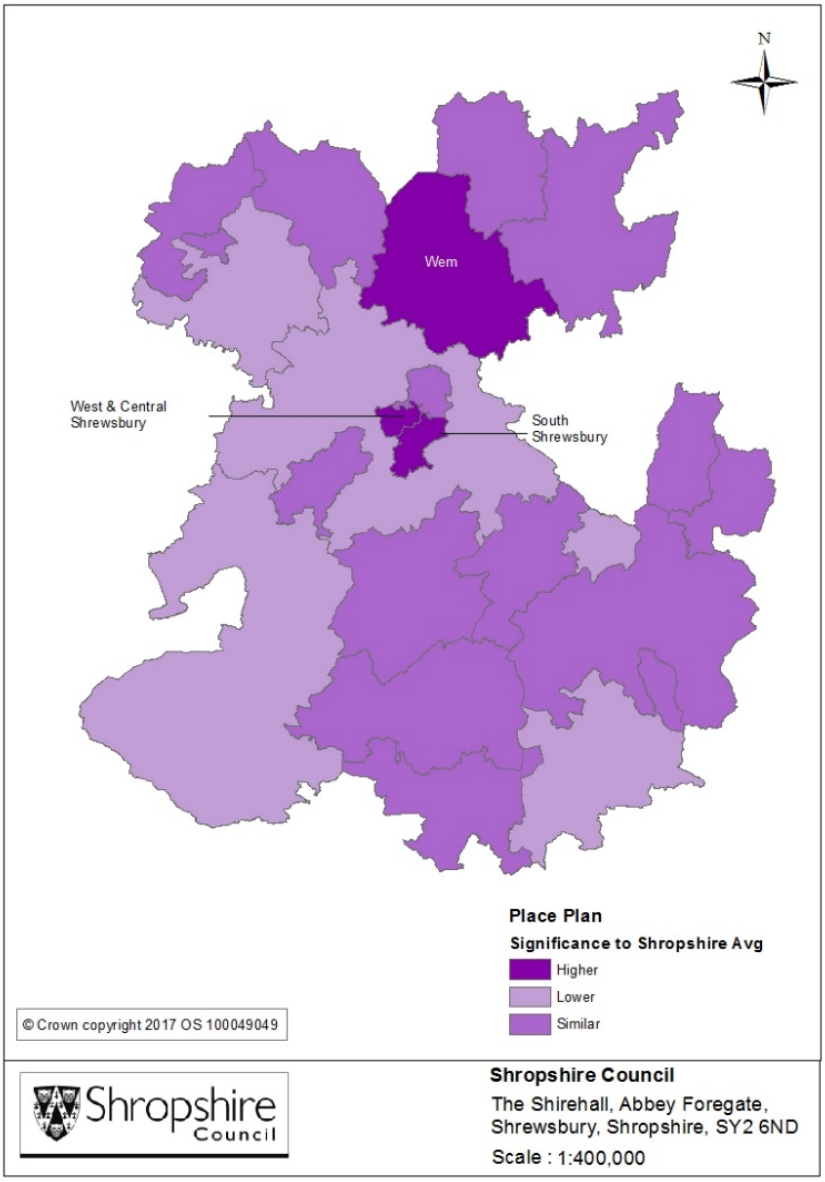
Rurality:

There were significantly higher rates of people from town areas compared to either rural or urban area, which were similar for all age and gender.

Place Plan:

Highlighted in the map overleaf, the dark purple are the place plan areas that were significantly higher than the Shropshire average for non-psychotic – very severe and complex cases and these were: Wem, West & Central Shrewsbury and South Shrewsbury.

Map *3.2.1:* Non-psychotic – very severe and complex: all age all gender by place plan
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

3.3 Psychotic Disorders

Psychotic disorders produce disturbances in thinking and perception that are severe enough to distort perceptions of reality. They include schizophrenia and affective psychosis.

Although psychotic illness is relatively uncommon there is a resulting high level of service and societal cost. The World Health Organisation calculates that the burden and human suffering associated with psychosis at the family level is only exceeded by dementia and quadriplegia. Research undertaken within the Adult Morbidity Survey identifies that people with a psychotic illness who live in the community have low rates of employment and when employed, are often in poorly paid and less secure jobs.

Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014

The key findings from the Adult Morbidity Survey 2014 (AMS) found the following common characteristic associations for people with a psychotic disorder;

- Higher rates in black men compared to men from other ethnic groups
- Economically inactive
- Receipt of benefits (claimants of Employment and Support Allowance)
- People who live alone (social isolation)

Key messages from the APMS on a national level include;

- Prevalence of psychotic disorder in the past year: less than 1 adult in 100 was identified with a psychotic disorder (0.7% in 2014)
- Prevalence of psychotic disorder in the past year by age and sex: No difference in rate was found between men and women (0.5% men and 0.6% women).
- In both men and women the highest prevalence was in those aged 35 to 44 years

Chart 3.3.1 identifies the estimated numbers of diagnosed psychotic disorders by age group, based on the application of national rates from respondents of the APMS (2014) and applied to the Shropshire mid year population estimates.

The numbers are small compared to common mental disorders with an estimated 1,299 psychotic disorders in Shropshire (548 for males and 742 for females). Chart 3.1 shows the peaks for both males and females are for ages 35 to 44 years and 55 to 64 years, with female numbers being slightly higher than males for those aged 16 to 35 years and aged 55 or more.

Due to the difficulties often associated with missing data where confirmation through SCAN interview was not undertaken in assessment. (SCAN is a set of instruments and manuals aimed at assessing, measuring and classifying psychopathology and behaviour associated with the major psychiatric disorders in adult life.)

Chart 3.3.2 identifies the estimated numbers of Shropshire people by age who are classified as having a probable psychotic disorder. This has been calculated in the same manner as Chart 3.1 using mid year population estimates and APMS rates. The Chart shows that although male prevalence peaks are the same as in Chart 3.1, the female peak is clearly defined for the 45 to 54 year old group.

Chart 3.3.1: Estimated number of Psychotic disorders in the past year based on mid year populations (2016) for Shropshire males and females by age and rates in the APMS (2014)

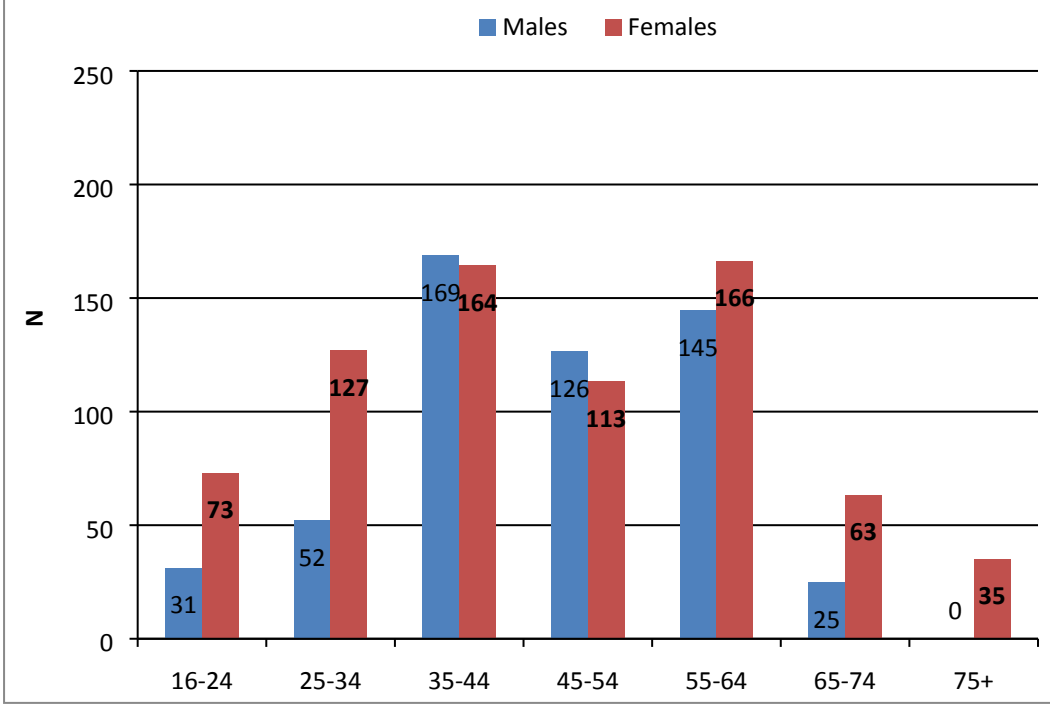
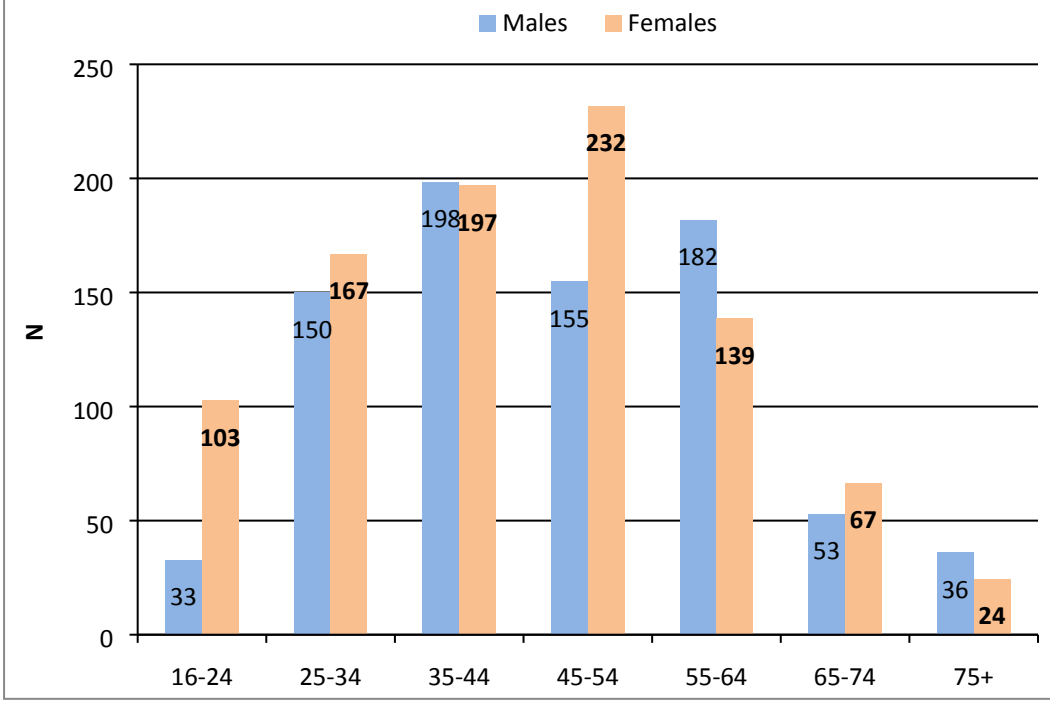


Chart 3.3.2: Estimated number of Probable Psychotic disorders in the past year based on mid year populations (2016) for Shropshire males and females by age and rates in the APMS (2014)



Public Health England Health Profile for Shropshire

Key messages from the Health Profiles indicate the following trends. Note there were no areas on the Profile where Shropshire was recorded as performing worse than the national average;

Shropshire performing similar to the England average
1. Social care mental health clients receiving services: rate per 100,000 population ▪ 2012-13 to 2013-14 Shropshire rates were significantly below both the England average and the West Midlands average. ▪ Shropshire rate in 2013-14 was 108 compared to the England average of 384 and the West Midlands rate of 247. ▪ Both the Shropshire County and England trends were decreasing
2. Schizophrenia emergency admissions: rate per 100,000 population aged 18+: ▪ 2011-12 were significantly lower than either the England or West Midlands averages. ▪ 2009-10-2011-12 the England rate (57) increased at a higher rate compared to Shropshire at 37
3. New cases of psychosis: estimated incidence rate per 100,000-population aged 16-64 ▪ 2011 synthetic data: Shropshire rates (16.3) were significantly lower than either the England average of 24.2 or the West Midlands average of 25

Findings from Shropshire County Mental Health Services Intelligence Report (Feb 2016 – Feb 2017)

In this section 4 groups of psychosis were defined;

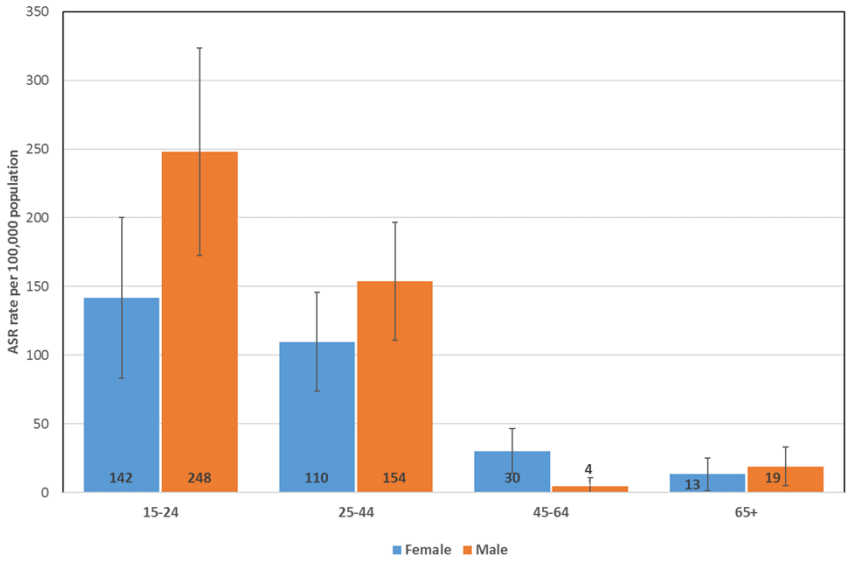
- Group 1: psychosis 1st episode
- Group 2: psychosis ongoing or recurrent
- Group 3: psychotic crisis
- Group 4: very severe engagement

Group 1: psychosis 1st episode

Age and Gender:

- There were similar rates between males and females for all ages and across all the age bands except for those aged 45-64 where there were significantly higher rates of females to males.
- For both males and females, rates were higher in 15-24 age band but were similar to those aged 25-44 but significantly higher than those aged 45+.

Chart 3.3.3: Psychosis - 1st episode: by age and gender: Age standardised rates per 100,000 population

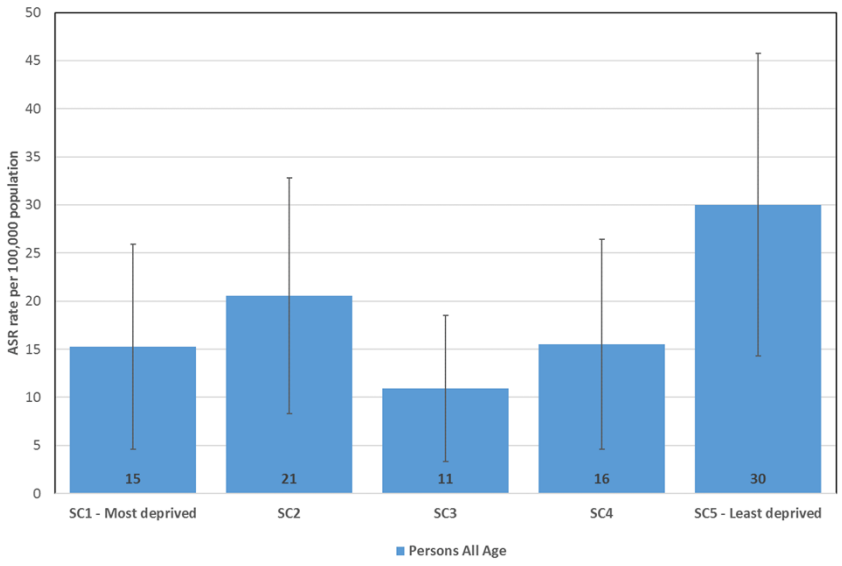


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

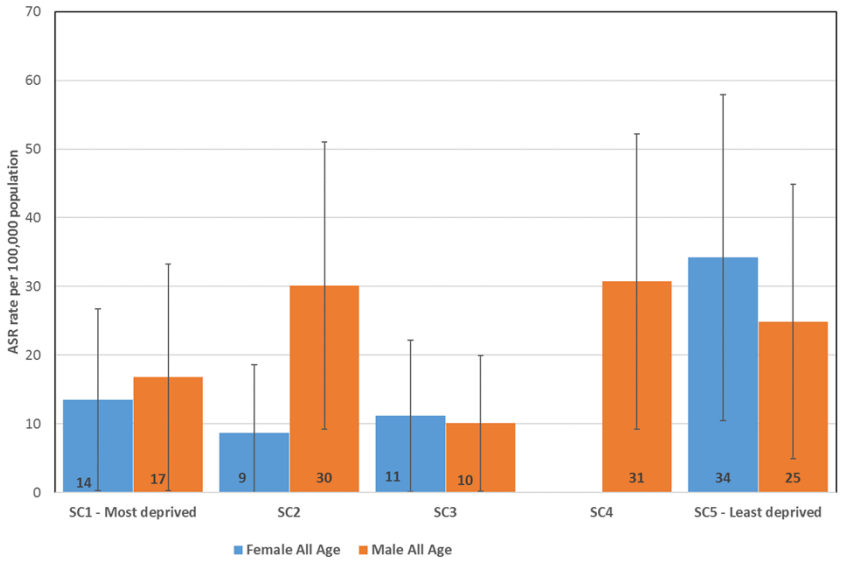
- Chart 3.3.4 shows that by all age all gender there were higher rates of people from the least deprived quintile but that the rates were statistically similar across all the deprivation quintiles.
- Chart 3.3.5 shows that where a rate was recorded, rates were higher for females from the least deprived area but were statistically similar across all the deprivation quintiles
- Rates were higher for males from both the second and fourth quintiles but were again statistically similar across all the quintiles.

Chart 3.3.4: Psychosis - 1st episode: All age all gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.5: Psychosis - 1st episode: All age and gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

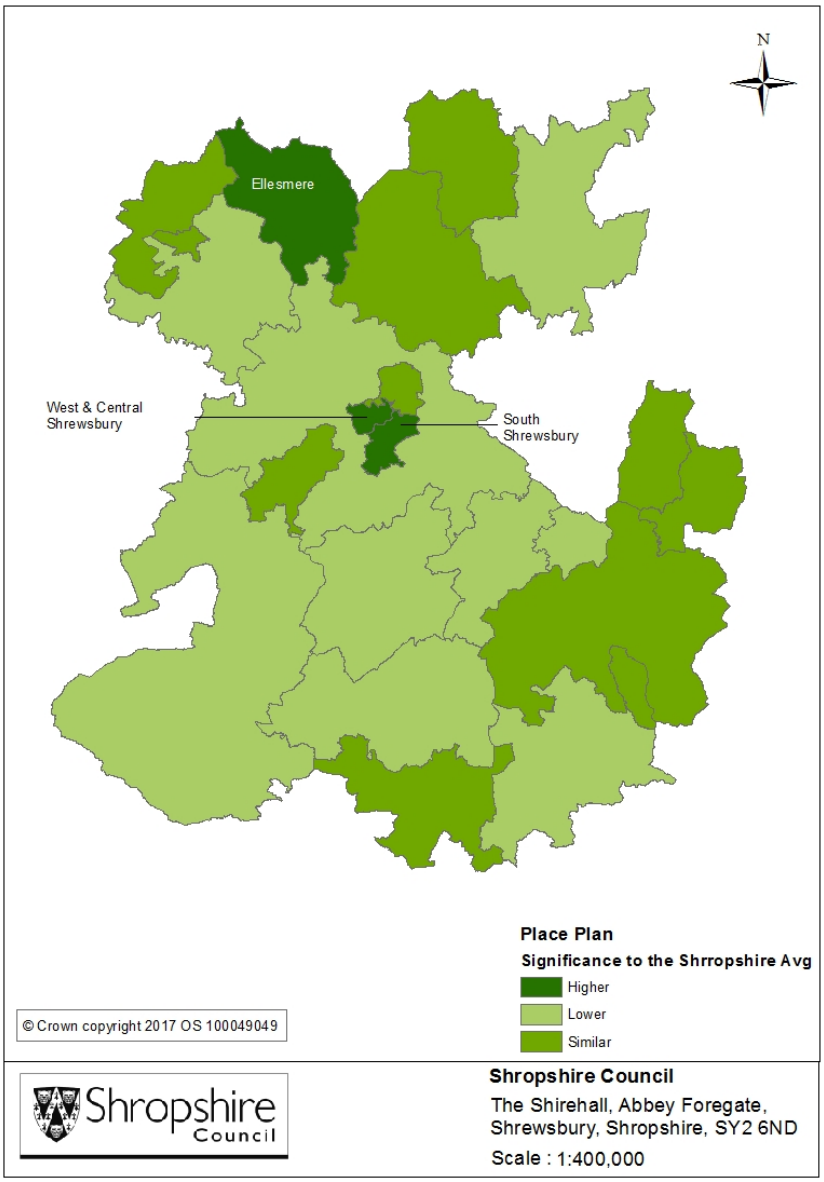
Rurality:

For all age all genders, there were similar rates from rural and town areas but significantly lower rates from urban areas.

Place Plan

Highlighted in dark green are the place plan areas that were significantly higher than the Shropshire average for Psychosis - 1st episode cases and these were: Ellesmere, West & Central Shrewsbury and South Shrewsbury.

Map 2.*3.1*: Psychosis - 1st episode: all age all gender by place plan
Age standardised rates per 100,000 population



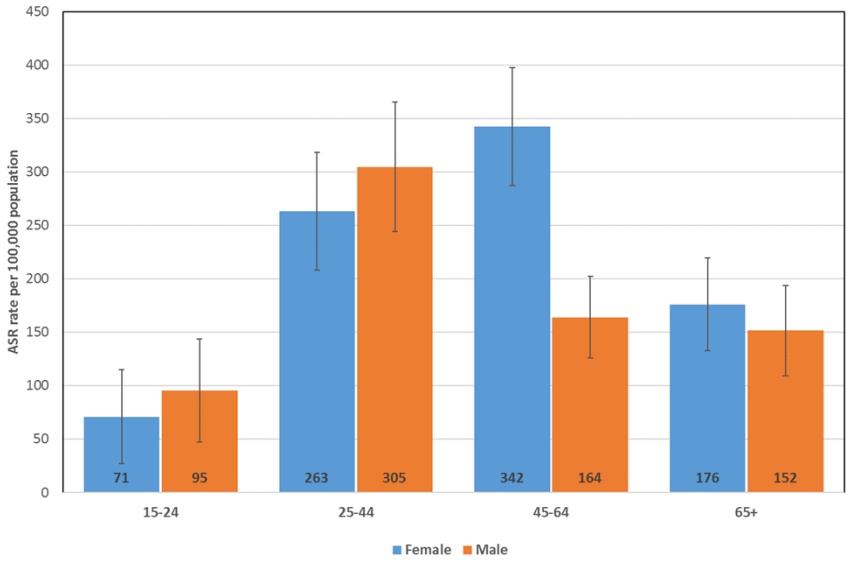
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Group 2: psychosis ongoing or recurrent

Age and Gender:

- Overall, there were higher rates of females to males but this was not significant.
- There were similar rates between the genders across all the age bands except for those aged 45-64 which had significantly higher rates of females compared to males.
- Figure 12 shows that there were higher rates for females in the 45-64 age band, which was similar to those aged 25-44 but significantly higher than those from the remaining age bands.
- There were significantly higher rates for males aged 25-44 compared to all the other age bands.

Chart 3.3.6Psychosis - ongoing or recurrent: by age and gender: Age standardised rates per 100,000 population

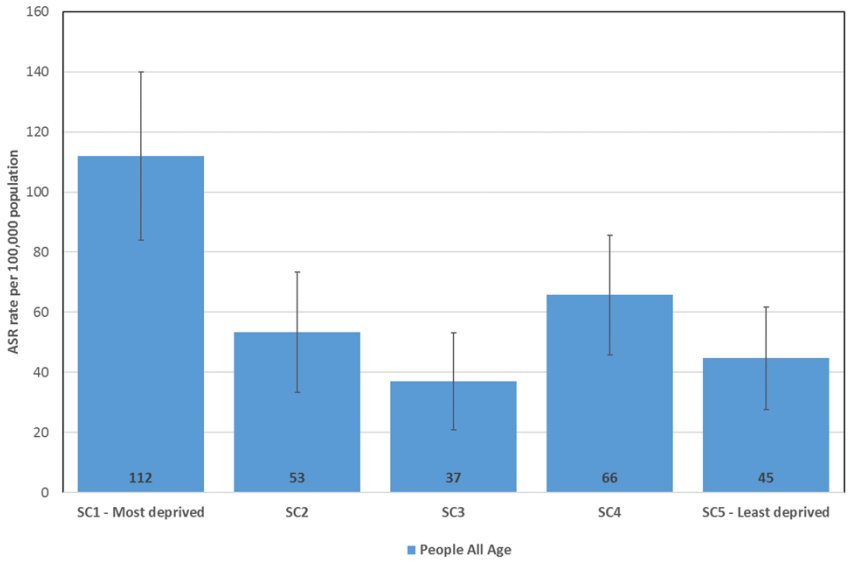


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

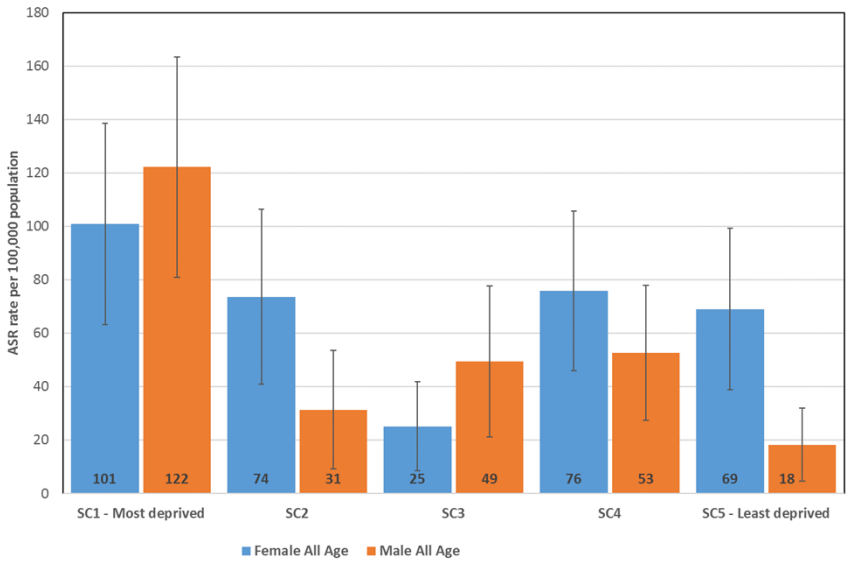
- For all age all genders, the highest rates were from the most deprived quintile and were similar to quintile 3 but was significantly higher than the remaining quintiles.
- Chart 3.3.7 shows higher rates of females from the most deprived quintile but was similar to all the remaining quintiles except quintile 3, which is significantly lower.
- There were significantly higher rates for males from the most deprived quintile compared to all the other quintiles.

Chart 3.3.7: Psychosis - ongoing or recurrent: all age all gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.8: Psychosis - ongoing or recurrent: all age and gender by deprivation: Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

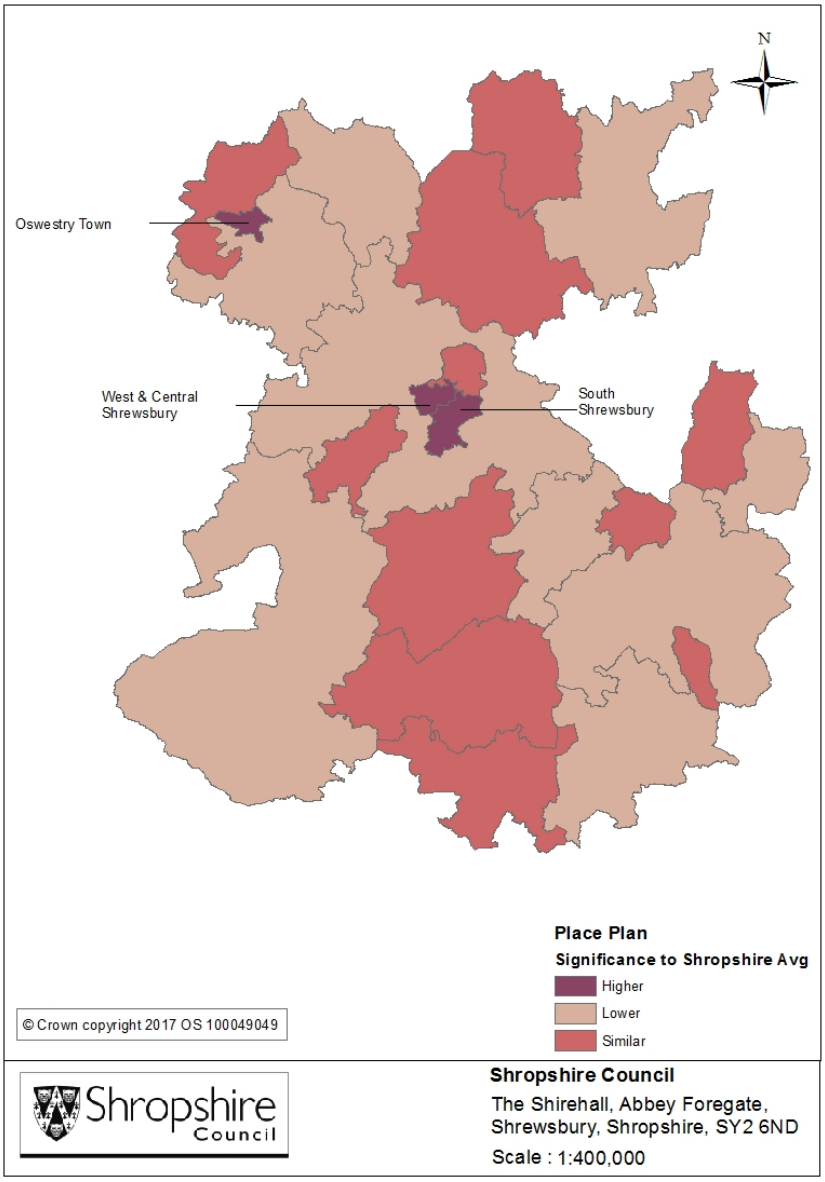
Rurality:

There were higher rates of people from towns but there was no significant difference between the areas.

Place Plan:

Highlighted in dark mauve are the place plan areas that were significantly higher than the Shropshire average for Psychosis - ongoing or recurrent cases and these were: Oswestry Town, West & Central Shrewsbury and South Shrewsbury.

Map *3.3.2*: Psychosis - ongoing or recurrent: all age all gender by place plan: Age standardised rates per 100,000 population



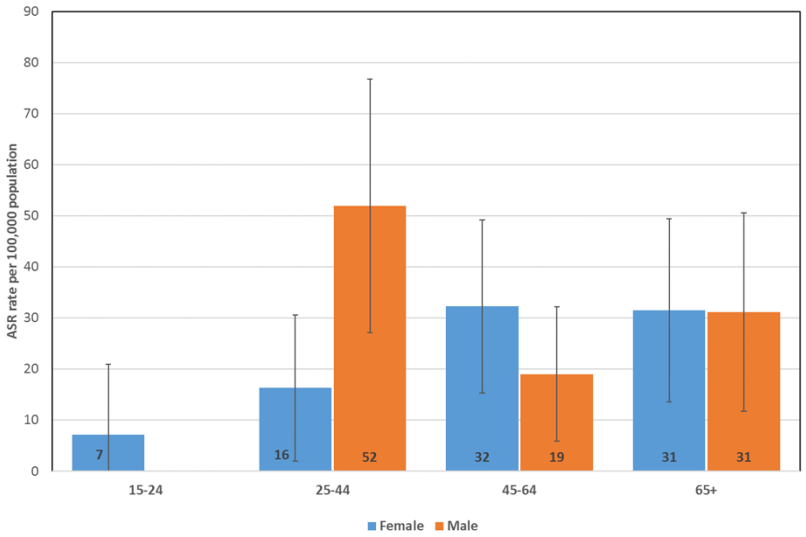
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Group 3: Psychotic crisis

Age and Gender:

- Overall, there were higher rates of males to females but this was not significant.
- Chart 3.3.9 shows that where a rate was recorded, the rates were similar between the genders across all the age bands and rates were similar between each age band for each gender.

Chart 3.3.9: Psychosis - psychotic crisis: by age and gender: Age standardised rates per 100,000 population

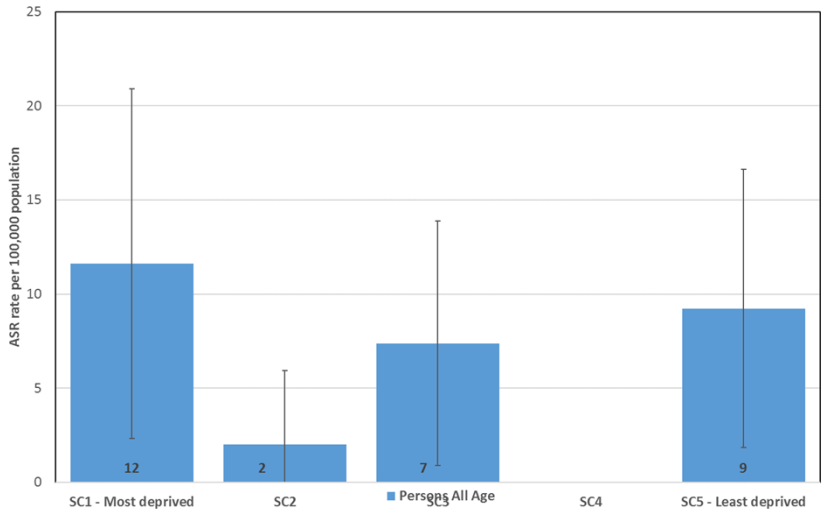


Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

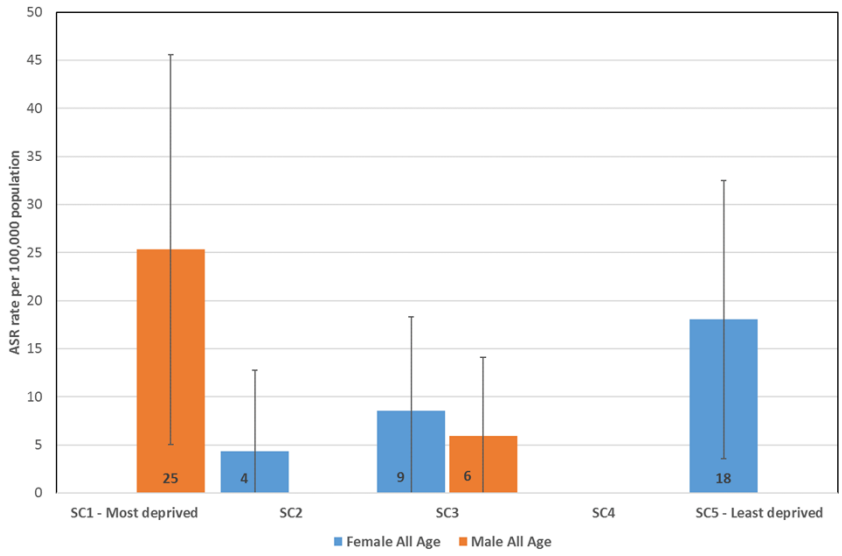
- Chart 3.3.10 shows that where a rate was recorded, a higher rate of people from the most deprived quintile; however, this was not significant.
- Chart 3.3.11 shows that rates were similar between the genders across all the quintiles
- There were higher rates of females from the least deprived quintile but this was not significant whilst there were higher rates of males from the most deprived quintile but this was similar to all the other quintiles.

Chart 3.3.10: Psychotic crisis: all age all gender: by deprivation
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.11: Psychotic crisis: all age and gender by deprivation
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

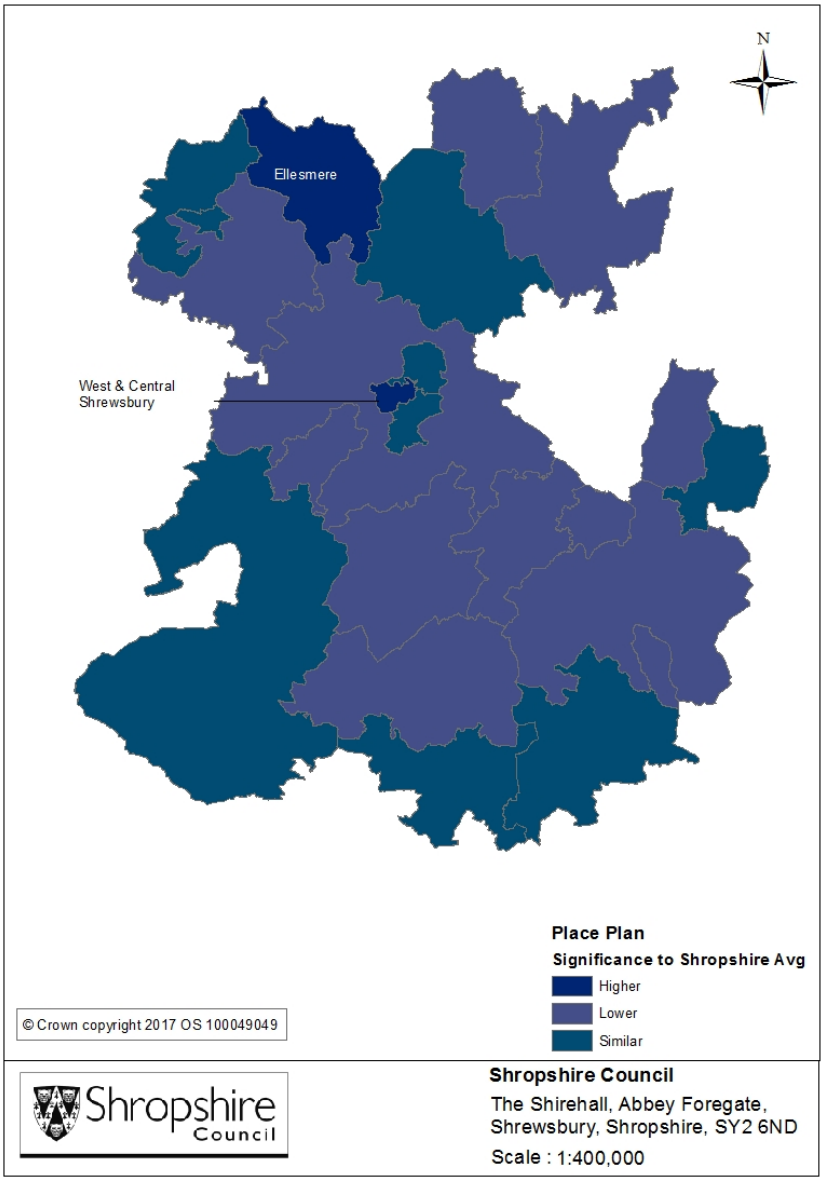
Rurality:

Rates for urban areas were nil but were similar between rural and town areas.

Place Plan:

Highlighted in dark blue are the place plan areas that were significantly higher than the Shropshire average for Psychotic crisis cases and these were: Ellesmere Town and West & Central Shrewsbury.

Map *3.3.3*: Psychotic crisis: all age all gender: by place plan
Age standardised rates per 100,000 population



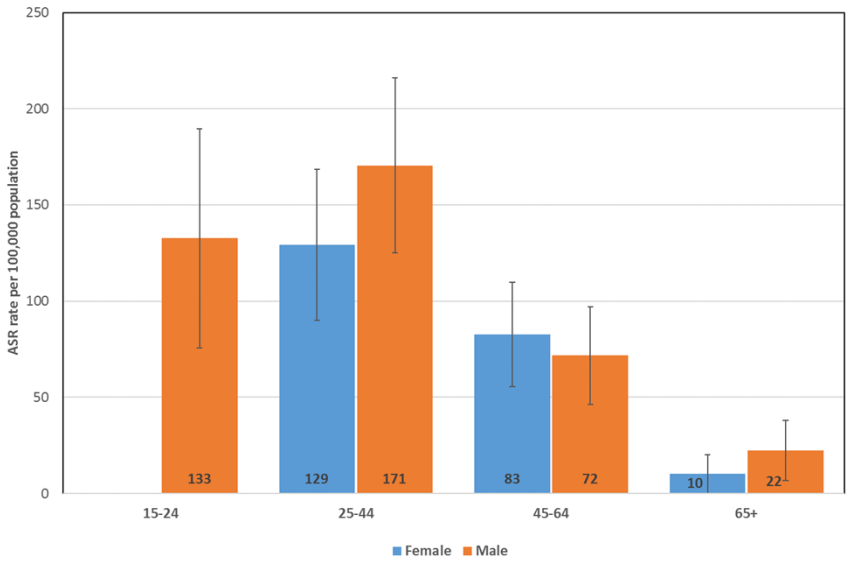
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Group 4: Psychosis with very severe engagement

Age and Gender:

- For all age all gender, there were higher rates for males compared to females but this was not significant.
- Rates between the genders across all the age bands were similar except for 15-24 year olds where there was a nil count for females.
- Figure 18 shows that where a rate was recorded, the highest rate for females was in the 25-44 age band and was similar to the 45-64 year age band but was significantly higher than the 65+-age band.
- There was a similar pattern for males: the highest rate being in the 25-44 age band and similar to those aged 15-24 but significantly higher than those aged 45+.

Chart 3.3.12: Psychosis - very severe engagement: by age and gender
Age standardised rates per 100,000 population



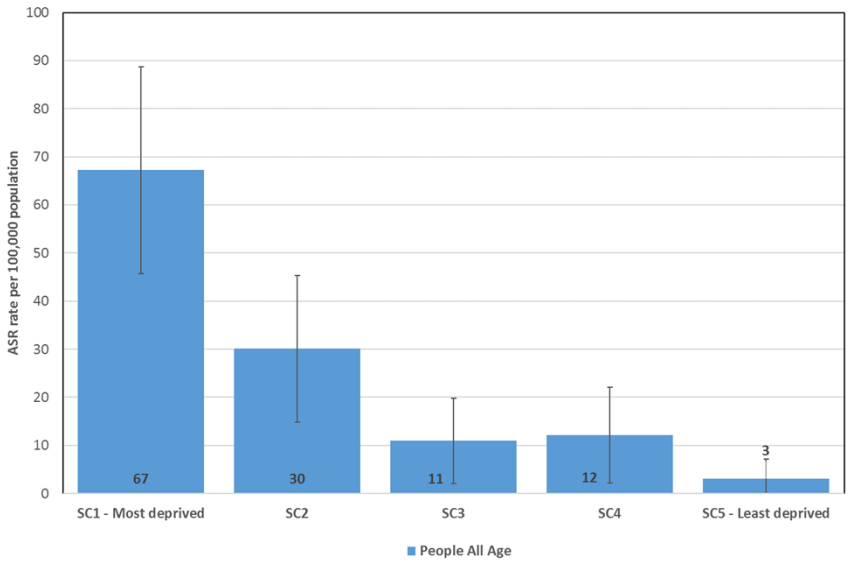
Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Deprivation:

- For all age, all gender there was a significantly higher rate of people from the most deprived quintile compared to all the other quintiles (figure 19).
- Chart 3.3.13 shows that where a rate was recorded, there was no significant difference between the genders; however there were higher female rates from the most deprived quintile which was similar to SC2 but was significantly higher than the lesser deprived area SC4.
- There were higher rates of males from the most deprived quintile, which was similar to SC3 but significantly higher than the lesser deprived quintiles SC4-SC5.

Chart 3.3.13: Psychosis - very severe engagement: all age all gender by deprivation

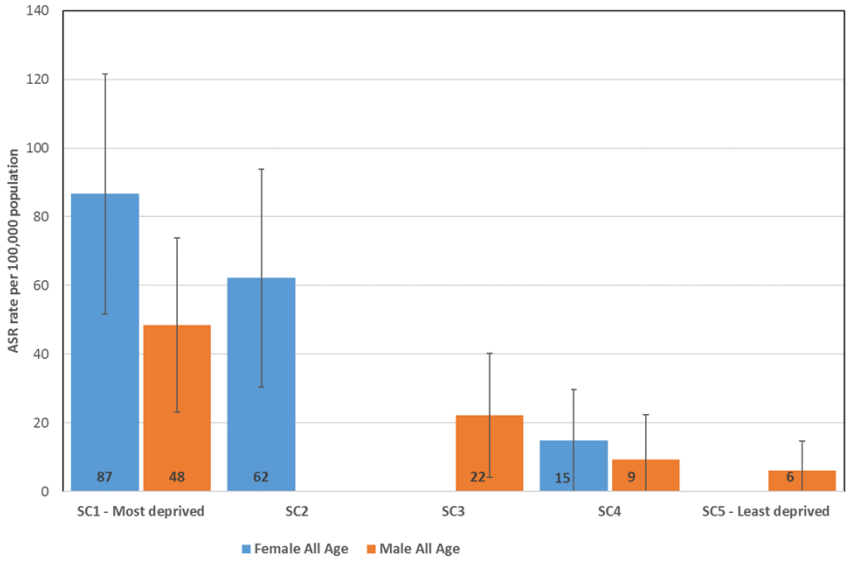
Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Chart 3.3.14: Psychosis - very severe engagement: all age and gender by deprivation

Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Rurality:

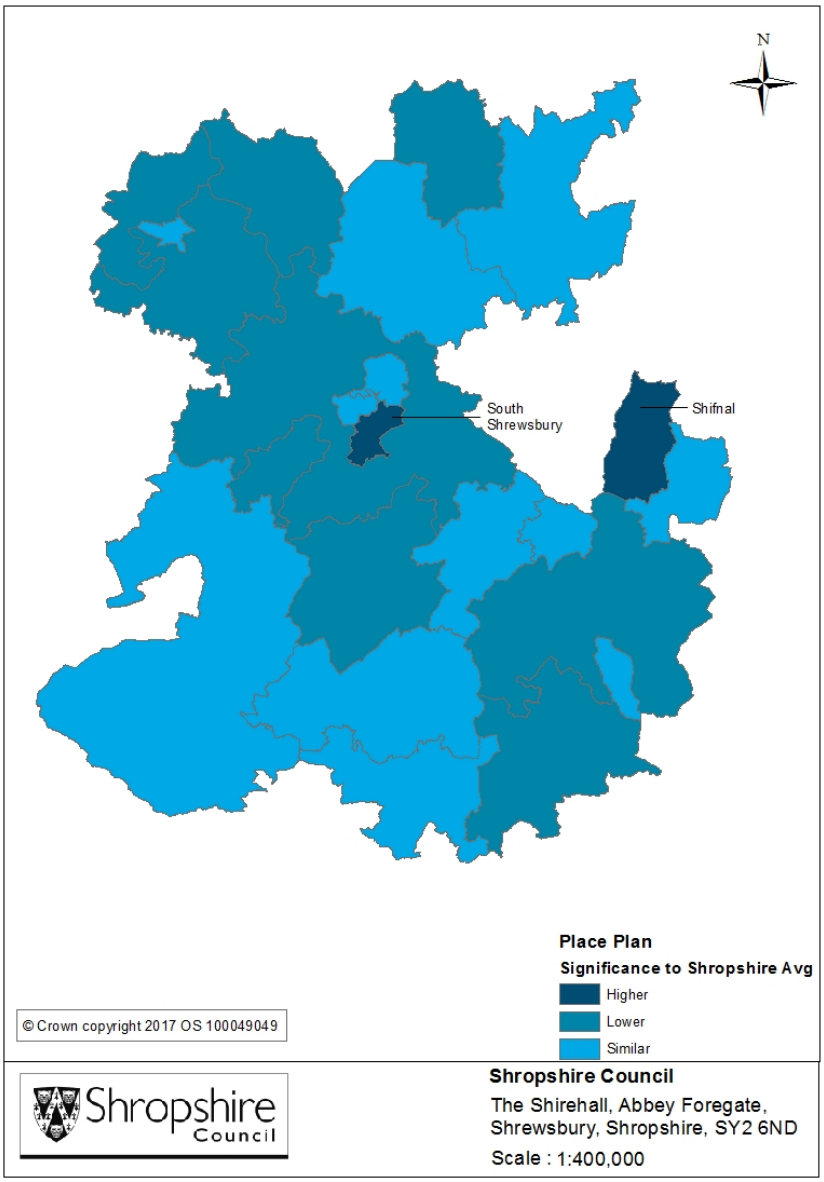
There was a higher rate of people from town areas but this was similar to both rural and urban areas.

Place Plan:

Highlighted in dark blue are the place plan areas that are significantly higher than the Shropshire average for Psychosis - very severe engagement cases and these are: South Shrewsbury and Shifnal.

Map 3.3.4: Psychosis - very severe engagement: all age all gender by place plan

Age standardised rates per 100,000 population



Source: South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSFT)

Section 4: Crisis, Self-Harm and Suicide

Crisis

A mental health crisis is where a person feels unable to cope or be in control of a situation and associated with extreme emotional distress or anxiety, inability to cope with day-to-day life or has thoughts about suicide, self-harm or experience hallucinations.

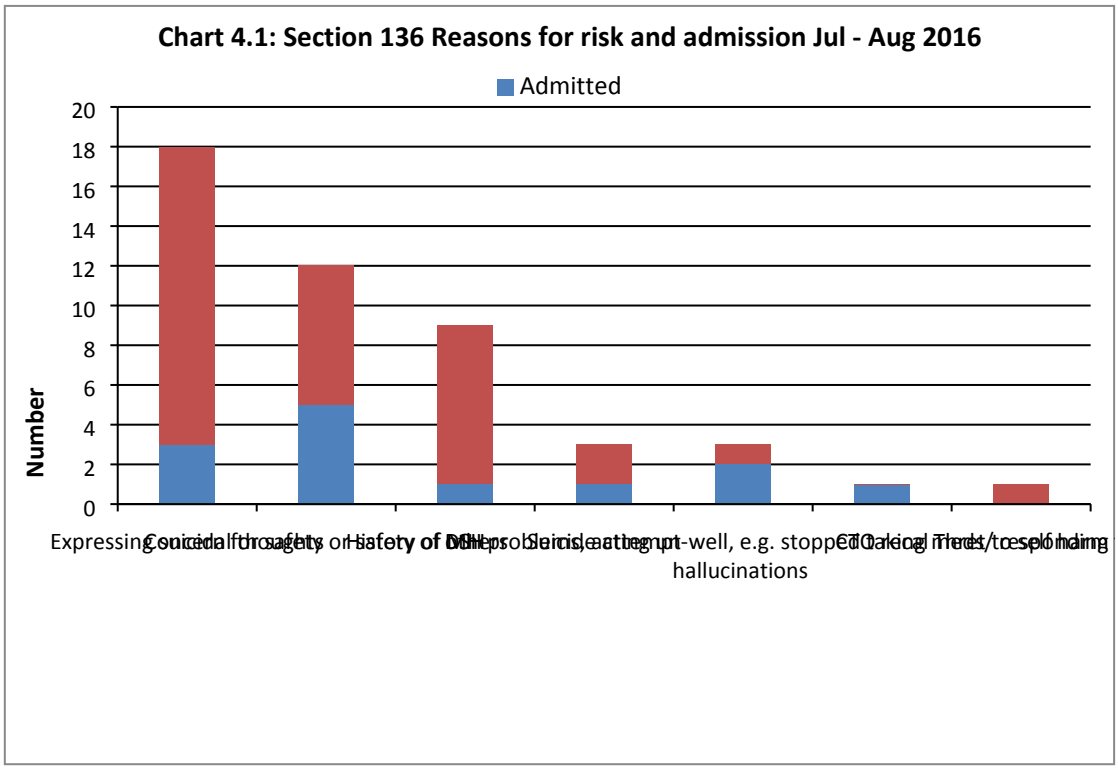
Section 136

A section 136 refers to an emergency power within the Mental Health Act which allows an individual to be taken to a place of safety from a public place, if a police officer considers that individual to be suffering from mental illness and in need of immediate care. A place of safety could be a person's home, a hospital or a police station. Rates of Section 136 in Shropshire have been reported locally as being high.

Within Shropshire there has been 1 Section 136 Suite with another opening recently in 2018. Chart 4.1 below shows the findings of an audit of activity during July and August 2016 identified the following reasons why people were identified under a Section 136 and whether they were admitted to the suite or not.

It can be seen that;

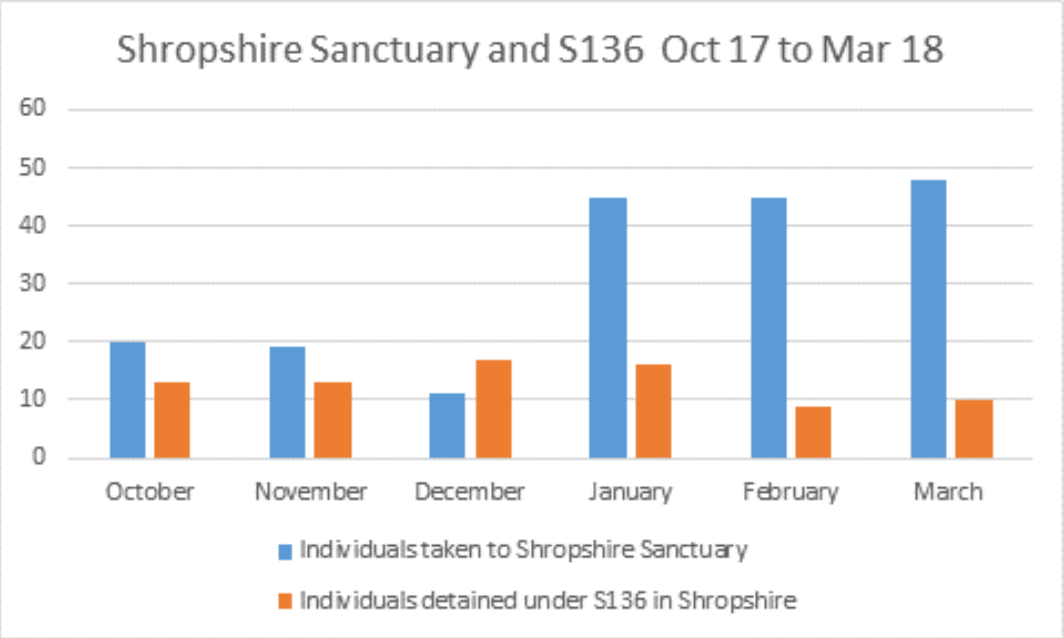
- 47 people were identified under a Section 136 during July and August 2016 with 13 being admitted to the Suite
- Suicidal thoughts were the most frequent reason for use of Section 136 but most likely to not be admitted to the Suite
- The primary reason for admittance to the Suite is where there was concern for the safety of the individual or for others



Shropshire Sanctuary

During 2016/17 Shropshire MIND and Shropshire CCG (and in partnership with West Mercia police and a range of other mental health providers) developed a sanctuary model of care in order to provide an alternative location to Section 136 for people in crisis/mental distress during after-hours. The Shropshire Sanctuary is based at Observer House in Shrewsbury and provides a safe, calm, welcoming and reassuring environment that is responsive to support individuals to relieve mental distress, anxiety and associated issues. Following a visit to the Shropshire Sanctuary, a follow up contact is attempted where appropriate to provide a "check up".

Use of the Shropshire Sanctuary has increased significantly since January 2018 and is helping to manage demand on the Section 136 Suite. In March 2018, there were 10 attendance for Section 136 and 48 for the Shropshire Sanctuary. At least half of the reason for visits were related to suicidal thoughts.



The latest qualitative feedback from the Shropshire Sanctuary indicates there has been increasing footfall, with more people being supported by the Sanctuary in the first seven days of January 2018 than the whole of the previous month. This equates to an average of 2 people per shift, with an average of 3 to 5 hours stay.

[23] J. Randall, N. Nickel and I. Colman, "Contagion from Peer Suicidal Behavior in a Representative Sample of American Adolescents," *Journal of Affective Disorders,* vol. 186, pp. 219-225, 2015.
[24] P. Qin, E. Agerbo and P. Mortensen, "Suicide Risk in Relation to Family History of Completed Suicide and Psychiatric Disorders: A Nested Case-control Study Based on Longitudinal Registers," *The Lancet,* vol. 170, pp. 1126-1130, 2002.
[25] S. Nilsson, C. Feodor, R. Hjorthoj, A. Erlangsen and M. Nordentoft, "Suicide and Unintentional Injury Mortality among Homeless People: A Danish Nationwide Register-based Cohort Study," European Journal of Public Health, vol. 24, pp. 50-56, 2013.
[26] A. Milner, A. Page and A. Lamontagne, "Long-Term Unemployment and Suicide: A Systematic Review and Meta-Analysis," *PLOS One,* vol. 8, 2014.

Suicide

Research has found evidence for risk of suicide increases with history of suicide or self-harm among close friends or family[2324] , alcohol or substance misuse[25], unemployment[26], male gender[27] and schizophrenia spectrum disorders[28].

Every day in England around 13 people take their own lives and the effects can reach into every community and have a devastating impact on families, friends, colleagues and others. It is the leading cause of premature mortality in men younger than 50 years and those who are bereaved by suicide are at three times the risk of making a suicide attempt themselves.

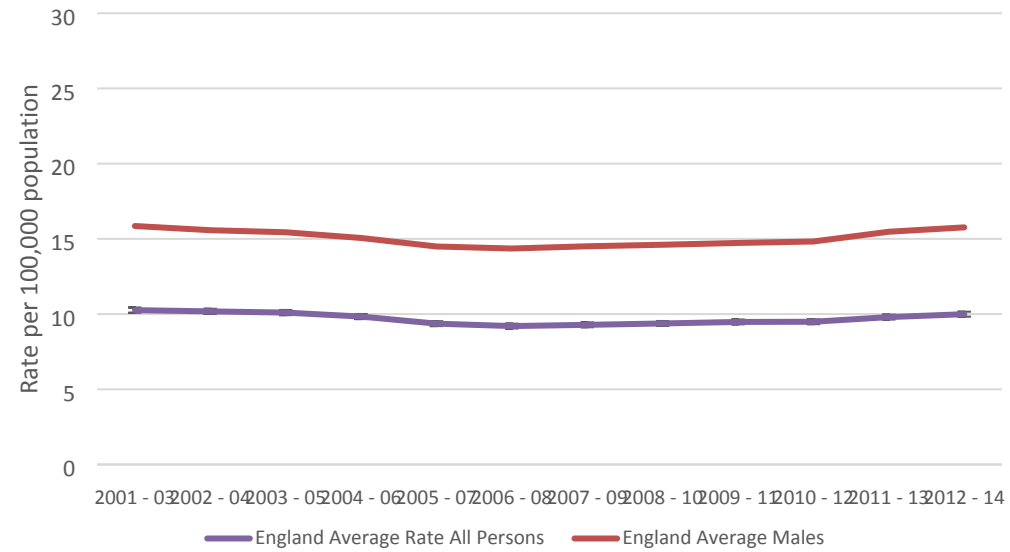
Suicide risk reflects the wider inequalities as there are marked differences in suicide rates according to people's social and economic circumstances, with those in poorer communities more likely to be affected.

National data on suicide identifies the following key themes;

- In 2014 in England there were 4,882 deaths registered as a result of suicide.
- The rate has remained similar since 2001 and is currently at 10.1 per 100,000 people (2013 – 15).
- Men are significantly higher risk with 3 out of 4 suicides being completed by men, with the greatest risk in those aged 45 to 49 years.
- There is a secondary peak in suicides for men aged over 75 years which is attributed to those affected by bereavement, loneliness and chronic illness
- There has been an increasing trend in recent years of female suicides
- Greater risk of suicide is associated for people with a history of self-harm, mental ill health, substance misuse and time spent in prison.
- Additional key risks include access to means, chronic illness and occupation (particularly medical, vets, farmers and those in lowest skilled occupations such as males in labourer or construction roles).
- Suicide rates for children and young people are low in England, with a total of 145 suicides between 2014 and 2015. Those in their late teens are at greatest risk, with 70% being male in this period.
- Reasons identified for the young people that committed suicide include bereavement by the suicide of a friend or family member, a chronic health problem such as asthma or acne, academic stress, bullying and social isolation.

[27] Department of Health, "Preventing suicide in England: Two years on. Second annual report on the cross-government outcomes strategy to save lives.," The Stationary Office, London, 2015.
[28] K. Hor and M. Taylor, "Suicide and Schizophrenia: A Systematic Review of Rates and Risk Factors," vol. 24.4S, 2010.

Chart 4.2: Suicide age- standardised rate: per 100,000 (3 year average) England average

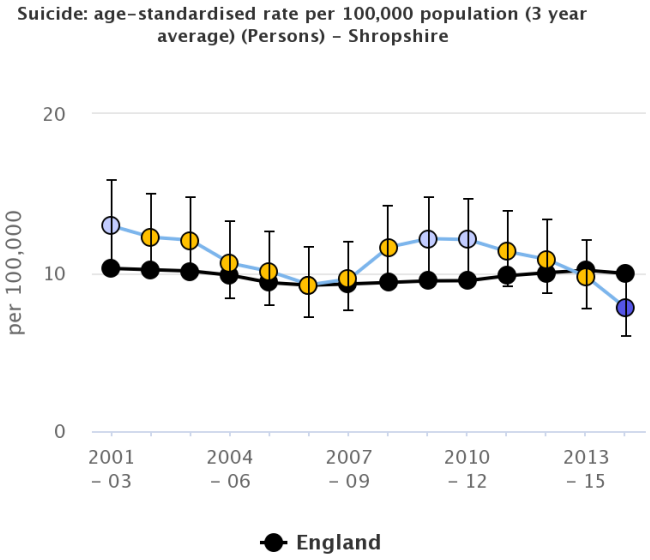


Application to Shropshire

Between 2013 and 2015 there were 131 deaths recorded as suicide across Shropshire and Telford and Wrekin (both LA areas which share a Coroner service). Of these, 100 were men and 31 were female.

Chart 4.3 (below) compares the age standardised rate of suicide for Shropshire compared to the England average, based on 3 year average data (due to small numbers). It can be seen that following an increase above the England rate in 2010-12, the local suicide rate has consistently been reducing to the latest data point for 2013-15 where it is now significantly lower compared to the national average.

Chart 4.3



Data from the Public Health England Health Profile identified the following trends of the age standardised suicide rate for Shropshire;

- Suicide rate in Shropshire declined in the period 2011-13 to 2013-15.
- The Shropshire rate (9.7 per 100,000 people) was similar in 2013-15 to both the England rate of 10.2 per 100,000 and the West Midlands rate of 10.3 per 100,000

An audit of Coroner inquests for deaths by suicide or expected suicide between 2014 and 2016 identified the following themes;

- 95 suicides across Shropshire and Telford and Wrekin
- 54 (57%) of these suicides took place within a Shropshire postcode
- 72% of suicides were male (n=69) and 28% female (n=27). The table below provides a summary of suicide by gender by location of death.

Suicide - by gender 2014 -2015 for T&W and Shropshire

Row Labels	Shropshire	T&W	Grand Total
Female	16	11	27
Male	38	30	68
Grand Total	54	41	95

Suicide Prevention in Shropshire

A Shropshire and Telford and Wrekin joint Suicide Prevention Strategy (2017 to 2020) was ratified in May 2017 and is currently being implemented through the creation of a Shropshire Partnership Action Group (with stakeholders representing health, social care, the voluntary and community sector as well as organisations that have regular interaction with high risk groups). The Strategy seeks to;

- Reduce suicide in Shropshire through early identification and intervention for people at risk
- Provide the best support for people affected by suicide and ensure they are connected to the services which can most meet their needs
- Promote clear pathways and signposting to the various sources of support for people experiencing crisis and who may be either self-harming or considering suicide
- Equip all services who may interact with people at greater risk of self-harm or suicide with the knowledge and confidence to recognise systems of risk and approaches to intervention.

As of December 2017, the Shropshire Suicide Prevention Action Group (a multi-agency partnership) agreed the formation of 6 work streams with dedicated operational teams to be established and progress actions to achieve the outcomes of the Strategy. The work streams are as follows;

Work-streams	Purpose
Communications and Media	▪ To develop and implement a Communications Strategy for the Shropshire Action Plan in order to raise awareness across the county and encourage participation with the agenda. ▪ To work with the media to reduce stigma, reduce the risk of imitation following a suicide death and information as to how to access local support services if writing a related story.
Access to support, Prevention and Care Plans	▪ To reduce the risk of suicide in high risk groups through the use of targeted programmes. ▪ To identify and promote the access points/services that can provide support for people who self-harm/are at risk of suicide/are in crisis or bereaved by suicide. ▪ To ensure clear pathways exist and are communicated between different agencies (including education, primary care, probation etc). ▪ To ensure continuity for access to appropriate support is built into other care pathways

	(such as depression) following discharge. ▪ To establish pathways that monitor parity of care between mental, physical health and long term conditions. ▪ To review support available and communication pathways for Carers of vulnerable people that are at risk of suicide. ▪ To ensure Care Plans are used and provided for people identified at risk in an appropriately timed manner for the situation (e.g. immediate plans for those presenting in crisis). Specific links to be made with perinatal mental health and older people.
Using Information and Data	▪ To identify what types of data will best inform impact of activity and how the partnership group can share relevant information. ▪ To consider whether the group can influence the collection of information that may better inform our actions (e.g. coding systems for deliberate self-harm in A&E).
Self-Harm	▪ To identify how we can best work with partners to identify people who deliberately self-harm, appropriate sharing of information and how to ensure they can access support.
Engaging post Suicide	▪ To provide a package of care for people who have been affected by a suicide death which establishes a consistent message as to the different types of support available, what will be happening as part of the post suicide process and can provide a link into/between these services.
Training	▪ To provide suicide awareness and self-harm training for all staff with a public facing role in order to identify warning signs and understand how to refer to appropriate support agencies. ▪ Suicide post-vention training to be provided to all people who are most likely to interact with bereaved people following a suicide death. ▪ To promote good emotional wellbeing and mental health first aid within workplaces and organisations across Shropshire.

Self-Harm

Self-harm, whether involving intentional self-poisoning or self-injury, is the most important risk factor for death by suicide, even though many people who self-harm do not intend to take their own life. People who frequently present to hospital following self-harm are a particularly vulnerable group.

While most people who self-harm do not die by suicide, the strong link between self-harm and suicide make this a matter of concern. Evidence as reported by Public Health England has found that;

- There are around 200,000 episodes of self-harm that present to hospital services each year nationally
- The true scale of the problem is not known as many people who self-harm do not attend A&E or seek help from health or other services
- Roughly 50% of people who die by suicide have a history of self-harm, in many cases with an episode shortly before death
- Around 15% of those who die by suicide have carried out an act of self-harm leading to presentation at hospital in the year before their death

Data from the PHE Health Profiles for Shropshire has identified for Emergency hospital Admissions for intentional self-harm;

- The rate has increased in the 3-year period 2012-13 to 2014-15
- Shropshire rates in 2014-15 (176) are similar to both the England rate of 191.4 and the West Midlands rate of 191

Shropshire demographics of self-harm

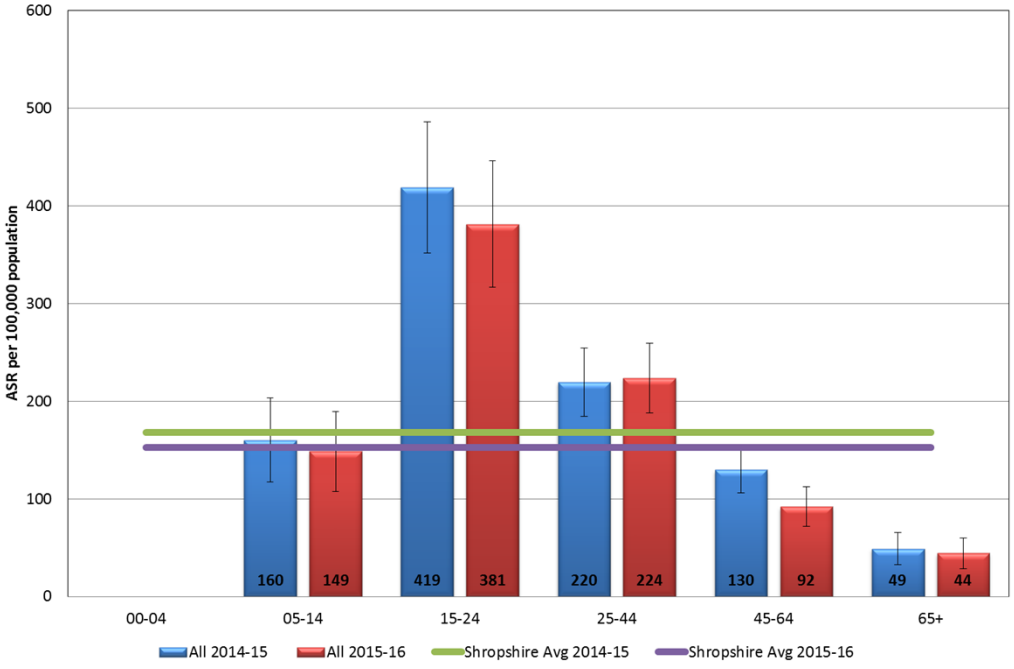
Local analysis from the Shropshire Emergency Self-harm Admissions 2014-15 & 2015-16 report (Shropshire Council, 2017) identified the following trends;

1. The top 10 self-harm hospital admissions by diagnosis in the reporting time period (which comprised over 85% of all diagnosed self-harm admissions) were;
    i. Open wound of forearm
    ii. Open wound of wrist and hand
    iii. Poisoning by hormones and their synthetic substitutes and antagonists, not elsewhere classified
    iv. Poisoning by nonopioid analgesics, antipyretics and antirheumatics
    v. Poisoning by narcotics and psychodysleptics [hallucinogens]
    vi. Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs
    vii. Poisoning by psychotropic drugs, not elsewhere classified
    viii. Poisoning by drugs primarily affecting the autonomic nervous system
    ix. Poisoning by primarily systemic and haematological agents, not elsewhere classified
    x. Poisoning by diuretics and other and unspecified drugs, medicaments and biological substances

2. There were no significant differences between the proportions of people admitted for self-harm between 2014-15 (437 admissions, 53%) and 2015-16 (387 admissions, 46.9%).

3. In both years there was a higher rate of females admitted for self-harm (a rate of 203 per 100,000 people in 14/15 and 191 per 100,000 people in 15/16) compared to males (rate of 134 per 100,000 people in 14/15 and 117 per 100,000 in 15/16). There were no significant differences between the years for each gender.
4. Chart 4.4 shows the rate of admissions by year and age band. There were significantly higher rates of admissions in both years for those aged 15-24 followed by those aged 25-44 both of which were significantly higher than the Shropshire average. Rates were similar between the years in all age bands.

Chart 4.4: Age standardised rate (per 100,000 population) of all self-harm admissions by year and age band



Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

5. A significantly higher rate of females compared to males was admitted from age bands 05-14 and 15-24 in both years; however rates were similar for each gender, across both years in each age band (table 1).

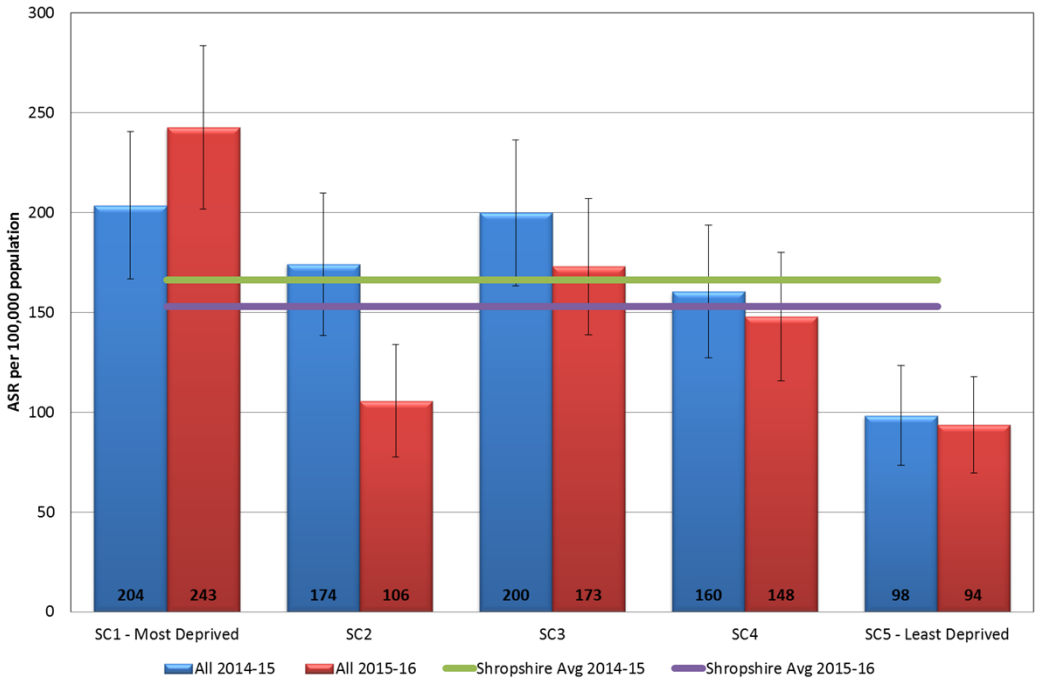
Table 4.1: Age standardised rate (per 100,000 population) of all self-harm admissions 2014-15 – 2015-16 by age band and gender

	95% confidence interval											
Age	Male 2014-15	LLC	UCL	Female 2014-15	LLC	UCL	Male 2015-	LLC	UCL	Female 2015-16	LCL	UCL
00-04	0	0	0	0	0	0	0	0	0	0	0	0
05-14	35	7	64	286	205	367	36	7	64	262	185	340
15-24	273	198	348	580	465	694	192	128	256	593	475	710
25-44	224	175	274	213	164	262	226	176	276	221	171	272
45-64	119	87	151	141	105	176	83	56	110	101	71	130
65+	42	20	64	55	31	79	49	24	74	42	21	63

Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

6. There were significantly higher admissions rates of people from the most deprived quintile compared to the least in both years and were above the Shropshire average in both years.

Chart 4.5: Age standardised rate (per 100,000 population) of deprivation by year – all age all gender 2014-15 – 2015-16



Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

7. In 2014-15 there were similar rates between the genders across all the quintiles except for quintile 2 which had a significantly higher rate of admissions for females compared to males. This pattern was similar in 2015-16 except for a significantly higher rate of admissions for females compared to males from the least deprived quintile.

8. In both years a significantly higher rate of self-harm admissions was for people from urban areas compared to rural areas, but both were similar to town areas.

9. Whitchurch, was significantly higher than the Shropshire average for all age, gender and diagnosis self-harm (as shown in Map 1 and table 3). In individual years: Shrewsbury North East and Oswestry Town were significantly higher than the Shropshire average in both 2014-15 and 2015-16 and Whitchurch was also significantly higher in 2014-15. Rates between the years across all the place plan areas were all similar.

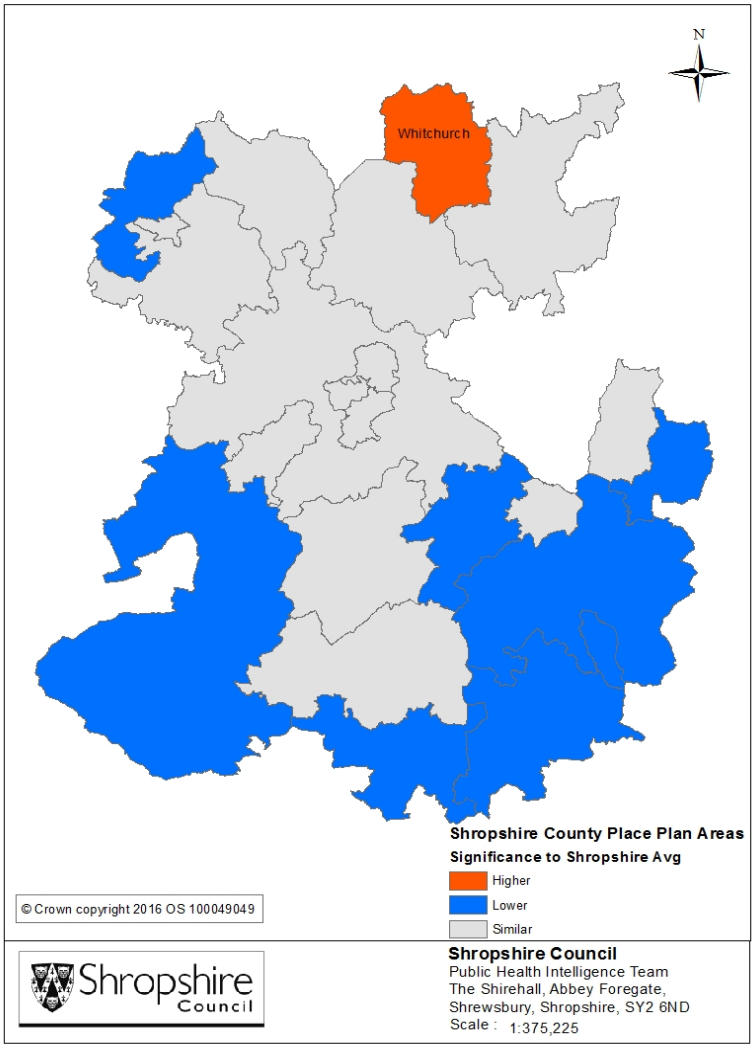
Table 4.2: All age, gender and diagnosis significance to Shropshire average : Age standardised rate by place plan map – 2014-15 & 2015-16

Place Plan Area	Albrighton	Bishop's Castle	Bridgnorth	Broseley	Church Stretton	Cleobury Mortimer	Craven Arms	Ellesmere	Highley	Ludlow	Market Drayton	Much Wenlock	North East Shrewsbury	North Oswestry	Oswestry Town	Pontesbury and Minsterley	Shifnal	Shrewsbury Rural	South & East Oswestry	South Shrewsbury	Wem	West and Central Shrewsbury	Whitchurch
Significance to Shropshire average: age standardised rate per 100,000 population	67	93	79	162	150	79	248	149	31	75	179	68	199	59	195	250	106	187	167	202	167	208	260

Lower | Similar | Higher

Source: SUS Hospital admissions data extracted by CSU 2014-15 & 2015-16

Map 4.3: All age, gender and diagnosis significance to Shropshire average: Age standardised rate by place plan map – 2014-15 & 2015-16

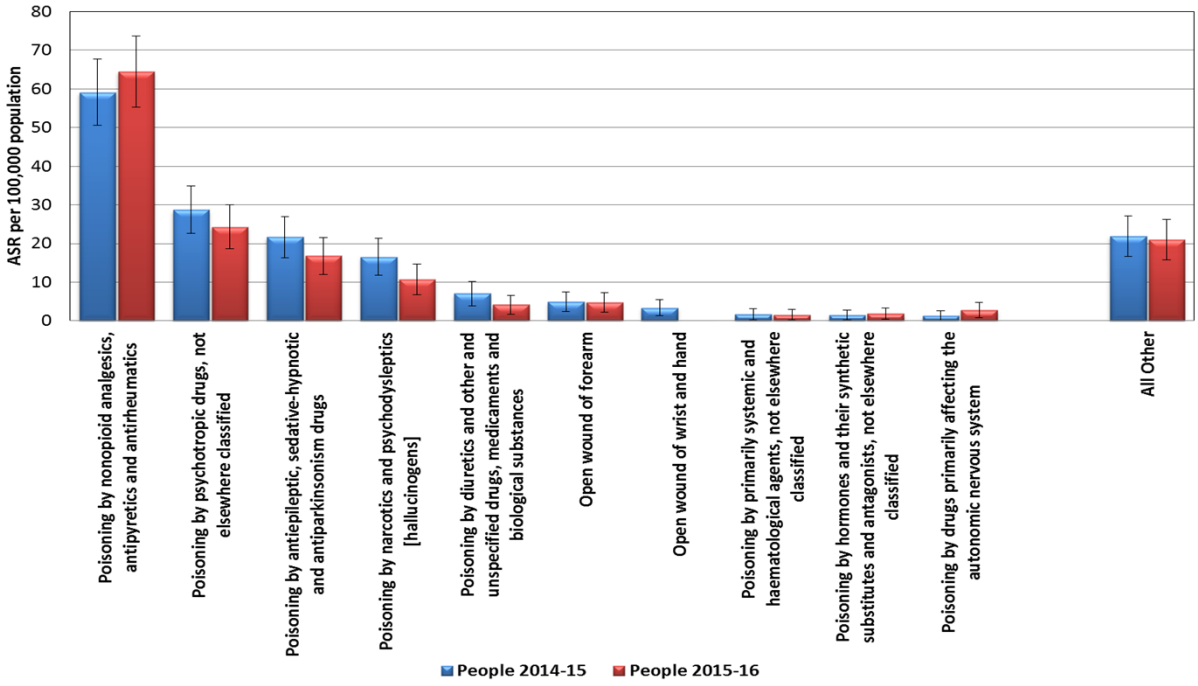


Source: SUS Hospital admissions data extracted by CSU 2014-15 & 2015-16

10. There were significantly higher rates of self-harm admissions were for *poisoning by nonopioid analgesics, antipyretics and antirheumatics* in both years and rates between the years were similar across the diagnosis headings (as seen in Chart 4.6).

11. In 2014-15 there were significantly higher rates of self-harm admissions for females compared to males for *poisoning by nonopioid analgesics, antipyretics and antirheumatics* and *open wound forearm*; the remaining diagnosis headings were all similar. In 2015-16 the pattern was similar between the genders across all the diagnosis headings except for a significantly higher rate of females admitted for *poisoning by nonopioid analgesics, antipyretics and antirheumatics* (table 4). Rates were similar across all the diagnosis headings between each year for each gender.

Figure 4.6: Age standardised rate (per 100,000 population) of all self-harm admissions 2014-15 – 2015-16 by diagnosis by year



Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

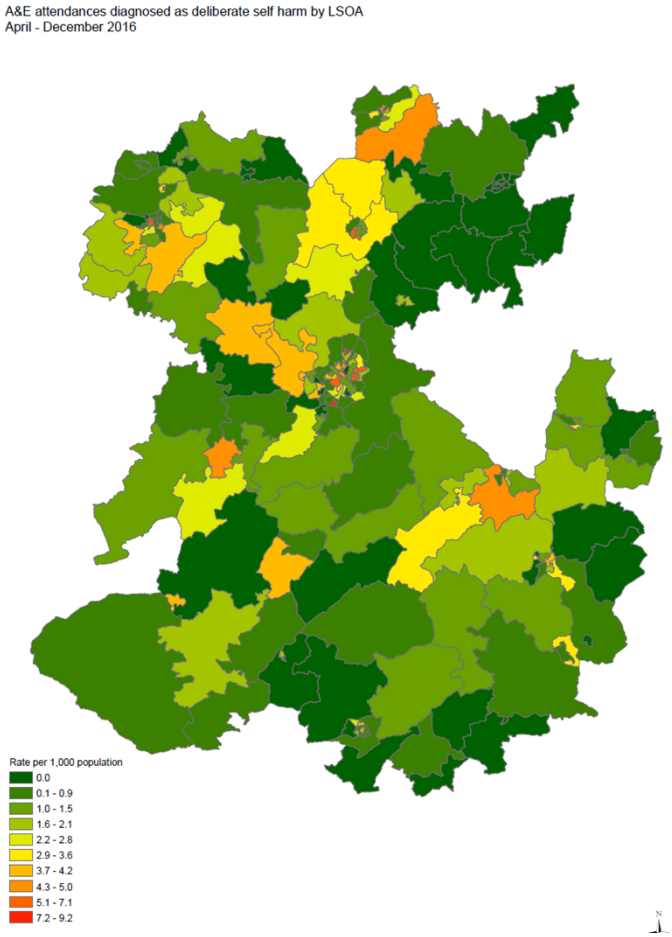
Table 1.3 Age standardised rate (per 100,000 population) of all self-harm admissions 2014-15 – 2015-16 by diagnosis by year and gender

	95% Confidence Interval											
ICD10 Description Heading	**Male 2014-15**	**LLC**	**UCL**	**Female 2014-15**	**LLC**	**UCL**	**Male 2015-16**	**LLC**	**UCL**	**Female 2015-16**	**LLC**	**UCL**
Poisoning by nonopioid analgesics, antipyretics and antirheumatics	41	31	51	78	64	92	46	35	57	84	69	100
Poisoning by psychotropic drugs, not elsewhere classified	25	17	33	33	23	42	17	11	24	31	22	41
Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs	20	12	27	23	15	31	13	7	19	20	13	27
Poisoning by narcotics and psychodysleptics [hallucinogens]	18	11	25	15	9	22	10	5	16	11	6	17
Poisoning by diuretics and other and unspecified drugs, medicaments and biological substances	5	2	9	9	4	14	3	0	6	5	1	9
Open wound of forearm	1	0	2	9	4	14	2	0	4	8	3	12
Open wound of wrist and hand	3	0	6	4	1	7	0	0	0	0	0	0
Poisoning by primarily systemic and haematological agents, not elsewhere	3	0	5	1	0	2	1	0	2	3	0	5
Poisoning by hormones and their synthetic substitutes and antagonists, not elsewhere	1	0	2	2	0	5	1	0	3	3	0	5
Poisoning by drugs primarily affecting the autonomic nervous system	1	0	4	1	0	3	5	1	8	1	0	3

Source: SUS Hospital admissions data extracted by CSU 2014-15 – 2015-16

The following map shows the usual residence of attenders for self-harm admissions (diagnosed as deliberate self-harm) at a rate per 1,000 population. The anonymised postcodes were then mapped in order to assess links with deprivation. The findings indicate that the highest rate of self-harm hospital attendances (8.1 per 1,000) came from the 10% most deprived communities and displays a step reduction as deprivation reduces.

Map 4.2: A&E attendances from deliberate self-harm in Shropshire



2015 IMD Decile	Rate per 1,000 population Q1-Q3 2016/17
10% most deprived	8.1
10-20% most deprived	4.7
20-30% most deprived	2.9
30-40% most deprived	1.7
40-50% most deprived	1.4
40-50% least deprived	1.8
30-40% least deprived	1.7
20-30% least deprived	0.8
10-20% least deprived	0.7
10% least deprived	0.5

Section 5: Mental Health and Substance Misuse – Dual Diagnosis

Substance misuse can often be seen as *usual* rather than the *exception* among people with severe mental health problems and the relationship between the two is complex. People with mental health problems can be more sensitive to the effects of modest amounts of substances due to the psycho-biological vulnerability that underlies their psychiatric disorder.

The combination of substance misuse and mental health issues in an individual is commonly referred to as "dual diagnosis", though in most circumstances there are more than just these two issues.

The majority of people in substance misuse services are likely to experience problems with their mental health. National research found 70% of drug users and 86% of alcohol users in treatment have mental health problems. In suicides of people experiencing mental health problems, 54% also have a history of problems with drugs and alcohol.

Research has also found people with drug/alcohol dependency who demonstrate mental health conditions are not always able to access the help they need. Reasons for this vary, from the level of mental health distress not great enough to warrant specialist services, to exclusion of support from mental health services due to their substance misuse. A number of reports and guidance, including clinical guidance from the National Institute of Clinical Excellence (NICE) promote better care co-ordination and support for this client group. Despite this, dual diagnosis and co-occurring drug/alcohol and mental health conditions has remained a challenging area, with many people falling through the delivery gaps.

Public Health England (PHE) have published guidance to compliment the NHS Five Year Forward View for Mental Health to support improved care for those with co-existing mental health and drug/alcohol dependency issues. *Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers (PHE, 2017)* provides a framework to support implementing change to support better care co-ordination. The guidance covers all age groups, all substances and all types of mental health conditions. It also promotes commissioners and providers of mental health and substance misuse services to have joint responsibility for meeting the needs of people with co-occurring conditions. Experts by experience and their carers should also be involved in the commissioning of evidence-based services.

The principles of this guidance are;

- **Everyone's Job** – All service providers (including homeless and wider social care teams) and commissioners have responsibility to work together to achieve shared solutions to meet the needs of this cohort.
- **No Wrong Door** – Treatment for any co-occurring condition is available through every contact point, all services have an open door policy for co-occurring conditions.
- **Understanding local need** – All partnerships should have a good understanding of need and be able to project likely future demands.
- **Using the evidence base** – All services should be commissioned using the evidence base

PHE have also developed a data tool Co-occurring substance misuse and mental health issues profiling tool to support this area of work. The tool supports an intelligence driven approach to supporting need, benchmarking areas against both regional and national trend against a number of indicators. The tool also measures the quality of the data used and whether there is any significant change in the direction of travel from previous years.

Alcohol Consumption

Alcohol misuse or *hazardous drinking* is a pattern of alcohol consumption carrying risks of physical and psychological harm to the individual and may include alcohol dependence.

The Adult Psychiatric Morbidity Survey (2014) identified the prevalence of harmful drinking in England for adults to be 16.6%. Levels of hazardous drinking have declined in men over the past 15 years (36.8% in 2000 among 16 to 74 year olds to 27.9% in 2014) and has remained stable in women. However, although hazardous drinking has become less common in 16 to 24 year olds (reducing from 6.2% in 2007 to 4.2% in 2014) it has become more common in 55 to 64 year olds (increasing from 1.4% in 2007 to 2.8% in 2014).

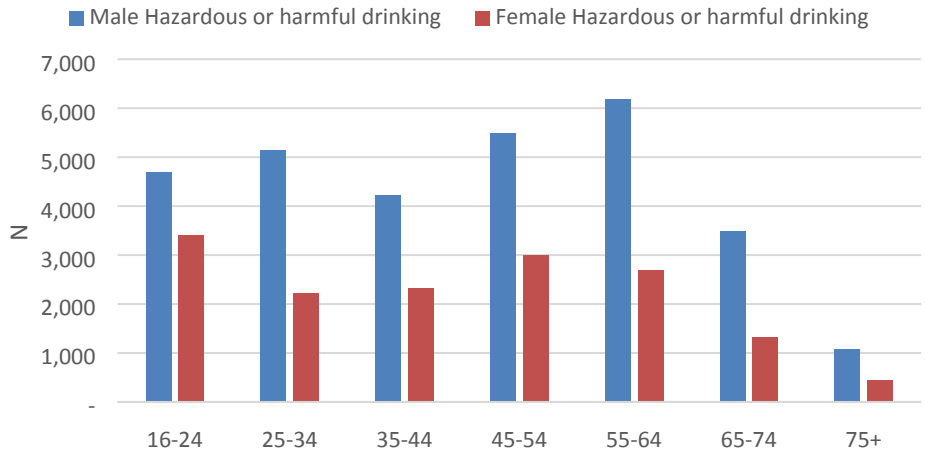
The survey identifies higher risk factors for alcohol misuse as;

- White British men and women
- Adults under 60 years of age living alone
- People in receipt of Employment and Support Allowance (ESA)

In addition to the above, a quarter of adults with probable alcohol dependence (an AUDIT score of over 20) were receiving treatment and services for a mental or emotional problem. Of this group, 6.1% were taking medication to treat substance misuse and 6.3% were in substance misuse counselling.

Chart 5.1 uses the mid year population estimates (2016) against the APMS (2014) rates for harmful and hazardous drinking. It can be seen that if Shropshire rates were similar to the national rates, there would be consistently more males at each group who misuse alcohol. The peak age for males in Shropshire is 55 to 64 years compared to females who peak at 16 to 24 years.

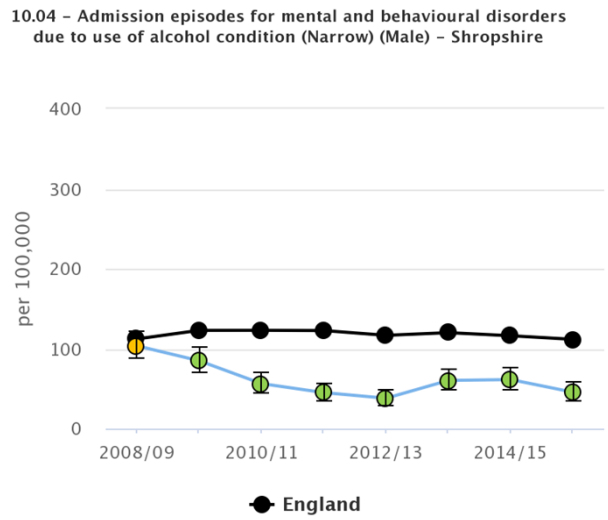
Chart 5.1: Estimated population in Shropshire with reported hazardous or harmful drinking behaviour in the past year (numbers)

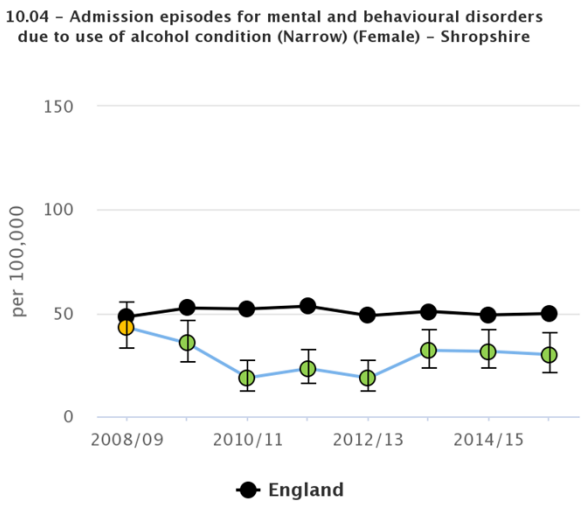


The Charts below display the rate of hospital admissions per 100,000 for mental and behaviour disorders due to the use of alcohol for males and females (PHE Local Alcohol Profiles for England, 2018). Although the male admission rates both locally and nationally are higher than female admissions, the Shropshire rates are significantly lower compared to the England averages;

- 45.5 per 100,000 for Shropshire males compared to 111.6 per 100,000 England average in 2015/16
- 29.9 per 100,000 for Shropshire females compared to 49.7 per 100,000 for England average in 2015/16

Chart 5.2





Drug misuse

Chart 5.3 uses the mid year population estimates (2016) against the APMS (2014) rates for drug dependence in the past year by age and gender. In total there is an estimated 9,705 Shropshire people who have any drug dependence. It can also be seen that if Shropshire rates were similar to the national rates, cannabis is reported to be the highest used dependent drug for males at each age group, followed by cocaine (highest usage in the 16 to 34 years group) and heroin/methadone (most common in the 25 to 44 year group). Male drug dependence reduces with increasing age from 11.8% in ages 16 to 24 years compared to 0.3% in males aged over 75 years.

Chart 5.3: Estimated male population in Shropshire with reported drug dependence

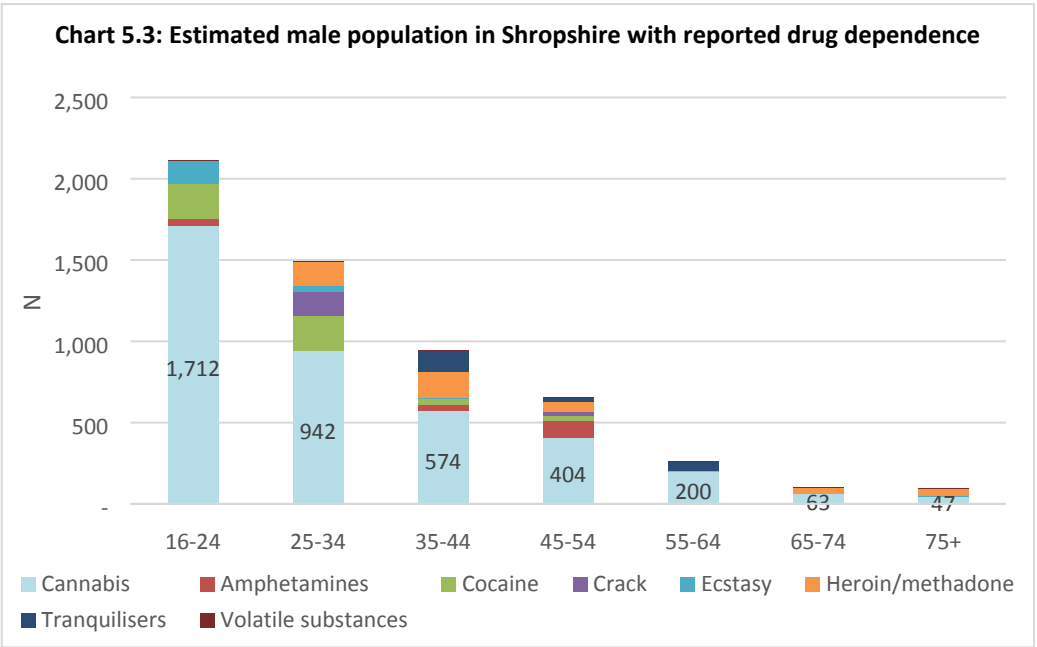
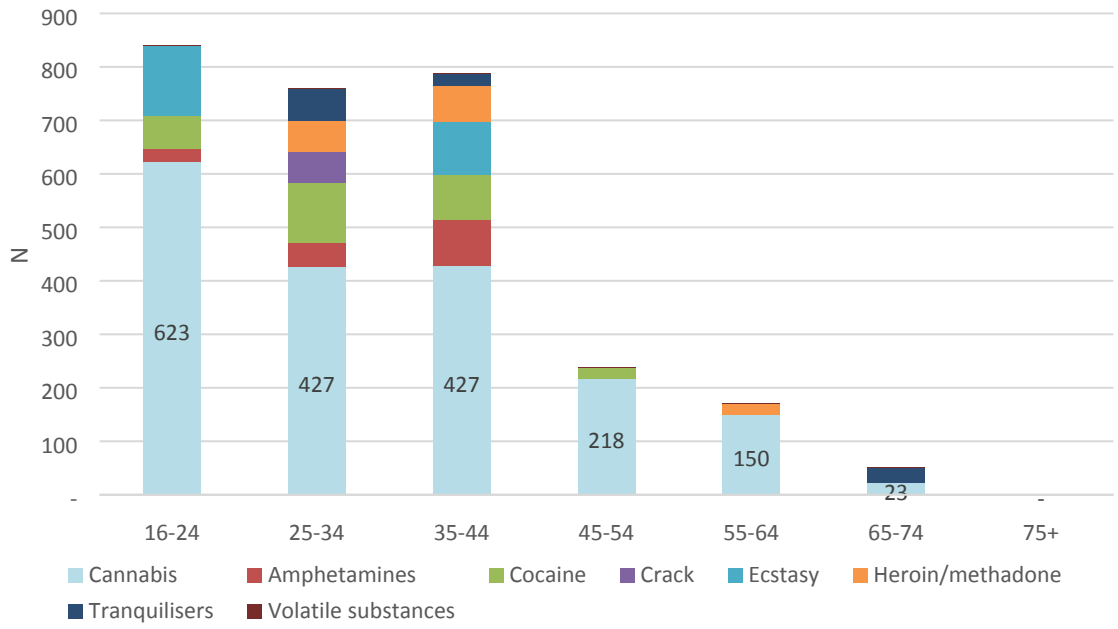


Chart 5.4 considers the same information for Shropshire females where cannabis is also the highest reported dependent drug followed by cocaine and ecstasy. The estimated numbers of dependency are roughly half that of males (except for ecstasy use which has a secondary peak use for females aged 35 to 44 years after those aged 16 to 24 years). For both males and females, dependence is most likely to be related to cannabis only.

Chart 5.4: Estimated female population in Shropshire with reported drug dependence



Adults receiving substance misuse and mental health treatment

Information from the latest JSNA provides information on the number of people who entered treatment in 2016-2017 and received care from a mental health services for issues other than substance misuse (tables 5.1 and 5.2).

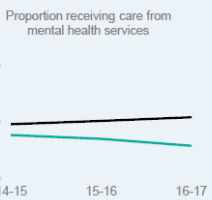
There were 38 (11%) new presentations for Shropshire alcohol misuse services during 2016/17 who were also receiving mental health treatment. This is below the England average of 21%. There was no local difference between the proportions of males or females accessing services (both at 11%), whereas nationally there is a greater proportion of females.

Table 5.1: Alcohol

Local National

Adults who entered treatment in 2016-17 and received care from a mental health service for reasons other than substance treatment

	Local n	Proportion of new presentations	Proportion by gender M	Proportion by gender F	National n	Proportion of new presentations	Proportion by gender M	Proportion by gender F
Receiving care from mental health services	38	11%	11%	11%	11,035	21%	19%	24%
Incomplete data	11	3%	2%	5%	3,905	7%	7%	8%



Please note the proportion of new presentations does not include those clients with a missing/incomplete dual diagnosis status.

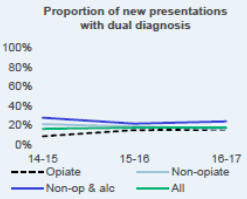
It can be seen in Table 5.2 that 51 people (17%) of all new presentations to drug misuse services in Shropshire during 2016/17 were also receiving mental health services (for a reason other than substance misuse). This is below the national average of 24%.

For each drug misuse category there is a greater proportion of Shropshire females being treated who also access mental health services which is consistent with the national data during this time period.

Table 5.2: Drugs

Adults who entered treatment in 2016-17 and received care from a mental health service for reasons other than substance misuse

	Local				National			
	n	Proportion of new presentations*	Proportion by gender M	F	n	Proportion of new presentations*	Proportion by gender M	F
Opiate	25	15%	13%	22%	8,846	22%	20%	27%
Non-opiate	12	16%	15%	27%	3,771	25%	23%	32%
Non-opiate and alcohol	14	24%	18%	50%	4,948	29%	26%	38%
All	51	17%	15%	28%	17,565	24%	22%	31%
Incomplete data								



** The proportion of new presentations does not include those clients with a missing/incomplete dual diagnosis status. There were 8 clients locally with a missing/incomplete status.*

Young people In Treatment (ages 10 to 18 years)

Information on young people is made available in the same format, however, in the JSNA for Young People in 2016/17 however, there were no young people identified as having a mental health need in young people's services. It is recognised locally there is an issue with the current referral pathways and this is a piece of work currently under review.

In the previous reporting period, 2015/16, the proportion of young people accessing substance misuse treatment in Shropshire with an identified mental health problem was higher (26%, n=9) than the England average (19%). The same proportion of 26% in Shropshire were identified as being involved with self-harm (n=9) compared with 17% of those entering treatment nationally. It is recognised however, that the small numbers involved make statistical differences between the local and national rates harder to identify.

Because of associated vulnerabilities such as mental health and self-harm, it is important that the pathways between treatment services and other specialist services such as child mental health services and children's social care work effectively so that those young people who are in a vulnerable situation can be protected from further escalation of substance misuse and the associated harms that that can cause.

Section 6: Co-morbidity in Mental and Physical Illness

The Kings Fund estimate that over four million people in England with a long term physical health problems also have a mental health problem[29] and that the risk factors for physical and mental health problems commonly overlap. The effect of social and environmental determinants on physical health can have a significant influence on resilience[30], which explains why the physical health of people with severe and enduring mental illness is often poor[31].

People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people[32], with two-thirds of these deaths from avoidable physical illnesses such as heart disease and cancer. This may be explained due to roughly half of all tobacco being consumed by people with a mental health problem and demonstrates a clear inequality. In addition, there are often difficulties for people with mental health problems to access physical healthcare support and people with long term illnesses suffer more complications if they also develop mental health problems, with depression increasing the risk of non-compliance with treatment programmes.

Conversely, mental wellbeing and resilience are protective factors for physical health as they reduce the prevalence of risky behaviours such as heavy drinking, illegal drug use, smoking and unhealthy food choices which are often used as coping and management mechanisms in the absence of other support. As such there is a sound argument towards achieving parity of esteem for mental health to be given equal priority to physical health.

Mental and Physical Health in Shropshire

Currently there is no readily available data to accurately quantify the numbers of people within Shropshire with both a long term illness and mental health problem and so estimates from the Adult Psychiatric Morbidity Survey (2014) have been applied.

According to the Adult Psychiatric Morbidity Survey, just over a quarter (27.7%) reported having at least one the following chronic conditions (in order of highest prevalence);

- High blood pressure (most common)
- Asthma
- Diabetes
- Cancer

The survey identified an association between common mental disorders and chronic physical conditions, with 37.6% of those with a more severe CMD symptom reporting a chronic physical condition compared to 25.3% of those with no or few symptoms of CMD.

[29] Naylor, C., Galea, A., Parsonage, M., McDaid, D., Knapp, M. and Fossey, M. (2012). Long-term conditions and mental health; the cost of co-morbidities. London: The Kings Fund/Centre for Mental Health.
[30] Faculty of Public Health (2016). Better mental health for all: a public health approach to mental health improvement. Available at: http://www.fph.org.uk/better_mental_health_for_all
[31] Barry S. Okena,B, Chaminea,I., Wakelandc, W. (2015). A systems approach to stress, stressors and resilience in humans. 44–154. P.150.
[32] NHS England (2016). The Five Year Forward View for Mental Health

Evidence has also found that the presence of self-reported diagnosed asthma and high blood pressure is associated with a wide range of different mental disorders including depression, anxiety disorders and phobias.

Table 6.1 applies the national rates of common mental disorders by chronic physical health to Shropshire adults. It can be seen that non-specified common mental disorders are the highest prevalent disorder associated which each long term health condition followed by anxiety disorder.

Table 6.1: Estimated number of Shropshire adults with co-morbidity chronic conditions and common mental disorder

Psychiatric disorders	All Adults in Shropshire (estimate)	Cancer	Diabetes	Asthma	High blood pressure
Generalized anxiety disorder	15,423	1,220	1,198	1,237	1,399
Obsessive-compulsive disorder	3,398	83	342	265	577
Depression	8,626	337	791	826	1,136
Phobia	6,274	120	373	558	1,016
Panic disorder	1,568	-	161	123	92
CMD Not otherwise specified	20,390	3,096	1,629	2,004	1,715

Section 7: Service User Feedback

Shropshire Council's Business Design Team were commissioned to undertake a research project between May and July 2017 to understand the mental health issues, trends, services provided and any gaps in service relating to mental health across Shropshire. This was achieved through undertaking 1 to 1 interviews (with the use of topic guides) to identify the opinions, thoughts and feelings expressed by service users and providers of mental health services in Shropshire.

A request was sent out via the Shropshire Mental Health Partnership Forum for any providers that would be interested in taking part in the project, both to be interviewed and to assist in recruiting service users. In total there were 19 clients (16 women and 3 men, age range estimate from early 20s to late 60s but mostly older people).

The interviewed service users were all from across the Shropshire area, all of whom have recently come into contact with Mental Health Services in Shropshire with some having long-term conditions that have meant many years of service use, being out of work and struggling to live independent lives. Conditions included anxiety/depression, eating disorders, bipolar, and psychosis, with some placed under a Section 136 and several having attempted suicide.

Nine provider organisations agreed to participate and were interviewed which included a mix of drop-in centres, counselling services, employment services, charities and advice and advocacy services. These organisations were;

1. Citizens Advice Bureaux
2. Confide Counselling Service
3. Designs in Mind (Oswestry)
4. Enable
5. Rethink -Shropshire Carers Group
6. Samaritans (Shrewsbury)
7. Shropshire Mind
8. SIAS - Shropshire Independent Advisory Service
9. Talking Point

In addition a paper survey was produced and shared for those who wanted to participate in the project but for whatever reason felt unable to speak with the interviewers directly. Initially there were 10 questionnaires which were completed and returned, however a further 15 men completed the survey in October 2017 with assistance from Shropshire MIND.

The key findings from these interviews are summarised below.

Overarching Themes

- Access to local mental health services is lengthy and complicated
- Users reported a good service once they found the right support
- Building relationships with professionals is very important to achieve positive outcomes
- Consistency in how support is provided needed to achieve positive outcomes
- Those with stronger family support generally achieve more positive outcomes supporting towards recovery (if can recognise signs before crisis)
- Peer support was identified as one of the most supportive ways of managing conditions along with counselling and medication
- Significant emerging trend of more younger people asking for help

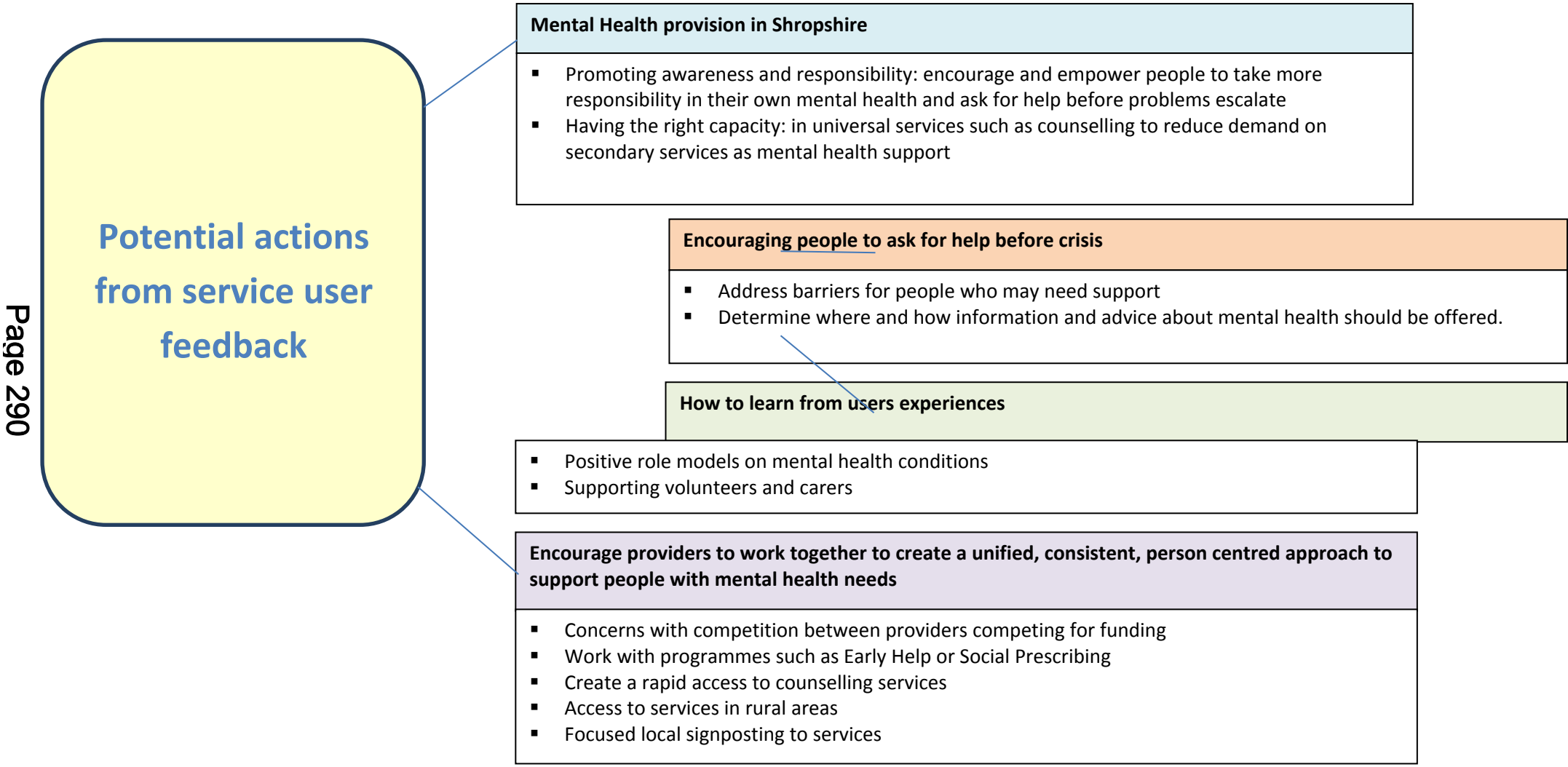
- Complexity of life (wider social problems) main contributing factor to mental wellbeing. For men this included gambling and debt. For women this included relationship problems and issues with abuse.

Emerging Trends

- Key reasons why people seek mental health help include Relationship difficulties, Problems at work, Bereavement, Financial (debt, gambling), Abuse, Addiction, Trauma/life events, Childhood trauma
- Trend of increasing older people seeking support - isolation and bereavement, dementia and Alzheimer's
- Children and young people are increasingly seeking mental health services for anxiety and depression from pressures at school, bullying, social media and abuse
- Isolation is a contributing factor not just of older people but amongst single parents (especially in rural locations) and those who work from home
- Increasing number of people from Caring professions seeking help for mental health issues (including teachers, medical professionals and police)

Potential Improvements identified by service users and providers

- Community Mental Health Team (CMHT) staff could shadow each other so that a wider range of experience could be learnt and share good practice across teams
- Those at a strategic level would benefit from shadowing 'ground level' staff and talking to service users
- Concerns raised by service users included the age and experience of some staff, who service users felt might be too young to really be able to empathise with their situation
- Counselling should be more tailored to individual needs rather than one size fits all approach (wider selection of counselling types)
- GPs should have more training in mental health issues
- A mental health specialist at every GP surgery who knows what support is available both formally and through the community
- Mental health service providers should attend at GP group sessions
- Service users wanted to ensure that all areas were served with mental health support services and that it should not just be a Shrewsbury centric service
- More drop in centres (Although a mixed review of their effectiveness was given) for more immediate support as well as being a regular place of safety for people who like to build relationships and have consistency in their support
- People wanted a faster, and less complicated way to access mental health services, with a central place that people can go to find information and advice
- Review individual circumstances not just the mental health issues as support to resolve wider social issues may assist with the mental health condition
- Shropshire needs a lean, joined up service, and that any strategy needs to have core principles that keep the person at its heart
- Importance of providing support services for mental health issues in the work place (felt there is currently a gap) - potential in working with the private sector to develop a model of support


Potential actions from service user feedback
Mental Health provision in Shropshire
Promoting awareness and responsibility: encourage and empower people to take more responsibility in their own mental health and ask for help before problems escalate
Having the right capacity: in universal services such as counselling to reduce demand on secondary services as mental health support
Encouraging people to ask for help before crisis
Address barriers for people who may need support
Determine where and how information and advice about mental health should be offered.
How to learn from users experiences
Positive role models on mental health conditions
Supporting volunteers and carers
Encourage providers to work together to create a unified, consistent, person centred approach to support people with mental health needs
Concerns with competition between providers competing for funding
Work with programmes such as Early Help or Social Prescribing
Create a rapid access to counselling services
Access to services in rural areas
Focused local signposting to services

Section 8: Commissioned Mental Health services in Shropshire

South Staffordshire and Shropshire NHS Foundation Trust (SSSFT) are commissioned to provide mental health and learning disabilities services to Shropshire patients and residents.

These services include the areas of;

i. Adult and older people's Mental Health Services
ii. Emotional Health and Wellbeing (for 0-25 year olds)
iii. Community Adult learning Disabilities
iv. Improving Access to Psychological Therapies

Adult and Older People's mental health services[33]

SSSFT are continuing to implement a service change in Shropshire called Community Remodelling which has moved service delivery away from traditional team based services to one of a pathway approach. In order for this to happen there needed to be a point of access, called Access, which provides triage for people and identifies which pathway they would be best suited to (as summarised in the table below);

Non-Psychosis Pathway (Care Clusters 1-7)	Provides assessment and evidence based time limited interventions for people who have complex mental health difficulties that are significantly impacting on daily life. *This would include mood disorders, anxiety disorders, trauma related conditions, and other severe emotional difficulties.*
Psychosis Team (Care Clusters 10 – 17)	Early intervention and services for people who may perceive or interpret reality in a different way from others, which may include having experiences of hearing or seeing things that others don't seem to, experiencing tastes, smells and sensations that have no apparent cause or holding beliefs that no one else seems to share even though logic and evidence may suggest other explanations. These thoughts and experiences may make it difficult to think clearly and can be distressing especially if they lead to feelings that others may want to cause harm.
Complex Care and Intensive Life Skills Team (Care Cluster 8)	Working with people who have complex mental health difficulties based on a personality disorder that is impacting on their ability to; regulate their emotions, maintain relationships (both within their own life but also with professionals and are often at high risk of harm to themselves. This pathway offers a structured approach to support the person to engage and learn to work with the distressing thoughts and feelings to achieve their goals.
Memory Service and Dementia Team (Care Clusters 18-21)	Provides assessment of people who are experiencing memory problems who may have Dementia and also a service to those who have a diagnosis of Dementia who require a routine review. The pathway also provides interventions to those diagnosed and/or their families /carers with specialised, intensive input from the team to help to remain in their home environment. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will also be supported through this pathway.
Crisis Resolution and Home Treatment	Urgent care pathways to help support people at home during a mental health crisis working with Psychiatry Liaison and the Rapid Assessment Intervention and

[33] A summary of the commissioned and community services provided by SSSFT is included within Tables 1 & 2

Team (CRHT)	Discharge team (RAID), based in the local accident and emergency departments of The Royal Shrewsbury Hospital in Shropshire and Princess Royal Hospital.

The pathways allow a more patient centred model with interventions and therapies being brought to the patient rather than them being referred internally to a different team. The intention is that under the pathways model the patient will receive more timely specialist interventions that have been clinically effective for their diagnosis and situation.

The Access team are available 24/7, the calls are answered by non-clinicians but they have direct access to clinicians between 8am-8pm Monday – Friday, outside of these hours they have clinical input from the crisis team. The Access team manage all requests for help including;

- General advice
- Arrangement new referrals including urgent referrals
- Arrangement of a Mental Health Act assessment
- To speak to clinician's about patients

Once a patient has been telephone triaged by Access they are picked up by the east or west administration hubs; east covering Market Drayton, Bridgnorth and Telford and west covering the rest Oswestry, Whitchurch, Shrewsbury and Ludlow, their assessment would generally take place locally to them.

Currently there is not a separate professional's line to phone. If a GP is seeking advice or to speak to a clinician about a new patient then the ACCESS number is the one to use. If a patient is open to the mental health team and the GP would like to speak to the patient's clinician about ongoing management concerns or to ask advice then the appropriate east or west admin hub would be phoned.

Emotional Health and Wellbeing Service (EHWB)

SSSFT won the tender for the new Child and Adolescent Mental Health Services (CAMHS) which is named the Emotional Health Wellbeing Service. The EHWB has a variety of options to help families, children and young people where their mental health and emotional wellbeing may need some extra support or help.

SSSFT are the lead provider of the EHWB service and deliver the CAMHS/NHS element of services including a community based mental health services (early intervention through to specialist treatment and crisis resolution for young people with mental health problems). The EHWB service is also delivered in partnership with The Children's Society, Kooth and Healios, with a range of support available includes online forums with peer support and trained counsellors, online CBT (Cognitive Behavioural Therapy) service, drop in sessions for young people and their families, specialist assessment and support via mental health practitioners including crisis care management.

The Children's Society	A national charity that runs local services in Shropshire to help children and young people when they are at their most vulnerable. This service delivers health promotion, prevention and early help and support as well as working with young people to aid transition/sign posting to other services or resources. Drop in' sessions are also being provided in Shrewsbury every Thursday 1pm-6pm at Palmers Coffee Shop, Belmont Church, Claremont Street. This drop in is open for children, parents and professionals. Other drop ins will be opening soon.

Kooth	A 24 hour available online support service which can be accessed anonymously via phone, tablet, laptop or PC and offers peer support, self-help material and gives children and young people access to live forums. Professional councillors for live online chats are available Monday to Friday 12pm to 10pm and weekends/bank holidays between 6pm and 10pm. Anyone aged 11-25, living in Shropshire and Telford & Wrekin, can register to access this service without referral.
Healios	An online psychological therapy service delivered by qualified practitioners and is available between 8am and 9pm, 7 days a week.

There were over 660 young people on the waiting list across Shropshire, Telford and Wrekin in January 2017 so the partnership was asked to begin work on addressing the waiting list in preparation for the contract commencing 1st May 2017.

As of September 2017 there were less than 50 people on the waiting list and all have been actioned and allocated to case workers.

The vision and specification for the EHWB service is a significant change to what was before and implementing the new service is a change in culture. The main focus of work is on implementing the IT infrastructure, moving from paper records to an electronic patient record. This is fundamental in order to operate across the partnership and be able to develop an effective single point of access.

The IT infrastructure is due to be complete at the end of October. Work will commence on the single point of access in autumn. Until then the referral process has not changed and it is still via COMPASS.

Adult Learning Disability Services

There is redesign of learning disabilities services underway and is expected to be out for consultation in autumn.

Improving Access to Psychological Therapies

A redesign of psychological therapies is underway and options appraisal on delivery models will be completed in October 2017.

The map on the following page displays the geographic location of the SSSFT Community Mental Health Services in Shropshire. Further details of access to specific services provided at each location are described in Tables 8.1 and 8.2.

Map 8.1: Locations of Mental Health Community locations across Shropshire

Mental Health Community Locations across Shropshire
13 views
SHARE

West Locality

- 71 Salop Road, Oswestry, SY11 2NQ
- Thomas Savin Close, Off Gobowen Road,...
- Redwoods Centre, Somerby Drive, Shrew...
- 28 Corve Street, Ludlow, SY8 1DA
- Severn Fields Health Village, Sundorne R...

East Locality

- Fuller House, Hall Court Way, Telford, TF...
- Market Drayton Cottage Hospital, Shrops...
- Northgate House, Bridgnorth, WV16 4EN

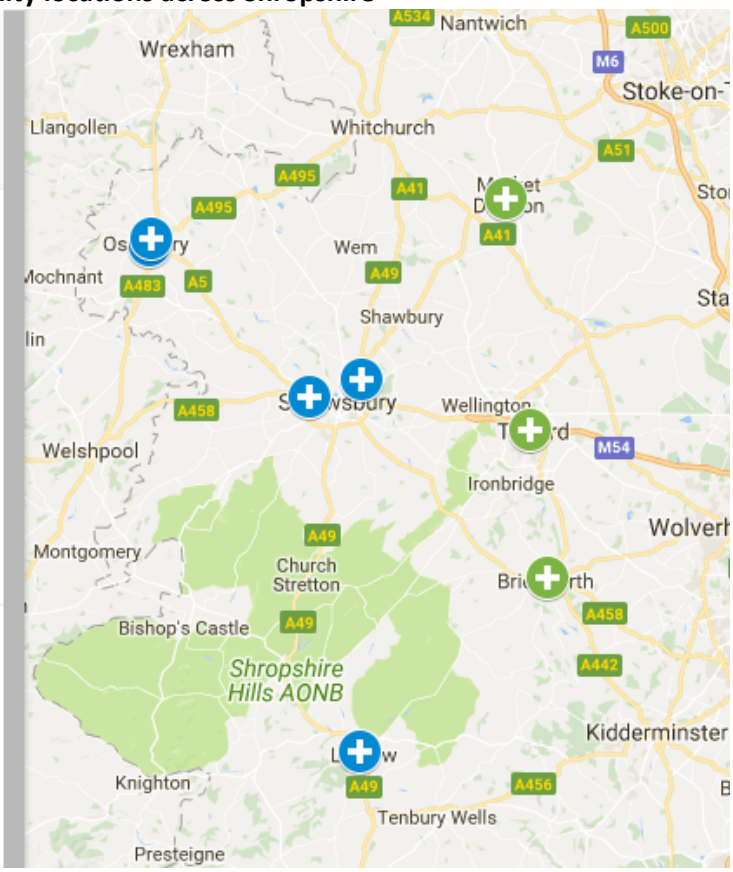


Table 8.1: Summary of South Staffordshire and Shropshire NHS Foundation Trust Commissioned services in Shropshire

Service area	Emotional Health and Wellbeing Service (0-25)	Adult Learning Disabilities	Improving Access to Psychological Therapies	Adult and Older people's Mental health Services
Contact	Is via COMPASS 0345 6789021 Web: http://mentalhealth.sssft.nhs.uk/322-corporate-content/0-to-25	Tel: 01743 211210 Mytton Oak Royal Shrewsbury Hospital(North) Shrewsbury SY3 8XQ	0300 123 6020	Is via ACCESS Tel: 0300 124 0365 Fax: 0300 3033425 Email: access.shropshire@sssft.nhs.uk The Redwoods Centre, Somersby Drive, Shrewsbury, SY3 8DS
Services	• Drop-ins (Shrewsbury and Wellington) • Kooth: Anonymous online counselling, peer support, self-help and forums via www.kooth.com • Healios. Evidence based psychological interventions delivered online. Access to this is via a face to-face assessment. • SSSFT – more traditional CAMHS element, mental health, neuro-development and learning disabilities	• Psychiatry • Learning Disability Nurses • Psychology • Occupational Therapy • Speech and Language	• Therapies include • CBT • Counselling, • EMDR (eye movement desensitisation and reprocessing), • ACT (acceptance and commitment therapy, • IPT (interpersonal psychotherapy • Wellbeing courses that can be delivered in person, by telephone, via email and in a group setting.	• New Referrals • Crisis • Mental Health Act Assessments • Advice • Speak to Clinician (new patient) West Admin Hub – 0300 303 4326 East Admin Hub – 0300 303 1601 • Speak to clinician about ongoing management of a patient already open to services.

Table 8.2: Summary of South Staffordshire and Shropshire NHS Foundation Trust Community services provided in Shropshire

Location site name	Name of services provided at location (If more than one type of service is provided at a location, list each service type in a separate row)	Brief description of team/ward and services provided (150 words max) OR provide link to document on Trust Website	Name, address and postcode for each service (Include name and contact details for community or inpatient service manager)	Main phone number for service
25 Corve Street	Memory Service and Dementia West Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Alison Marpole, 25 Corve Street, Ludlow, Shropshire, SY8 1DA alison.marpole@sssft.nhs.uk	0300 303 3426
25 Corve Street	MH Non-Psychosis West Shrops	"This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attacks and obsessive-compulsive disorder and trauma experiences across the West Shropshire locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke for this pathway with the main hub being based in Severnfields, Shrewsbury.	Carrie Spafford, 25 Corve Street, Ludlow, Shropshire, SY8 1DA carrie.spafford@sssft.nhs.uk	0300 303 3426

25 Corve Street	MH Psychosis West Shrops	This service provides specialist intervention for people with more complex mental health problems across West Shropshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke with the main hub for this service being Severn Fields, Shrewsbury.	Rob Fry, 25 Corve Street, Ludlow, Shropshire, SY8 1DA rob.fry@sssft.nhs.uk	0300 303 3426
71 Salop Road	MH Non-Psychosis West Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the West Shropshire locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke for this pathway with the main hub being based in Severnfields, Shrewsbury.	Carrie Spafford, 71 Salop Road, Oswestry, Shropshire, SY11 2NQ carrie.spafford@sssft.nhs.uk	0300 303 3426
71 Salop Road	MH Psychosis West Shrops	This service provides specialist intervention for people with more complex mental health problems across West Shropshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke with the main hub for this service being Severn Fields, Shrewsbury.	Rob Fry, 71 Salop Road, Oswestry, Shropshire, SY11 2NQ rob.fry@sssft.nhs.uk	0300 303 3426

71 Salop Road	Memory Service and Dementia West Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Alison Marpole, 71 Salop Road Oswestry, Shropshire SY11 2NQ alison.marpole@sssft.nhs.uk	0300 303 3426
Hall Court	Memory Service and Dementia East Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Sarah Broadbent, Hall Park Way, Telford, Shropshire, TF3 4NF sarah.broadbent@sssft.nhs.uk	0300 303 1601
Hall Court	MH Non-Psychosis East Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the East Shropshire and Telford and Wrekin locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. Hall Court is the main hub for this pathway across the	Helen McIntyre, Hall Park Way, Telford, Shropshire, TF3 4NF helen.mcintyre@sssft.nhs.uk	0300 303 1601

		locality.		
Hall Court	MH Psychosis East Shrops	This service provides specialist intervention for people with more complex mental health problems across East Shropshire and Telford and Wrekin. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is the main hub for this service.	Kerry Endsor, Hall Park Way, Telford, Shropshire, TF3 4NF kerry.endsor@sssft.nhs.uk	0300 303 1601
Hall Court	Intensive Life Skills Shropshire	This service is for people who experience a fractured sense of self, have difficulties managing their emotions and tolerating distress. They may be self-harming in a number of ways that are potentially life threatening and experiencing on-going suicidality. They will have difficulties that stretch beyond their internal experiences in terms of difficulty forming and maintaining good attachments, occupying themselves in a way that is satisfying and may gamble, be sexually promiscuous and/or misuse drugs or alcohol. The model of care is a team approach, using structured clinical care, DBT and Mentalisation work to support service users to develop life skills that will support them.	Kerry Endsor, Hall Park Way, Telford, Shropshire, TF3 4NF kerry.endsor@sssft.nhs.uk	0300 303 1601
Hall Court	IAPT Telford & Wrekin	The Wellbeing service in Telford and Wrekin are a 16+ service who encourage self-referral to access a range of NICE approved treatment options for low mood and/or anxiety disorders.	Lucy Cotterill lucy.cotterill@sssft.nhs.uk St. Hall Park Way, Telford, Shropshire, TF3 4NF	01952 457415
Hall Court	CRHT Telford & Wrekin	Crisis Resolution and Home Treatment teams focus on delivering care to acutely mentally unwell people in the community. They: • Respond quickly to and assess people who appear to be suffering from a MH related crisis • Support people with identified moderate to severe MH problems to stay at home where it is likely that without that support they would need psychiatric hospital care • Gate-keep all admissions to general adult and older adult psychiatric beds to ensure that they are used according to need • Work with certain people admitted to hospital to try and facilitate discharge at the earliest and safest opportunity.	Maryan Davies, Hall Court, Hall Park Way, Telford, TF3 4NF maryan.davies@sssft.nhs.uk	01952 741880

Market Drayton Day Centre	Memory Service and Dementia East Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Sarah Broadbent, Shropshire Street, Market Drayton, Shropshire, TF9 3DQ sarah.broadbent@sssft.nhs.uk	0300 303 1601
Market Drayton Day Centre	MH Non-Psychosis East Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the East Shropshire and Telford and Wrekin locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. Hall Court is the main hub for this pathway across the locality.	Helen McIntyre, Shropshire Street, Market Drayton, Shropshire, TF9 3DQ helen.mcintyre@sssft.nhs.uk	0300 303 1601
Market Drayton Day Centre	MH Psychosis East Shrops	This service provides specialist intervention for people with more complex mental health problems across East Staffordshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is the main hub for this service.	Sam Kearns, Shropshire Street, Market Drayton, Shropshire, TF9 3DQ sam.kearns@sssft.nhs.uk	0300 303 1601

Northgate Health Centre	Memory Service and Dementia East Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Sarah Broadbent, Northgate, Bridgnorth, WV16 4EN sarah.broadbent@sssft.nhs.uk	0300 303 1601
Northgate Health Centre	MH Non-Psychosis East Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attacks and obsessive-compulsive disorder and trauma experiences across the East Shropshire and Telford and Wrekin locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a spoke with the main hub being Hall Court, Telford	Helen McIntyre, Northgate Health centre , Bridgnorth, WV16 4EN helen.McIntyre@sssft.nhs.uk	0300 303 1601
Northgate Health Centre	MH Psychosis East Shrops	This service provides specialist intervention for people with more complex mental health problems across East Shropshire and Telford and Wrekin. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is a hub with the main hub being Hall Court, Telford for this service.	Kerry Endsor, Northgate Health centre, Bridgnorth, WV16 4EN kerry.endsor@sssft.nhs.uk	0300 303 1601

Oswestry Primary Care Centre	IAPT	Providing CBT, counselling, EMDR and other NICE Guidance recommended psychological therapy interventions for patients with low mood, stress or anxiety problems. Service covers the whole of Shropshire county and uses various community venues including, but not limited to, GP surgeries.	Anne O'Shea, Thomas Savin Close, Off Gobowen Road, Oswestry, Shropshire, SY11 1HS anne.oshea@sssft.nhs.uk	0300 123 6020
Severn Fields Health Village (Ground Floor)	MH Non-Psychosis West Shrops	This pathway delivers support, treatment and therapy for patients who suffer from depressive and anxiety disorders such as phobias, panic attaches and obsessive-compulsive disorder and trauma experiences across the West Shropshire locality. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. These pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This is the main hub for this pathway and locality	Carrie Spafford, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ carrie.spafford@sssft.nhs.uk	0300 3033426
Severn Fields Health Village (Ground Floor)	MH Psychosis West Shrops	This service provides specialist intervention for people with more complex mental health problems across West Shropshire. The service consists of multi-disciplinary teams providing community care in collaboration with partner agencies, both statutory and non-statutory. Pathway teams have been established in line with the nationally developed Mental Health Care Clusters, replacing Community Mental Health Teams (CMHTs) by operating a 'hub and spoke' model of service delivery. This location is the main hub for this service.	Rob Fry, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ rob.fry@sssft.nhs.uk	0300 3033426
Severn Fields Health Village (Ground Floor)	Intensive Life Skills Shropshire	This service is for people who experience a fractured sense of self, have difficulties managing their emotions and tolerating distress. They may be self-harming in a number of ways that are potentially life threatening and experiencing on-going suicidality. They will have difficulties that stretch beyond their internal experiences in terms of difficulty forming and maintaining good attachments, occupying themselves in a way that is satisfying and may gamble, be sexually promiscuous and/or misuse drugs or alcohol. The model of care is a team approach, using structured clinical care, DBT and Mentalisation work to support service users to develop life skills that will support them. .	Kerry Endsor, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ kerry.endsor@sssft.nhs.uk	0300 3033426

Severn Fields Health Village (Ground Floor)	Memory Service and Dementia West Team Shrops	This service supports people of all ages with a cognitive impairment in Clusters 18-21. People with a psychosis or non- psychosis presentation in Clusters 1-17, but whose physical health impacts on their mental health resulting in increasing complexity of their needs, will pull support from this service. The service consists of the following: - Extend the use of specialist nurse practitioners in memory clinics to support earlier diagnosis and treatment. - Partnership working with 3rd sector providers with post diagnostic support local to the service user's home. - Extend and enhance the Home Treatment (SHIELD) service to further support people with dementia and their carers at home. - Provide a broader spectrum of psychological therapies for older people across all pathways, including within home treatment delivery.	Alison Marpole, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ Alison.marpole@sssft.nhs.uk	0300 3033426
Severn Fields Health Village (Ground Floor)	IAPT	Providing CBT, counselling, EMDR and other NICE Guidance recommended psychological therapy interventions for patients with low mood, stress or anxiety problems. Service covers the whole of Shropshire county and uses various community venues including, but not limited to, GP surgeries.	Anne O'Shea, Sundorne Road, Shrewsbury, Shropshire, SY1 4RQ anne.oshea@sssft.nhs.uk	0300 123 6020
The Redwoods Centre	CRHT Shropshire	Crisis Resolution and Home Treatment teams focus on delivering care to acutely mentally unwell people in the community. They • Respond quickly to and assess people who appear to be suffering from a MH related crisis • Support people with identified moderate to severe MH problems to stay at home where it is likely that without that support they would need psychiatric hospital care • Gate-keep all admissions to general adult and older adult psychiatric beds to ensure that they are used according to need • Work with certain people admitted to hospital to try and facilitate discharge at the earliest and safest opportunity.	Dave Wilkinson, The Redwoods Centre, Somerby Drive, Bicton Heath, Shrewsbury, SY3 8DS dave.wilkinson@sssft.nhs.uk	01743 210050

The Redwoods Centre	Access Shropshire	Providing a single point of contact for enquiries and referrals 24/7 for the mental health pathways Psychosis, Non-Psychosis, Intensive Life Skills and Dementia and Memory Services. The single point of access manages all requests for help, including: - Urgent and non-urgent referrals, including self-referrals - Booking and rebooking of appointments - Providing facilitated guidance, advice and information including signposting to other services - Gathering all relevant information and documentation in preparation for the assessment appointment	Colin Gittins, Redwoods Centre, Somerby Drive, Shrewbury, SY3 8DS colin.gittins@sssft.nhs.uk	0300 124 0365

Additional Services:

Shropshire Sanctuary

As discussed in a previous Chapter, the Shropshire Sanctuary provides an alternative location to Section 136 for people in crisis/mental distress. The service is provided by Shropshire MIND in conjunction with other partners (including West Mercia Police) and is commissioned by Shropshire CCG to provide an out of hours service. As of January 2018, Telford CCG has also contributed funding for 3 months (until 31st March 2018) to provide the service for 18 hours a day and covering the whole of the Shropshire and Telford areas. There is ambition that funding to continue the longer opening hours will be made available from April 2018.

The wider voluntary and community organisations in Shropshire which provide service to help people manage and improve mental wellbeing are described in Table 8.3 (on the following page).

Table 8.3: Summary of Voluntary and Community Sector organisations supporting wellbeing and mental health in Shropshire

Focus	Organisation	Contact
Advocacy	Age UK	3 Mardol Gardens, Shrewsbury SY1 1PR 01743 233 123 Enquiries@ageukstw.org.uk
	SIAS (Shropshire Independent Advocacy Service	The Redwoods Centre, Somerby Drive, Shrewsbury SY3 8DS 01743 361702 enquiries@siasonline.org
	PCAS (Peer Counselling and Advocacy Service)	2 The Old Railway Station, Oswald Rd, Oswestry SY11 1RE 01691 658008 info@shropshire-pcas.co.uk
	POhWER (Independent Mental Capacity Advocacy)	0300 456 2370
Autism	A4U	The Autism Hub, Louise House, Roman Road, Shrewsbury, SY3 9JN 01743 539 201
Bereavement	Cruse	The Roy Fletcher Centre 12-17 Cross Hill, Shrewsbury 0 0845 606 6812 Shropshiretelford&wrekin@cruse.org.uk
Counselling	Confide	The Roy Fletcher Centre 12-17 Cross Hill, Shrewsbury 0 01743 351319 enquiries@confide.org.uk
	Green Oak	Unit B, Silkmoor, New Street, Frankwell, Shrewsbury SY3 8LN 01743 340880 info@greenoakfoundation.co.uk
Disability	Disability Network	Info@shropshire-disability.net
Domestic Abuse / Violence	Shropshire Domestic Abuse Service	0300 303 1191 http://www.shropshirehousing.org.uk/domesticviolence
	West Mercia Women's Aid	0800 7831359
Ex-service people	Walking with the Wounded	01263 863900 info@wwtw.org.uk

	Combat Stress	0800 138 1619 Text 07537 404 719 helpline@combatstress.org.uk
Homelessness	The Ark	10 Castle Foregate, Shrewsbury SY1 2DJ 01743 363305 ark@shrewsburyark.co.uk
Mental Health	Mind	Observer House, Holywell street Shrewsbury SY2 6BL 01743 368647
Money problems / debt	StepChange	0800 138 1111
	Citizens Advice Bureau	0344 499 1100
	Barnabas	01743 364101 barnabascommunityprojects@gmail.com
Older Men	Men in Sheds	Louise House Roman Road, Shrewsbury SY3 9JN 07833204273
Older People	Age UK	3 Mardol Gardens, Shrewsbury SY1 1PR 01743 233 123 enquiries@ageukstw.org.uk
Self-harm	Sapphire	07946 061 463
Rape and Sexual Abuse	Axis	Fletcher House, Coleham Head, Shrewsbury SY3 7BH 01743 357777
	The Glade	0808 178 2058 info@theglade.org.uk
People with suicidal thoughts and people in need of emotional support	Samaritans	Swan House, Coleham Head, Shrewsbury SY3 7BH Helpline Local phone 01743 369696 Helpline Freephcall 116123 Helpline Email jo@samaritans.org Helpline Text 07725 90 90 90Office Voicemail 0772 467 1122 Office Email enquiries@shrewsburysamaritans.org.uk

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Shropshire Mental Health Partnership Board

Shropshire Adult Mental Health Needs Assessment

May 2018

Purpose of the Health Needs Assessment

1. To describe the patterns of mental health problems for adults within Shropshire
2. Identify inequalities in Mental Health
3. Determine priorities for the most effective use of resources

Note:

- The focus of the Needs Assessment is adult mental health
- This is because children & young people's needs have been recently considered during the commissioning of the 0 to 25 year Emotional Health & Wellbeing Service

Introduction: What is a mental health problem?

A term used to define poor mental health and negative mental health status.

It includes;

Mental disorders:

- An identified mental health problem
- Can meet the criteria for psychiatric diagnosis
- Or can be recognised but falls short of the diagnostic criteria threshold

Common mental health problems:

- Can lead to long term physical, social or occupational disability if not treated
- High prevalence and greater cumulative cost to society
- Includes anxiety, depression & specific phobias

Severe mental health problems:

- Can produce disturbances in thinking to distort perceptions of reality
- Can involve crisis – unable to cope or be in control of a situation
- Uncommon but high level of service and societal cost
- Includes schizophrenia, bipolar disorder and various behavioural disorders

What is emotional wellbeing?

Defines non-diagnosable positive mental health

It includes

Feeling good:

- A subjective measures
- Includes happiness and life satisfaction

Functioning well:

- A wide range of psychological wellbeing factors
- Includes self-acceptance, personal growth, life purpose, positive relations with others and control over one's environment

Managing a state of mental wellbeing is associated with positive social outcomes such as;

- ❑ Educational success
- ❑ Wealth
- ❑ Employment
- ❑ Acceptance of others
- ❑ Compassion
- ❑ Self awareness

Risk Impact of poor Mental Health

The majority of mental ill health problems go unrecognised and untreated

People with mental health problems are more likely to experience;

- ❑ Physical health problems
- ❑ Smoke
- ❑ Be overweight
- ❑ Use drugs and drink alcohol to excess
- ❑ Have a disrupted education
- ❑ Be unemployed/have low socio-economic status
- ❑ Take time off work
- ❑ Fall into poverty
- ❑ Be over-represented in the criminal justice system
- ❑ Relationship difficulties

- Mental health is the cause of 40% of new disability benefit claims each year in the UK
- 70% of people with severe mental health problems are economically inactive and on disability benefit (compared to 30% of the general population).

Singh, S. (February 2014). Mental Health and Work: United Kingdom Paris: Organisation for Economic Co-operation and Development. Available at: http://www.oecd.org/els/mental-health-and-work-united-kingdom-9789264204997-en.htm

Mental Health during the Lifecourse

Starting Well

Mental health problems often begin early in life

- Over 50% of problems are established by age 14 and 75% by age 24 years

- Perinatal mental health illness during pregnancy and during the first year after birth affects up to 20% of women
  - If left untreated it can have a significant and long lasting effects on the woman and her family

Living Well

- During adulthood, mental health problems can impact upon an individual's ability to maintain employment, housing and secure family relationships.

Ageing Well

- Depression in older people affects up to 25% of the population and up to 40% of people in Care Homes.

- Dementia affects 1 in 5 5 of people over the age of 80 years, which is of even greater risk in an ageing population.

Methodology

Inclusion Criteria assessed within the Needs Assessment	• Analysis of the epidemiology of adult mental health problems in Shropshire • Use of local and national qualitative information related to diagnosis and access to mental health services • Use of qualitative information from adult service users who currently access or who have accessed mental health services in Shropshire • Consideration of co-morbidity of mental and physical health issues • Mental health illness due to psychoactive substance misuse

Exclusion Criteria	• Children and young people aged under 18 years
	• People with learning disabilities
	• Adults where the primary diagnosis is related to autism and conditions such as ADHD
	• Conditions and circumstances where a Strategy is already in place (and can be referenced for the production of an overarching Mental Health Strategy)
	  • Alzheimer's and dementia as a dementia strategy was developed in 2017
	  • Carers as an All Age Carers Strategy for Shropshire was developed in 2017
	  • Shropshire CCG and Shropshire Council: Dementia Strategy 2017 - 2020
	  • Shropshire Together All Age Carers Strategy for Shropshire 2017 – 2021

Findings

- In general the mental health of people in Shropshire is better than that of the West Midlands and the England average
- Mapping of the wider determinants risks of poor mental health in Shropshire of; living in social housing/rented accommodation, living alone, being a single parent household, having a lower educational attainment identified the locations of Highley, Ludlow, Market Drayton, Shrewsbury, Oswestry, Wem and Whitchurch as the highest risk localities
- This aligns with the highest prevalence of recorded conditions in Shropshire (as shown below)

Mental Disorder	Highest standardised prevalence density rate per 100,000 people in Shropshire
Common Mental Disorders	Oswestry Town, Wem, Whitchurch, Market Drayton
Severe, enduring MH illness	Wem, West & Central Shrewsbury and South Shrewsbury
Psychotic Disorders	Ellesmere, Oswestry Town, West & Central Shrewsbury and South Shrewsbury.

Client and Provider Experience: Qualitative Feedback

- 9 provider organisations were interviewed (mix of drop-in centres, counselling services, employment services, charities and advice and advocacy services)
- One-to-one interviews with 19 clients (16 women and 3 men)
- In addition - 28 paper questionnaire returns

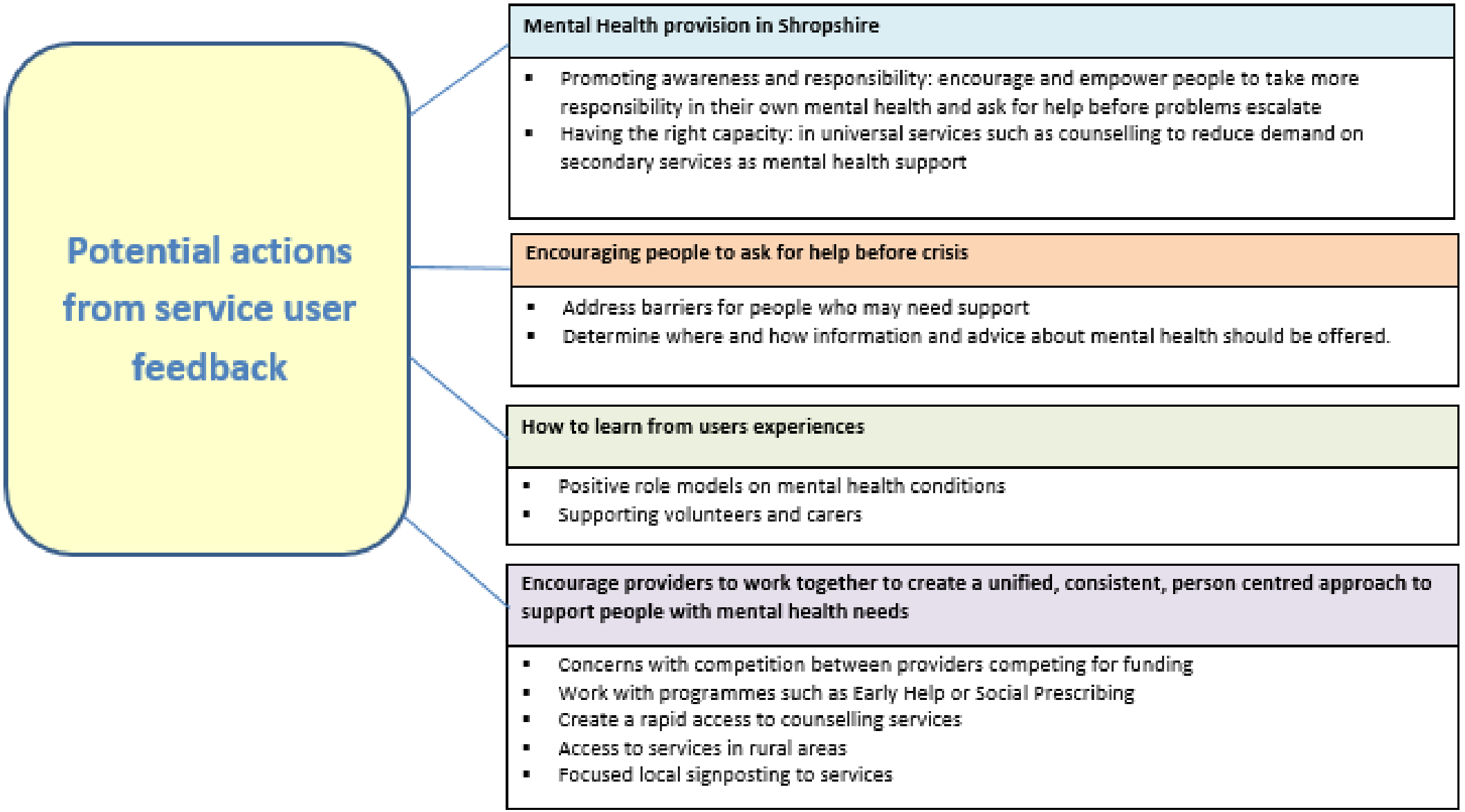
Overarching Themes

- Access to local secondary mental health services is lengthy and complicated
- Users reported a good service once they found the right support
- Building relationships with professionals is very important to achieve positive outcomes
- Consistency in how support is provided needed to achieve positive outcomes
- Those with stronger family support generally achieve more positive outcomes supporting towards recovery (if can recognise signs before crisis)
- Peer support identified as a very supportive way of managing conditions along with counselling and medication
- Significant emerging trend of more younger people asking for help
- Complexity of life (wider social problems) main contributing factor to mental wellbeing. For men this included gambling and debt. For women this included relationship problems and issues with abuse.

Client and Provider Experience: Qualitative Feedback

Emerging Trends

- Key reasons why people seek mental health help include Relationship difficulties, Problems at work, Bereavement, Financial (debt, gambling), Abuse, Addiction, Trauma/life events, Childhood trauma
- Trend of increasing older people seeking support - isolation and bereavement, dementia and Alzheimer's
- Children and young people are increasingly seeking mental health services for anxiety and depression from pressures at school, bullying, social media and abuse
- Isolation is a contributing factor not just of older people but amongst single parents (especially in rural locations) and those who work from home
- Increasing number of people from Caring professions seeking help for mental health issues (including teachers, medical professionals and police)


Potential actions from service user feedback
Mental Health provision in Shropshire
Promoting awareness and responsibility: encourage and empower people to take more responsibility in their own mental health and ask for help before problems escalate
Having the right capacity: in universal services such as counselling to reduce demand on secondary services as mental health support
Encouraging people to ask for help before crisis
Address barriers for people who may need support
Determine where and how information and advice about mental health should be offered.
How to learn from users experiences
Positive role models on mental health conditions
Supporting volunteers and carers
Encourage providers to work together to create a unified, consistent, person centred approach to support people with mental health needs
Concerns with competition between providers competing for funding
Work with programmes such as Early Help or Social Prescribing
Create a rapid access to counselling services
Access to services in rural areas
Focused local signposting to services

Emotional Wellbeing

People in Shropshire report better emotional wellbeing compared to the West Midlands and England average, with;

- Higher feelings of happiness
- Greater life satisfaction
- More feeling the things they did in their lives were worthwhile
- Fewer reporting feelings of anxiousness compared to England and West Midlands averages

Taken from ONS statistical bulletin: Personal wellbeing in the UK. July 2016 to June 2017
https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/july2016tojune2017

Common Mental Disorders (CMD)

Risk associated with poverty, unemployment, being female, social isolation, ethnic populations and smokers

In Shropshire

- Highest rates for mixed anxiety and depression diagnosis (based on mapping results of the Adult Psychiatric Morbidity Survey (2014) to local population)
- Significantly higher rates for women compared to men
- Higher rates in women aged 25 to 44 years (849 per 100,000 people)
- Highest rates in men aged 15 to 24 years (836 per 100,000 people)
- Most prevalent in deprived areas

Improving Access to Psychological Therapies (IAPT)

IAPT provides interventions to treat depression and anxiety disorders and is accessed via self-referral or via GP/other services

Key messages (from PHE Fingertips)

Access to Services		
Increasing national and local trend between 2013 and 2017 of people estimated to have depression/anxiety accessing services (statistically similar rates)	Referral rates into IAPT and the rate of people who enter treatment following referral are consistently lower in Shropshire compared to England averages	A consistently higher proportion of people between May 2015 and May 2017 accessed their first treatment within 6 weeks in Shropshire compared to England
Completion and Recovery		
Between 2013/14 and 2016/17, a consistently lower proportion of people complete IAPT treatment in Shropshire compared to the England average	Conversely, since June 2015 a similar to higher proportion of Shropshire clients that completed their treatment have moved onto recovery compared to the England average	69.6% (n=400) clients that completed IAPT treatment achieved reliable improvement in 2017/18 (similar to England average of 66.4%)

Common Mental Disorders (CMD)

Shropshire is performing better than the England average for

- Lower rates of mixed anxiety and depressive disorder (6.6% compared to England 8.9%, PHE 2012)
- Lower rates of all other CMDs including phobias, obsessive compulsive disorder, panic disorder & eating disorders)
- Lower hospital admission rate for depression (20.9 per 100,000 people compared to England 32.1 per 100,000 people)

Shropshire is performing worse than the England average for

- QoF recorded depression prevalence (9.9% compared to England 9.1%, PHE 2016/17 and increasing trend)

Severe and Enduring Mental Illness

Risk associated with ethnicity, economically inactive and social isolation

In Shropshire

- Significantly higher rates of women with non psychotic but severe and complex mental health illness, particularly aged 15 to 24 years
- Similar rates for males and females for ongoing psychotic episodes, with highest female rate aged 45 to 64 years and highest male rate aged 15 to 44 years
- Higher rate of psychotic crisis in males with similar rates between age bands
- 0.36% (n=1,409): estimated prevalence of psychotic disorder in people over 16 years in Shropshire
- Rate of GP prescriptions for psychoses and related disorders is lower in Shropshire compared to England average between 2014/15 and 2107/18

Severe and Enduring Mental Illness

Shropshire is performing better than the England average for

- Lower GP practice registers with recorded severe mental illness prevalence (0.78% compared to England 0.92%, PHE 2016/17)
- Lower rate of people subject to be detained in hospital by the Mental Health Act (9.8 per 100,000 people, n=25 compared to England 38.4 per 100,000 people, PHE Q1 2017/18)
- Incidence of new cases of psychosis is significantly lower than the England average (16.3 per 100,000 people compared to 24.2 per 100,000 nationally)

Shropshire is performing worse than the England average for

- Higher proportion of people with a long term health problem or disability (18.6% compared to England 17.6%, PHE 2011)

Crisis: Suicide

- Suicide is the leading cause of premature death in men under 50 years
- Risk is associated with self-harm history, suicide history in friends or family, substance misuse, unemployment, loneliness, chronic illness, and occupation (including medical, vets, farmers, those in labourer or construction roles)

In Shropshire

- Across Shropshire and Telford & Wrekin there were 95 suicide deaths between 2014 and 2016 (69 men, 27 women)
- The local suicide rate (9.7 per 100,000 in 2013-15) has been statistically similar to the England average rate since 2010/12 and the rate has been reducing in recent years.
- Suicidal thoughts are the predominant reason why people in Shropshire are admitted to a Section 136 Suite (police based place of safety) or access the Shropshire Sanctuary (an out of hours care suite set up by Shropshire MIND and CCG as an alternative to a Section 136)
- A&E attendance for deliberate self harm is strongly associated with those from most deprived parts of Shropshire

Suicide Prevention

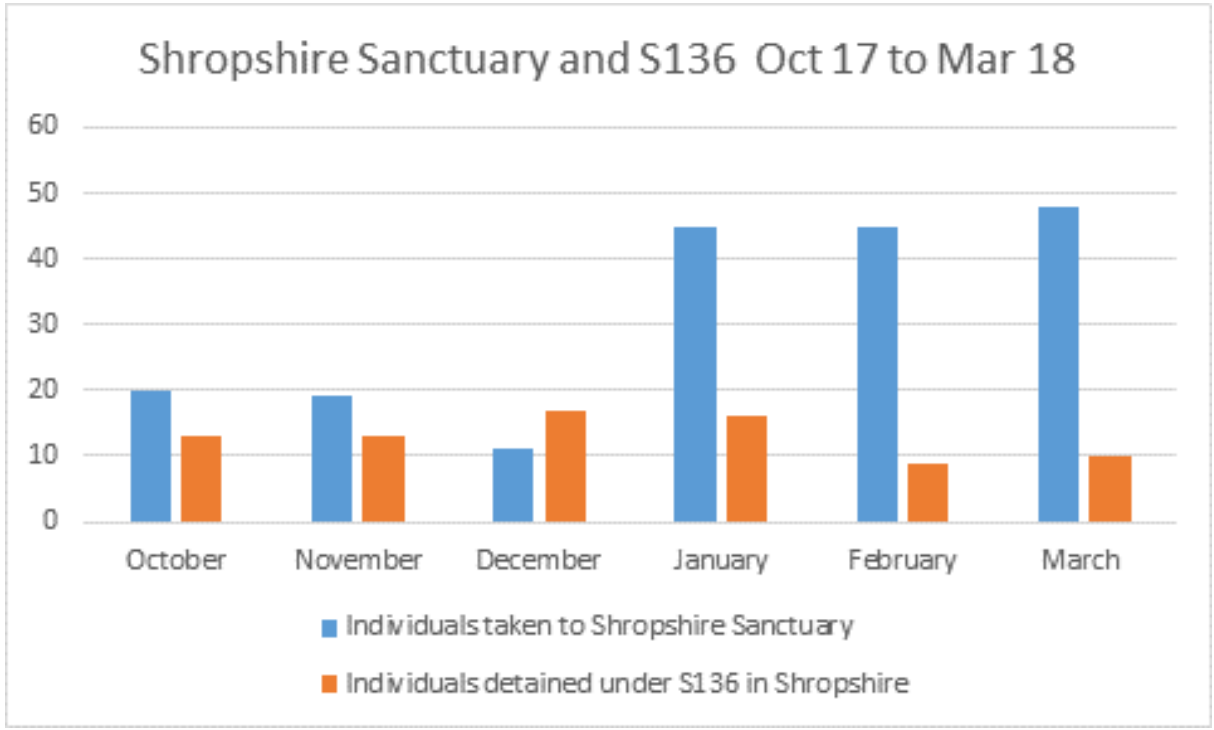
- A joint Shropshire and Telford & Wrekin Suicide Prevention Strategy was launched in September 2017
- The Strategy is being implemented by the multi-agency Shropshire Suicide Prevention Action Group
- Key areas of activity focus includes;
  - **Comms and Media**: raise awareness of risk and co-ordinate messages
  - **Access and Prevention**: reduce risk and promote early intervention
  - **Using data**: to identify those at highest risk and measure impact
  - **Self harm**: to identify those at risk and promote appropriate support
  - **Post Suicide support**: for those affected by a suicide death
  - **Training**: of suicide awareness and sign posting for staff most likely to encounter at risk groups

Shropshire Sanctuary impact on Section 136

- Section 136 is part of the Mental Health Act the police can use to detain a person with a mental illness in a safe place when they are in need of care or control.
- There is 1 Section 136 Suite in Shropshire but demand has outweighed availability of appropriate resource
- The Shropshire Sanctuary was launched in 2017 by Shropshire MIND, Shropshire CCG (supported by other partners) as an alternative to Section 136 and is based at Observer House in Shrewsbury
- The Sanctuary provides a safe, calm, welcoming and reassuring environment to support people to relieve mental distress & anxiety and provides a follow up “check up”

Shropshire Sanctuary impact on Section 136

- Use of the Shropshire Sanctuary has increased significantly since January 2018 and is helping to reduce demands on the Section 136 Suite
- In March: n=10 S136 attendances and n=48 Sanctuary attendances



Dual Diagnosis: Mental Health and Substance Misuse

- The majority of people in substance misuse services are likely to experience problems with their mental health
- National research has identified those with dual diagnosis needs are not always able to access the help they need

Alcohol

- The local rates of hospital admissions for mental and behaviour disorders due to the use of alcohol are consistently lower than national rates between 2008/9 and 2014/15
- Male rates of admission are higher than females both in Shropshire and for England average
- 38 (11%) of new presentations for Shropshire alcohol misuse services in 2016/17 that also received mental health treatment (lower than England average of 21%)
- No difference of presentations by gender

Substance Misuse

- Cannabis is the highest reported drug of dependence for all age groups based on findings in the Adult Psychiatric Morbidity Survey (2014)
- 51 (17%) of new presentations for Shropshire substance misuse services in 2016/17 that also received mental health treatment (lower than England average of 24%)
- Higher rate of females being treated in Shropshire which is similar to the national trend

Co-morbidity: Mental Health and Physical Health

- The Kings Fund estimate over 4m people in England with a long term physical health problem also have a mental health problem
- Estimates from the Adult Psychiatric Morbidity Survey (2014) suggest in Shropshire, 27.7% of people with a mental health disorder have at least one of the following chronic conditions;
  - High blood pressure
  - Asthma
  - Type 2 diabetes
  - Cancer
- The presence of a mental health disorder can make adherence and treatment of a chronic condition more challenging
- The presence of a chronic condition can increase the risk of an untreated mental health disorder more severe

Recommendations

To develop a Shropshire Mental health Strategy using the findings of this Needs Assessment

Better identification and recording of mental ill health:
Data collection across services on issues, characteristics and demographics of clients (particularly with emerging ethnic or migrant populations)

Data sharing between organisations to improve client experience:
Essential information for analysis of risks, understanding needs, service review and promoting equity for clients across different services and for better targeting of care and prevention programmes

Timely access to mental health services based on need:
Feedback from service users indicators identified access to services can be slow and complicated

Raised awareness of and access to support networks that signpost services: Improved communication to communities and between health & social care services of the range of mental health services and support organisations and how to access them (which may also include links with primary care via Social Prescribing Advisors & Community Care Co-Ordinators)

Frequent service user consultation:
Providers to seek feedback from clients who contact or use mental health service and support networks to review, learn & better respond to changes in community mental health needs

Consistent professional training of frontline staff:
For those working across health, social care, the voluntary sector and other services that are most likely to work with people with mental health needs to promote mental wellbeing to the public and among themselves. This would include upskilling of volunteers & support for carers to empower them to have conversations to support mental health & wellbeing.

Shropshire Council

NHS
Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
Meeting Date

Shropshire Care Closer to Home – An Overview

Responsible Officer Lisa Wicks Shropshire Clinical Commissioning Group
Email: Lisa.Wicks@nhs.net

1. Summary

The report provides an overview of the Shropshire Care Closer to Home programme of change that is being organised and coordinated by Shropshire CCG to achieve better value care for our population.

2. Recommendations

The Health and Wellbeing Board is recommended to note the information in the report.

REPORT

3. Background

Unlike health systems in many other western countries, the past 40 years has seen relatively little change in the way in which the NHS delivers care. The way care is delivered (also known as the "model" of care delivery), is still heavily dependent upon the use of general hospitals. Whilst there is absolutely a need for general hospitals, it is important to remember that hospitals were built to provide care to people who could not be looked after safely at home.

Some aspects of our modern lives would have been considered science fiction 40 years ago, with huge changes seen in the way that we communicate, shop and manage our finances. However, despite advancements in technology, our dependence on general hospitals in the UK has altered very little. The pressure that the NHS is now faced with is unprecedented; people are living for longer with far higher levels of need complexity than has ever been seen. This is particularly true for Shropshire whose population is older than most other counties in the UK.

In many parts of the country, changes in the model of care delivery are being seen with a view to move the NHS towards a place that embraces technology, in order to meet the needs of the people it serves. Whilst this will be key to the health service being able to meet the long-term needs of the population, another crucial element is the way in which the organisations that make-up our local health systems, also known as "Health Economies", work together. In order for the Health Economy of Shropshire to successfully evolve to meet the needs of Shropshire people, the organisations that belong to it need to agree to work towards a common goal, in other words they need to be "Strategically Aligned".

Once the change is complete, it is then the CCGs responsibility to keep the providers on-track and monitor the impact that the change is making. The process then begins again, working to understand the needs of the population and how they have changed and so on. This is also known as the commissioning cycle, and it is this process that has led to the CCGs ambition to work with stakeholders to bring Shropshire Care Closer to Home.

4. What is Shropshire Care Closer to Home?

When service change is required in order to attain a higher value of provision for the population, the change must be organised and coordinated to ensure that the change takes place in a planned way. For small-scale changes, this process is referred to as a "project", however some changes, such as bringing Shropshire Care Closer to Home, require a collection of projects to be managed

simultaneously, this is referred to as a "programme" of change. Shropshire Care Closer to Home is a programme of change that is being organised and coordinated by Shropshire CCG to achieve better value care for our population.

5. Why is Change Needed?

Care delivered in general hospitals often comes at a significant price for the recipient, at worst it can result in the end of independent living, contracting additional health needs or a change in home address. Enabling people to receive treatment that allows them to live their day to day lives is a priority for not only Shropshire CCG, but for the NHS as a whole. If we were to bring Shropshire Care Closer to Home for our population, we would enable people to avoid the risks associated with being admitted to hospital whilst experiencing minimal levels of disruption to their lives whilst receiving treatment.

As discussed earlier, we at the CCG absolutely believe that there is a need for general hospitals as some of the diagnostic testing and treatments delivered cannot safely be undertaken in another environment. However, in Shropshire just like many other parts of the UK we have developed an unhealthy cultural dependence upon our general hospital. We at the CCG have engaged with our stakeholders and have reached the conclusion that we have a duty to address this overdependence, and bring Shropshire Care Closer to Home.

6. Who is it for?

Long-term health conditions are those that a person lives with for a long time, such as diabetes, coronary heart disease and dementia. When a person lives with a number of these conditions, their needs are known as complex. Information collected locally, also known as "data" tells us these people are particularly susceptible to being admitted to the general hospital, and that if there were suitable services in place, many of them could be treated at home. Due to this, Shropshire Care Closer to Home is being aimed at improving health outcomes for people with multiple long-term health conditions aged 65 and over. Although our future ambition is that other patient groups or "cohorts" as they are also known will be targeted for improving health outcomes, moving Shropshire Care Closer to Home represents a big change for our Health Economy. If we were to try to change everything that needs fixing all at once, we would be likely to fail, and fail we must not!

7. What Changes will we see?

In the CCG, we often describe services at a "high level", which means describing them in a non-detailed way. The reason for this is that in a Health Economy such as Shropshire, details surrounding local-level service provision may differ from place to place. For example people in Whitchurch may receive services differently to those in Craven Arms. When considering how we will bring Shropshire Care Closer to Home, it is important to understand that at this stage, this can only be described at a high level. Considering this, Shropshire Care Closer to Home will initially be comprised of three high-level phases,

Phase 1

Phase 1 is already in place, it is the Frailty Intervention Team (FIT) based at the A&E department at the Royal Shrewsbury Hospital. This team works to ensure that where possible people with complex needs (also referred to as frail) have their needs met quickly in order to either prevent a hospital admission from occurring, or to achieve a shorter admission than would otherwise be possible through coordinating discharge requirements to a higher degree than was previously achieved.

Phase 2

The second phase is about delivering a model of care called "Case Management", this model has two parts; the first is about our community-based NHS workforce working closely with GP practices across Shropshire to get a clear understanding of how many people over the age of 65 have complex care needs. A crucial part of this process relates to categorising the people identified in terms of whether their need complexity is low, moderate, or severe, a process known as "Risk Stratification".

Once Risk Stratification is complete, those identified as severe are given the opportunity to work with a designated professional also known as a "Case Manager" who in turn will be responsible for a group of patients, also known as a "caseload". The professional background of a Case Manager may vary dependent on what the most pressing needs of the recipient of support are, for example in some cases a nurse would be best placed to provide support, whereas in others a social worker may be more suitable.

The Case Manager is responsible for developing and reviewing care plans with those on the caseload, and where required, coordinating services to meet their needs. Case Managers will promote recovery and identify when people under their supervision are deteriorating. This will enable them to put preventative measures to be put in place to minimise the occurrence of acute and severe ill health, also known as a "health crisis". This development of care plans and their delivery represents the second part of the Case Management model.

Phase 3

The third phase is made up of three high-level models; the first is called "Hospital at Home". The aim of Hospital at Home is to provide diagnostic testing and treatment interventions traditionally associated with care in a hospital setting, in peoples own homes, or from places close-by. Just as is the case in the local general hospital, this model would be delivered by a multi-disciplinary team made up of a range of health professionals including: GPs; Specialist Consultants; Social workers; Community Nurses; District Nurses; Advanced Nurse Practitioners; Mental Health Nurses; Pharmacists, Physio Therapists, Occupational Therapists and Dieticians to names but a few. However, Hospital at Home is not a rapid-response model of care delivery, it functions in a planned fashion working alongside the Case Management model to prevent health crisis from happening. That said, we do not live in a perfect world and sometimes health crises do occur.

The second model of the third phase of Shropshire Care Closer to Home is about creating a Health Crisis Response Team. This would be set up to deliver both diagnostic testing and treatment interventions similar to those available from in the Hospital at Home model, but within a standardised 2 hour response window. This team would be made up of senior clinical staff, for example Advanced Nurse Practitioners who are capable of making clinical decisions and in most cases prescribing and administering medicines to manage acute health needs. However, if the Health Crisis Response Team should feel that the person is too unwell to be safely managed at home, there are two options which they can consider; they could admit the person to a "Step-up bed", or to the general hospital.

The provision of "Step-up beds" is the final model of the third phase of moving Shropshire Care Closer to Home, and involves the provision of bed-based care in the localities in which people live, albeit away from their usual place of residence. These beds which could be provided in community hospitals or nursing homes will allow for high-intensity supervision of acutely unwell people whilst they undergo diagnostic testing and receive treatment. Should the Health Crisis Response Team decide to admit someone to a local Step-up bed, it may be that they continue to provide support to the recipient of care with a view to promoting safe discharge in as timely a way as is possible.

8. Are Models Going to be the Same Across the County?

As described earlier, this document provides a high-level overview of the models that are required to move Shropshire Care Closer to Home. The detail surrounding exactly how and who delivers them has not yet been agreed. There are a number of ways in which the models described above could be delivered, and this will vary across the county depending upon a number of factors.

9. What is Happening Right Now?

The CCG is working on an ongoing basis with the public and all stakeholders in the process of designing how we with enable Shropshire Care Closer to Home. As this is a rapidly developing programme of work, things are changing all of the time.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder)
Local Member
Appendices

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For Information

Health and Wellbeing Board

Meeting Date: 24/05/2018

Item Title: Pharmaceutical Needs Assessment

Responsible Officer Emma Sandbach
Email: emma.sandbach@shropshire.gov.uk
Tel: 01743 253967

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1. Summary

The Pharmaceutical Needs Assessment (PNA) is a statutory requirement of Local Authority Health and Wellbeing Boards. The PNA is a statement of the local need for pharmaceutical services and supports the commissioning of pharmacy services based on local priorities. It is used by NHS England to decide whether there is a need for new pharmacies in the area.

2. Recommendations

To note that the final PNA has been published on the 28th March 2018 in accordance with the statutory guidance.

REPORT

3. The PNA had been completed and published and is available at the following link:

http://www.shropshiretogether.org.uk/wp-content/uploads/2016/06/PNA-2018-Final.pdf

Findings from the consultation have been added to the report and there has been some additional key points added to the executive summary.

The consultation received several responses and views from the LPC, neighbouring Local Authorities, pharmacists, GPs, members of the public and other organisations. There was generally a lot of very positive comments about pharmaceutical services across Shropshire, with responses stating that they would like to see the level of service maintained and emphasising the importance of pharmacies in rural areas. In terms of the gaps that were highlighted in the PNA there was agreement from several responses about the lack of provision on Sunday's in the South of Shropshire.

Further comments made during the consultation included:

- Support for the recommendation on joint training between different organisations and community pharmacy.

- Improving communications on what was provided in community pharmacies would be useful and could be a way of educating patients and the public.

- That community pharmacy supporting the delivery of community based health care, was important and a way to ensure provision of services in rural areas.

- That currently patients accessing dispensing only services from GP dispensaries, are denied access to full pharmaceutical services.

The responses were reviewed by PNA steering group members and added to the final document.

4 Risk Assessment and Opportunities Appraisal

N/A

5 Financial Implications

N/A

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Lee Chapman
Local Member
Appendices

Health and Wellbeing Board
Meeting Date: 21st May 2018

Item Title: Health and Wellbeing Board Communication and Engagement Group update and Action Plan 2018-2019

Responsible Officer Val Cross, Health and Wellbeing Officer
Email: val.cross@shropshire.gov.uk
Tel: 01743 253994

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1. Summary

This report provides a summary of activity for the Health and Wellbeing Board Communication and Engagement Group over the last twelve months (April 2017 to March 2018).

The report also includes the Health and Wellbeing Board Communication and Engagement Action Plan for the period 2018-2019. The campaign calendar within this has been updated, (see appendix A) and a decision to focus on three key campaigns was agreed at the Health and Wellbeing Board Communication and Engagement meeting which was held on the 17th April 2018. These are;

i) Mental Health Awareness Week, 14th to 20th May 2018
ii) Carers Week, 11th to 17th June 2018
iii) Campaign to be agreed, with a families, children and young people focus, September 2018.

Work continues to work collaboratively for Future Fit and Sustainability and Transformation Partnerships (STP) messages and communications.

2. Recommendations

That the Board approve the Action Plan, or approve with amendments.

REPORT

1.0 Report on last twelve months progress (April 2017 to March 2018)

1.1 At the beginning of this period, the strategy and Action Plan were agreed by the Health and Wellbeing Board.

1.2 A calendar of events to promote generic and targeted health campaigns to the population of Shropshire was produced. These all linked to the Sustainability and Transformation Partnership (STP) and the HWB Partnership Prevention Programme 'Healthy Lives.'

1.2 Campaigns for 2017 included; Mental Health Awareness Week, Dementia Awareness Week and the Falls Prevention 'Let's talk about the F word' campaign launch in May.
Diabetes Week, Child Accident Prevention Week and launch of the All-Age Carers Strategy to coincide with Carers Week were promoted in June. Analytics linked to the carers' campaign showed a twitter reach of over 86,000 for that month through 'Shropshire Together'. This was significantly higher than the usual monthly reach.
World Suicide Prevention Day in September was promoted, and was linked to the launch of the Shropshire Prevention Strategy.
National Public Health campaigns promoted included; the 'One You' brisk walk app. and 'One You' Active 10.
'Stay Well This Winter' was a prolonged campaign over the winter months which incorporated; promoting flu vaccination, self-care, pharmacy use and prescription planning over the festive period.

1.4 Toolkit for campaigns are developed that all partners are able to use. These include press releases, key facts and twitter messages. This ensures key messages are matched across the county, and all the partners use their own networks to cascade information as wide as possible to Shropshire people.

1.5 Meetings were held quarterly, and well attended. Communications and messages were shared through the network between meetings, as required.

1.6 Shropshire Together distributes a monthly Health and wellbeing e-newsletter with a reach of 1,814 subscribers. Partner organisations are encouraged to contribute, and Healthwatch Shropshire is the contact for public questions to the Health and Wellbeing Board.

2.0 Health and Wellbeing Board Communication and Engagement Action Plan 2018-2019

2.1 The Action Plan (see appendix A) is based on three outcomes:

- Local residents feel that they are well-informed about health and social care services across Shropshire and feel confident in knowing how to access them
- Partners are working collaboratively to communicate and engage effectively with each other and with the public
- Local residents feel that they are able to have their say and to influence key decisions about health and social care services

2.2 The Action Plan reflects the need for partners to develop consistent messages for the public, which will be easily understood and have meaning. For example; what the 'Healthy Lives' programme is.

2.3 The campaign calendar within this has been updated, and a decision to focus on three key campaigns was agreed at the Health and Wellbeing Board Communication and Engagement meeting, which was held on the 17th April 2018. These are;

i) Mental Health Awareness Week, 14th to 20th May 2018
ii) Carers Week, 11th to 17th June 2018
iii) Campaign to be agreed, with a families, children and young people focus, September 2018.

These all link with the Sustainability and Transformation Plan (STP) and the HWB partnership prevention programme 'Healthy Lives'.

2.4 Work continues to work collaboratively for Future Fit and Sustainability and Transformation Partnerships (STP) messages and communications.

3.0 Conclusion

3.1 The 2018-19 Action Plan should contribute towards improving the health and wellbeing of Shropshire people by the whole system working together to; deliver consistent messages, people knowing points of access for health needs, and alleviating concerns around Future Fit and the STP.

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

There are no known Human Rights, Environmental consequences, Community or Equality issues with this Strategy and Action Plan. Communication and Engagement is a core principle of the Health and Wellbeing Board

Risk Assessment has identified potential threats as;

1. *Losing engagement of key stakeholders.* This risk will be reduced by; communicating with partners regularly via email and through bi-monthly meetings.

4. Financial Implications

The action plan does not incur expenditure over and above existing budgets as the group will promote campaigns across their networks through social media, e-newsletters and websites.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr. Lee Chapman
Local Member
Appendices **App. A** Health and Wellbeing Board Communication and Engagement Action Plan 2018-19

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Health and Wellbeing Communication and Engagement Group Action Plan 2018-19

PRIORITY	ACTION	Further detail	WHO?	DATE	Measurement and Milestones
Outcome 1 Local residents feel that they are well-informed about health and social care services across Shropshire and feel confident in knowing how to access them					
1	**Supporting access through information, advice and guidance**	Engaging the population and delivering information to ensure that the public are aware where they can go for services. Partners work together to ensure web based and printed information is current and communicated through individual communication channels.	All HWB Communication and Engagement Group organisations represented*	Ongoing	
Outcome 2: Partners are working collaboratively to communicate and engage effectively with each other and with the public					
	Partners to develop consistent messages for the public, which will be easily understood and have meaning. For example; what the 'Healthy Lives' programme is.	Agreed wording, and method of communicating to people.	All HWB Communication and Engagement Group organisations represented*		
	Consistent, straightforward health messages and campaigns for Shropshire people.	Programme of monthly themed health campaigns, based on the STP Neighbourhoods Programme; Partnership Prevention Programme: Healthy Lives. 3 agreed key campaigns to be focussed on for 2018/19 **See calendar plan below**	All HWB Communication and Engagement Group organisations represented*		
	Deliver consistent and regular communications to alleviate public concerns e.g. around Sustainability and Transformation Partnerships (STPs)	Clear project management approach for carrying out the work from the HWBB and local campaigns. Networking and working together. Developing protocols for deciding upon and delivering campaigns. This will include supporting the communication and engagement of key programmes such as Sustainability and Transformation	All HWB Communication and Engagement Group organisations represented*		

		Partnerships (STPs, NHS Future Fit and the Better Care Fund. (BCF) and associated service change projects. Tools such as; a shared social marketing and communications resource platform, single consultation portal, news story feed through to the HWBB website (Shropshire Together), local network for working together (communication and engagement leads), agreed media protocol (including across social media), shared photo library, a regular health column in newspapers, shared evaluation tools to monitor effectiveness of communication and engagement Individual organisations sharing information about individual campaigns, events or updates via an effective forum or platform. These actions will lead to joint working and promotion of health and wellbeing across the health economy. *Shropshire Council, Shropshire CCG, Shropshire & Telford Hospitals (SaTH), Healthwatch, Shropshire Patients Group (SPG), South Staffordshire and Shropshire Foundation Trust (SSSFT), West Midlands Ambulance Service (WMAS), Shropshire Local Pharmacy Committee (LPC), Shropshire Partners in Care (SPIC), Voluntary and Community Sector Assembly (VCSA), Shropshire Community Health Trust (SCHT) Shropshire Transforming Partnerships (STP)	All HWB Communication and Engagement Group organisations represented*		
Outcome 3: Local residents feel that they are able to have their say and to influence key decisions about health and social care services					
4	**Develop tools for evaluation**	To generate an understanding of the most effective methods of communication and engagement and to ensure that we achieve the outcomes we set.			

5	**Determine the best way to engage those who are not routinely engaged**	Linking with the locality Joint Strategic Needs Assessment to understand better the population, making a targeted approach to ensure inclusion and consideration is given. This includes considering how best to engage with children and young people, vulnerable persons and those with protected characteristics.			

Health Campaign Calendar 2018/19

Month	Programme stream	Activity	Date	Partner Activity	Lead
March	Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention Social prescribing, Mental Health, Carers Dementia, Falls Prevention, NHS Health check Future Planning, COPD and Respiratory Prevention	Prostate Cancer Awareness month			
April	Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention Social prescribing, Mental Health, Carers Dementia, Falls Prevention, NHS Health check Future Planning, COPD and Respiratory Prevention	World Health day Carry over next year – World Autism Awareness	07/04/18		

May	Mental Health	Mental Health Awareness week https://www.mentalhealth.org.uk/campaigns/mental-health-awareness-week **High Level Partner campaign**	14th to 20th May 2018		
	Carers Dementia Mental Health Future Planning	Dementia Awareness Week https://www.alzheimers.org.uk/info/20167/dementia_awareness_week	21st to 27th May 2018		
	Carers Dementia Mental Health Future Planning	Dying matters http://www.dyingmatters.org/AwarenessWeek	14 – 20 May 2018		
June	Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention	Diabetes Week www.diabetes.org.uk **Key campaign**	12th to 18th June 2018		
		Child Accident Prevention Week	4th to 10th June 2018		
	Carers, Dementia Mental Health	Carers Week www.carersweek.org **High Level Partner campaign**	11th to 17th June 2018		
	Mental Health, Carers Dementia,	World Elder Abuse Day	15th June 2018		
July	Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention Social prescribing, Mental Health, Carers Dementia, Falls Prevention, NHS Health check Future Planning, COPD and Respiratory Prevention	Health Information Week	2nd to 8th July 2018		

August	Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention Mental Health Future Planning, COPD and Respiratory Prevention	World Breastfeeding Week	1st to 7th August 2018		
Sept.	Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention Social prescribing, Mental Health, Carers Dementia, Falls Prevention, NHS Health check Future Planning, COPD and Respiratory Prevention Mental Health	**High Level Partner campaign**- Families, Children and young people focus Stay Well This Winter UK Recovery Walk 2018. World Suicide prevention Day Sexual Health Week	From Sept. 2018 8th Sept. 18 10th Sept. 2018 11-17 Sept 2019		
Oct.	COPD and Respiratory Prevention, Social prescribing, NHS Health check Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention Social prescribing, Mental Health, Carers Dementia, Falls Prevention, NHS Health check	Stoptober Older Peoples' Day- All categories Women's Sports Week World Mental Health Day	October 2018 1st October 2018 2-8 Oct 2018 10/10/18		.

	Future Planning, COPD and Respiratory Prevention Mental Health				
Nov.	Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention COPD and Respiratory Prevention COPD and Respiratory Prevention, Carers Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention, Dementia Carers Social prescribing, Mental Health, Carers, NHS Health check, Future Planning	World Diabetes Day COPD Awareness month Stay Well This Winter – Flu vaccinations Carers rights day Alcohol Awareness Week https://www.alcoholconcern.org.uk/alcohol-awareness-week **Key campaign**	14th November 2018 Mid Nov 18 30th November 2018 No dates as yet		
Dec.	NHS Health check, Social prescribing, Mental Health Diabetes (including pre-diabetics) & Cardio-Vascular Disease (CVD) prevention Social prescribing, Mental Health, Carers Dementia, Falls Prevention, NHS Health check Future Planning, COPD and Respiratory Prevention	Dry January planning Stay Well This Winter – Prescription collection World AIDS Day	January 2019 All month 1st Dec 2018		

Jan 19	Carers	Young Carers Awareness Day National Obesity Awareness Week	End Jan 19		
Feb 19					
Other Activity	PHE campaigns: Sepsis, Be clear on cancer, Top tips for teeth, One You, Change4life, Sexual health				

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Health and Wellbeing Board

Meeting Date: 24th May 2018

Item Title: Shropshire All-Age Carers Strategy - Update

Responsible Officer Val Cross, Health and Wellbeing Officer
Email: val.cross@shropshire.gov.uk
Tel: 01743 253994

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1. **Summary**
This Board agreed the Shropshire All-Age Carers Strategy and Action Plan in June 2017. Work has been progressing well to implement identified actions since, and this report provides an update.

2. **Recommendations**
A further update is provided at the November 2018 Health and Wellbeing Board meeting.

REPORT

3. **Updates**
The Action Plan has 5 key areas, and the information below illustrates current activity to meet these:

Priority 1: Carers are listened to, valued and respected

- **'**Carers Voice**'** Work continues with the joint NHS England, Shropshire and Telford & Wrekin 'Carers Voice' project. An agreed communication toolkit has been produced, and includes; background to the project, a press release and scheduled Twitter messages. Recommendations from the Carers Voice report are linked in to the strategy and action plan

- Following discussions with Shropshire CCG, identification of an unpaid carer is now on hospital 'Fact Finding Assessment' (FFA) paperwork. First Point Of Contact (FPOC) is the referral number, and this has been agreed with the FPOC Team

- From January 2018, a carers hospital lead has been in place at the Royal Shrewsbury Hospital (RSH). The lead will bridge the gap between hospital staff and carers in the discharge process

- Shropshire Council has a 20-minute on-line carer awareness module for staff, which was publicised for Carers Rights Day on the 24th November 2017. This is available on the 'Leap in to Learning' on-line, staff training platform.

Priority 2 Carers are enabled to have time for themselves

- The Carer section on Shropshire Choices has been added to, updated, and interactive guides produced. The Family Carer Partnership Board have reviewed this information

- A partnership event to celebrate Carers Rights Day was held on the 24.11.17. This included a series of short workshops and stalls.

Priority 3 Carers can access timely, to up to date information and advice

- A Joint Shropshire/Telford & Wrekin working group started meeting in January 2018, to help address and action mental health carers, including forensic carers, needs

- Carers are identified and referred to support, with consent, via the Shropshire Fire and Rescue Service 'Safe and Well' visits

- Shrewsbury and Telford Hospital Trust (SaTH) have updated their web based information for carers, following recommendations from a Carers Strategy task and finish group. South Staffordshire and Shropshire Foundation Trust (SSSFT) have started updating their information for Shropshire carers, following the group's recommendations, as this was Staffordshire focussed.

Priority 4: Carers are enabled to plan for the future

- Following a successful joint funding bid to NHS England from Shropshire and Telford & Wrekin, ten countywide workshops for carers are to be delivered for between June and September 2018, which will have a focus on reducing stress and seeking timely support.

Priority 5: Carers are able to fulfil their educational, training or employment potential

- Following a successful joint funding bid to NHS England from Shropshire and Telford & Wrekin, young carers from Shropshire, Telford & Wrekin attended a creative workshop in April 2018, to create publicity materials to raise awareness of young carers in educational settings. The designs the young people created are now to be formatted and printed.

4. Conclusions

Implementation of actions identified through the strategy are now taking place. Opportunities for joint working between Shropshire and Telford & Wrekin has been very beneficial and positive.

5. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

There are no Human Rights, Environmental consequences, Community or Equality issues with this Strategy and Action Plan. Indeed, it aims to help improve the visibility and needs of carers in the communities they live in.

Risk Assessment has identified potential threats as;

1. *Losing engagement of key stakeholders.* This risk will be reduced by; communicating with partners regularly via email, sharing findings and information, holding regular meetings (face to face), holding a stakeholder event and inviting a wide range of partners, requesting partner involvement in designing the interventions, legitimise interventions and ideas through evidence, including national best practice as well as locally collected ethnographic data and include carers and primary care providers as key partners.
2. *Insufficient funding to implement effective Strategy* This risk will be reduced by potential funding from the Better Care Fund and Social Care. Carers Trust 4 all are already contracted to supply and deliver services. Good communication with partners to report on progress of strategy, funding required and potential shortfalls will take place.
3. *Staffing issues impacting on implementation of strategy*. This risk will be reduced by communicating with providers and partners such as; Carers Trust 4 all, Adult Social Care, Children's Services and School Nursing etc. to anticipate staffing issues which may have an impact.

6. Financial Implications

Financial constraints across the whole system have been kept in mind when formulating the Action Plan, and the outcomes focus is more on changing ways of working, reviewing policies and pathways and making information available. This will involve staff time. Provision has been made within existing

Adult Social Care budgets to fund the Carer's Hospital Lead post based at the Royal Shrewsbury Hospital and associated expenditure.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) None
Cabinet Member (Portfolio Holder) Cllr. Lee Chapman
Local Member
Appendices None

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Health & Wellbeing Board – Work Programme 2018

Our Aim:

To improve the population's health and wellbeing; to reduce health inequalities that can cause unfair and avoidable differences in people's health; to help as many people as possible live long, happy and productive lives by promoting health and wellbeing at all stages of life.

Our Vision:

For Shropshire people to be the healthiest and most fulfilled in England

Meeting Dates **Thursdays** **Commence at 9:30am**	18th Jan 2018	8th March 2018	24th May 2018	**5th July 2018** **Please note 10:30am start**	13th Sept 2018	15th Nov 2018

24th May 2018 **Deadline for reports 14 May 2018**	Agenda Item	Purpose of report	Owner
	System update:	Regular report to the H&WBB to provide an update on: • the Sustainability and Transformation Plan for Shropshire, Telford & Wrekin. • Neighbourhoods work • Future Fit	Phil Evans
	Digital Roadmap	Update on digital transformation	Julie Davies TBC
	Report from the HWB Joint Commissioning Group	Regular report from the Health & Wellbeing Board Joint Commissioning Group • Better Care Fund Performance •	Tanya Miles
	Public Health Annual report	Annual report of the Director of Public Health Shropshire	Rod Thomson
	Exemplar development – Carers Strategy	Bi annual report that highlights progress on the actions identified in the All Age Carers Strategy	Val Cross
	Children's Trust	To provide a regular update to the H&WBB on the work of the Children's Trust	Karen Bradshaw
	Mental Health Partnership Board	To provide a regular update to the H&WBB on the work of the MHPB - Adult Mental Health Needs Assessment	Andy Begley / Gordon Kochane

	Communications and Engagement Group	To provide an update to the H&WBB on work of the Communications and Engagement Group	Val Cross

5th July 2018 **Please note 10:30am start** **Deadline for reports 25 June 2018**	Agenda Item	Purpose of report	Owner
	System update:	Regular report to the H&WBB to provide an update on: • the Sustainability and Transformation Plan for Shropshire, Telford & Wrekin. • Neighbourhoods work • Future Fit	Phil Evans
	Report from the HWB Joint Commissioning Group	Regular report from the Health & Wellbeing Board Joint Commissioning Group • Better Care Fund Performance	Tanya Miles
	Children's Trust	To provide a regular update to the H&WBB on the work of the Children's Trust	Karen Bradshaw
	Mental Health Partnership Board	To provide a regular update to the H&WBB on the work of the MHPB	Andy Begley
13th September 2018 **Deadline for reports 3rd September 2018**	Agenda Item	Purpose of report	Owner
	System update:	Regular report to the H&WBB to provide an update on: • the Sustainability and Transformation Plan for Shropshire, Telford & Wrekin. • Neighbourhoods work • Future Fit	Phil Evans
	Report from the HWB Joint Commissioning Group	Regular report from the Health & Wellbeing Board Joint Commissioning Group • Better Care Fund Performance	Tanya Miles
	Healthwatch		

	Children's Trust	To provide a regular update to the H&WBB on the work of the Children's Trust	Karen Bradshaw
	Mental Health Partnership Board	To provide a regular update to the H&WBB on the work of the MHPB	Andy Begley
	Agenda Item	Purpose of report	Owner
15th November 2018 **Please note 10:30am start** **Deadline for reports 5th November 2018**	System update:	Regular report to the H&WBB to provide an update on: • the Sustainability and Transformation Plan for Shropshire, Telford & Wrekin. • Neighbourhoods work • Future Fit	Phil Evans
	Report from the HWB Joint Commissioning Group	Regular report from the Health & Wellbeing Board Joint Commissioning Group • Better Care Fund Performance	Tanya Miles
	Children's Trust	To provide a regular update to the H&WBB on the work of the Children's Trust	Karen Bradshaw
	Mental Health Partnership Board	To provide a regular update to the H&WBB on the work of the MHPB	Andy Begley

NB The work programme is a guide for future reports. However, it is a live document and therefore will change to reflect the requirements of the Health and Wellbeing Board

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