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

Date: 15 May 2019

Committee:
Health and Wellbeing Board

Date: **Thursday, 23 May 2019**
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
Director of Legal and Democratic Services (Monitoring Officer)

Members of Health and Wellbeing Board

VOTING
Shropshire Council Members
Lee Chapman – PFH Organisational Transformation and Digital Infrastructure (Co-Chair)
Dean Carroll – PFH ASC and Public Health
Ed Potter – PFH Children's Services

Rachel Robinson - Director of Public Health
Andy Begley - Director of Adult Services
Karen Bradshaw - Director of Children's Services

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

Lynn Cawley – Shropshire Healthwatch
Jackie Jeffrey – VCSA

NON-VOTING (Co-opted)
Megan Nurse – Non-Executive Director Midlands Partnership NHS Foundation Trust

Simon Wright - Chief Executive, Shrewsbury & Telford Hospital Trust

Ros Preen - Shropshire Community Health Trust

Dr Tony Marriott - Chair GP Federation

Peter Loose – Chairman, Shropshire Partners in Care (Chief Executive Bethphage)

Paul Bennett - Business Board Chair

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 - 8)

To confirm as a correct record the minutes of the meeting held on 7 March 2019.

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 Maternity Transformation Plan (Pages 9 - 14)

Report attached.

Contact: Chris Morris

7 System Update (Pages 15 - 70)

Regular update reports to the Health and Wellbeing Board are attached:

Shropshire Care Closer to Home
Report attached.

Contact: Barrie Reis-Seymour, Shropshire CCG

System Update:

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

Contact: Martin Harris, Telford and Wrekin CCG

Better Care Fund, Performance
Report to follow.

Contact: Penny Bason, Shropshire Council / Shropshire STP/Tanya Miles

Healthy Lives Update
Report to follow.

Contact: Val Cross, Health and Wellbeing Officer

8 STP All-Age Mental Health Strategy Update (Pages 71 - 88)

Report attached.

Contact: Steve Trenchard

9 Public Health Financial Changes

Report to follow.

Contact: Andy Begley, Director of Adult Services, Shropshire Council

10 Shropshire Alcohol Strategy 2016-2019 Update and next steps plus New Provider Update (Pages 89 - 100)

Report attached.

Contact: Jayne Randall

11 Healthy Child Programme (Pages 101 - 112)

Report attached.

Contact: Anne-Marie Speke

12 **Shropshire Children's Trust Update** (Pages 113 - 114)

Report attached.

Contact: Karen Bradshaw, Director of Children's Services

13 **AOB** (Pages 115 - 116)

Correspondence: Action for Noting

Shropshire Council

Committee and Date

Health and Wellbeing Board

23 May 2019

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 7 MARCH 2019
9.30 - 11.45 AM

Responsible Officer: Michelle Dulson
Email: michelle.dulson@shropshire.gov.uk Tel: 01743 257719

Present

Councillor Lee Chapman (Co-Chairman)	PFH Health and Adult Social Care
Councillor Nicholas Bardsley	PFH Children's Services and Education
Councillor Lezley Picton	PFH Culture and Leisure
Professor Rod Thomson	Director of Public Health
Andy Begley	Director of Adult Services
Karen Bradshaw	Director of Children Services
Dr Julian Povey (Co-Chairman)	Clinical Chair, Shropshire CCG
Dr Julie Davies	Director of Performance and Delivery, Shropshire CCG
Lynn Cawley	Shropshire Healthwatch
Jackie Jeffrey	VCSA
Peter Loose	Chairman, Shropshire Partners in Care

Also in attendance:
Lorraine Laverton, Val Cross, Penny Bason, Phil Evans, Gail Fortes-Mayer, Tanya Miles, Steve Trenchard, Debbie Vogler, Jo Robins, Ivan Powell, Lisa Wicks, Councillor Madge Shineton, Councillor Karen Calder, Councillor Kevin Pardy.

61 **Apologies for Absence and Substitutions**

The following apologies were reported to the meeting by the Chair

Neil Nisbet Finance Director & Deputy CE SaTH NHS Trust
Ros Preen Shropshire Community Health NHS Trust
Anne-Marie Speke Healthy Child Programme Coordinator, Shropshire Council

62 **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.

63 **Minutes**

Minute Item 58 – Healthwatch Shropshire Update

It was clarified that the two pieces of work referred to in the second paragraph were the STP Long Term Plan and Maternity Mental Health Services.

The final sentence of the third paragraph should read 'The Clinical Chair, Shropshire CCG *would welcome* the work of Healthwatch Shropshire....'

RESOLVED:

That the Minutes of the meeting held on 17 January 2019, be approved and signed by the Chairman as a correct record, subject to the above.

64 **Public Question Time**

A public question was received from Mr George Rook, requesting that the Health and Wellbeing Board take positive action to ensure that a Joint Commissioning Lead for Dementia in Shropshire be appointed and that the Dementia Strategy for Shropshire be implemented. A joint response from Shropshire CCG and Shropshire Council was circulated around the table at the meeting which reported that the Joint Commissioning Lead post had been advertised but had been unsuccessfully appointed to and that there were a number of proposals currently being explored (copy of question and response attached to the signed Minutes).

65 **Annual report of the KASIS Board**

Ivan Powell, Independent Chair of the Shropshire Safeguarding Children Board (SSCB) introduced and amplified the Keeping Adults Safe in Shropshire (KASIS) Annual Report 2017/18 (copy attached to signed minutes) and gave a brief presentation, which covered the following areas:

- The 4 Board Priorities;
- Adult Safeguarding in Shropshire;
- Training;
- Safeguarding Adult Reviews;
- Multi-Agency working;
- Areas of focus moving forward

The Independent Chair reported that the personalisation agenda had led to a big shift in approach and that there was now a duty on local authorities under the Care Act to support people in the safeguarding process.

In response to a query, the Independent Chair explained that the Police Service had no bespoke policy on safeguarding and had a different definition of Vulnerable Adult. He explained that the Mental Health service would provide a response rather than the police however some Police forces operated a triage system in order to respond more appropriately.

RESOLVED: That the report be noted.

66 **Annual report of SSCB**

Ivan Powell, Independent Chair of the SSCB, introduced and amplified the Shropshire Safeguarding Children Board Annual Report 2017/18 (copy attached to signed minutes) and gave a brief presentation, which covered the following areas:

- The 3 Board Priorities;
- Child Death Overview Panel (CDOP);
- Training and Multi Agency Audits;
- Section 11 Audits;
- Ofsted Inspection;
- Working Together 2018;
- Serious Case Reviews (SCRs);
- Areas of focus moving forward

The Independent Chair reported that the Shropshire Safeguarding Children Board had received a 'good' from Ofsted with one action around the narrative and collection of multi-agency data, which was, in part, due to the introduction of a new IT system which had reduced the quality and timeliness of the data.

Turning to the Board's 3 priorities, the Independent Chair informed the Board that this year 340 children had been exposed to domestic abuse, whilst 85 referrals had been considered by the CSE Panel, 15 of which were considered high risk and most were females. He reported that the Regional Organised Crime Unit along with the Children's Society had delivered a workshop to professionals across the West Mercia area to improve knowledge.

The Independent Chair explained that Compass looked at all missing incidents, some of which may include victims of CSE. There had been a significant reduction in the number of missing episodes this year (630). It was confirmed that two staff now conducted return home interviews for those missing children from Shropshire.

It was reported that by year end 2017 there had been a 6% reduction to 53% in children subject to a Child Protection Plan under the category of neglect however the current year workload has returned to 59%. The Independent Chair explained that a focus was being kept on this area and that the Neglect Strategy was being revised.

The Independent Chair informed the Board that the Child Death Overview Panel Annual Report was very robust, detailed, and provided reassurance of how agencies worked together. National oversight of the COPD was moving from the Department of Education to the Department of Health with CCGs leading the work locally.

In relation to Serious Case Reviews, the Independent Chair confirmed that the SCR for Child C had been finalised and published whilst that for Child E had been completed and would be reported in next years' Annual Report.

In response to a query, it was confirmed that all agencies were fully sighted in relation to CSE. Concern was raised in relation to training for the teaching profession when dealing with safeguarding issues. In response, the Independent Chair confirmed that anyone in contact with children had a responsibility for safeguarding and he referred to the threshold / level of need document which

contained details of the referral process. There was also a podcast and supporting information available on the website.

RESOLVED: That the report be noted.

67 **System Update**

i. Future Fit

Debbie Vogler, Programme Director introduced the Future Fit update and gave a presentation (copy of slides attached to the signed Minutes), which covered the following areas:

- Decision Making
- Key Benefits of the new model
- Recommendations agreed by the Joint Committee
- Next steps

In response to comments from the Director of Public Health that the Council wished to see changes in clinical behaviour whereby patients do not have to attend hospital unnecessarily for eg repeat out patient appointments, the Programme Director confirmed that there was a separate pathway being looked at which considered alternative ways to follow up.

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

Phil Evans, STP Director introduced the STP Programme update (copy attached to the signed Minutes) which provided an update on the STP system response to developing a draft system narrative and the next steps. The STP Director drew attention to the Commissioning Capability programme and the Integrated Care System Development Programme, for which providers had been agreed.

He reported that feedback from NHS England had been received on the first draft of the System Operational Plan submitted on 19 February 2019. The deadline for the next submission was 11 April 2019 and this would be followed up by engagement and communications activities.

The Director of Adult Services commented that although the NHS Long Term Plan had been published there was still no Green Paper for adult social care. It was felt that the Green Paper would point in the direction of considering Adult Social Care in a broader sense and how other services impacted on wellbeing. In response, the STP Director explained that the green paper may not materialise for a number of years so they were doing what they could anyway rather than wait for it.

A brief discussion ensued in relation to what the system priorities and ambitions should be whilst the Director of Public Health drew attention to the lack of assurances around rural proofing / disconnect prevention and the lack of investment.

The Chair felt that the Health and Wellbeing Board had struggled with a crisis of identity as to its obligations under the STP with no real acknowledgement of how to discharge its statutory duty and governance under which it was established. Partners had been too focused on their own organisations instead of taking a system

view. Without commitment to a system approach, individual organisations would continue not to be able to take the best opportunities. The HWBB needed to understand how to take the lead and how to progress as a system. Stronger engagement was needed across both Local Authorities with clinical organisations being more open to accept the contribution that the LA's can make.

Dr Povey agreed that there needed to be a system answer. He explained that the long-term plan was merely a list of wishes, however, money was a huge problem and he urged the Board not to under estimate the challenges of the system.

iii. Shropshire Care Closer to Home

Lisa Wicks, the Head of Out of Hospital Commissioning and Redesign introduced the Shropshire Care Closer to Home update (copy attached to the signed Minutes) and highlighted progress with the three phases of the programme. She reported a change to the paper whereby it had been agreed to pilot all eight demonstrator sites. Work on phase 3 was progressing well with draft models and service specifications for phase 3 services having been shared with stakeholders.

The Head of Out of Hospital Commissioning and Redesign drew attention to the 'What Matters to Me Campaign' which was hosting an event on 27 March. The event had been promoted through various routes and 100 attendees had indicated attendance at the event. Councillors Calder and Shineton requested an invitation to this event.

iv. Better Care Fund, Performance

Penny Bason, STP Programme Manager and Tanya Miles, Head of Adult Social Care Operations confirmed that a proper analysis of why performance was off target for Q4 would come to the May 2019 Board meeting.

v. Healthy Lives

Val Cross, the Health and Wellbeing Officer gave a presentation (copy of slides attached to the signed Minutes) which provided the Board with an update on the Healthy Lives programme, and covered the following areas:

- Partnership Work
- Falls Prevention
- Healthy Conversations training
- Communications – 'Prescription' Pad

The Health and Wellbeing Officer informed the Board that Healthwatch would be providing feedback to a future meeting on its work around knowledge of social prescribing, in particular, young men and those living rurally.

She reported that 449 referrals had been made to the elevate classes which provided postural stability instruction in order to build muscle strength. This was a very popular programme with 2 out of 3 people being self-referred.

The Health and Wellbeing Officer drew attention to the 'prescription pad' for social prescribing that was being piloted.

RESOLVED: That the updates be noted.

68 Social Prescribing Progress Update and Current Opportunities

Jo Robins, Consultant in Public Health introduced and amplified her report (copy attached to the signed Minutes) which provided an update on progress. The Consultant in Public Health drew attention to the slides attached to the report at Appendix 1 which set out feedback following the Shropshire Social Prescribing External Evaluation conducted by Westminster University.

The Shropshire model mirrored the NHS England national guidance and had been identified as an exemplar site and had been invited to participate in regional events and national conferences.

The Consultant in Public Health touched on the national picture following publication of the NHS Long Term Plan which gave a clear commitment to social prescribing and the creation of 1,000 social prescribing link workers nationally fully funded for 5 years and assigned to Primary Care Networks.

Jackie Jeffrey of the VCSA praised this great scheme and stressed that it had achieved a lot despite no funding or support for the voluntary sector so delivery was dependant on what the funding allowed. Dr Julie Davies welcomed the opportunity to link in via Primary Care Networks. Dr Povey appreciated that it was a challenge for the voluntary sector with restrictions on funding however he cautioned that there was a lot of unknowns in relation to PCNs including how they would be funded, but that no money would be forthcoming from the CCG.

The Chairman welcomed the commitment to social prescribing and questioned whether agreement should be sought as to what social prescribing as a policy should look like.

RESOLVED:

1. That endorsement be sought for a system wide approach for the creation of one joint model of social prescribing which builds on the Shropshire model, uses the learning from the evaluation findings and fulfils the guidance from NHS England linked to the Primary Care Networks (PCN).

2. That support be sought to work with the CCG and PCN on a joint plan to achieve recommendation 4.

69 0-25 Emotional Health and Wellbeing Service update

Steve Trenchard the Programme Director for Mental Health introduced and amplified his report (copy attached to the signed Minutes) which informed the Board of progress made in relation to improvements to the service in line with an action plan agreed by system leaders in October 2018 following the visit of the NHS Intensive Support Team in June 2018.

The Programme Director informed the Board that additional clinics for physical health screening had been delivered to 215 children and young people who had not previously been offered a health check because they were on medication. No concerns were raised about any of those assessed to date. He confirmed that work was ongoing to identify those young people that had been discharged to Primary Care that may be on medication and where physical health checks were required.

The Programme Director drew attention to Programmes 4 (Targeted Prevention) and 9 (Crisis Resolution) set out at Paragraph 9 of the report which required immediate attention and he confirmed that a meeting date had been arranged to look at these.

The Programme Director reported that a meeting of the system leaders was taking place later that month for a reflective look back and would be reported to a future HWBB meeting. The Chair was encouraged to see the level of progress and was keen to hear about the review and any lessons learnt.

The Chair expressed concern about the significant pressures around Looked After Children and how to access more early intervention. He accepted that there were issues in relation to triage but leaving those least serious longer was an opportunity for them to get worse. The Programme Director shared the Chair's concerns but stated that the long term plan did prioritise young people's services and investment for mental health especially within schools could see the school nurse workforce providing some of that intervention.

RESOLVED:

1. To note the contents of the update and the assurance given that appropriate steps have been and continue to be taken, to continue to make the improvements identified.

2. To schedule a further update on the 0 – 25 Emotional Health and Wellbeing Service to a future meeting of the Health and Wellbeing Board.

70 HWBB Communications and Engagement Group Year End Report

Val Cross, the Health and Wellbeing Officer introduced and amplified her report (copy attached to the signed Minutes) which provided a summary of activity and progress for the Health and Wellbeing Board Communication and Engagement Group during 2018-19.

It was confirmed that the 2019/20 Action Plan would be presented to the Board at its next meeting in May 2019.

The Chairman thanked the Health and Wellbeing Officer for the excellent work and requested that Board Members ensure their Communication leads attend this Group.

RESOLVED: That the contents of the report be noted.

71 **STP Estates - update Whitchurch**

The Board received and noted a progress report (copy attached to the signed minutes) on the Pauls Moss Project in Whitchurch.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

Shropshire Council

NHS Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
Meeting Date

Responsible Officer: Fiona Ellis, Local Maternity System Programme Manager

Email: fiona.ellis3@nhs.net **Telephone:**

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1. Summary

This report sets out in more detail the activity taking place through the Local Maternity System in order to deliver the transformation set out in Better Births. A table summarising progress against the trajectories is provided in the table below.

KLOE	2019 Target	2020 Target	2021 Target
Stillbirths and Neonatal Deaths	4.8/1000 (23)	4.5/1000 (22)	4.2/1000 (20)
Brain Injury	1.8/1000 (9)	1.7/1000 (8)	1.5/1000 (7)
Personalised Care Plans	0	100%	100%
Three Places of Birth	100%	100%	100%
Continuity of Carer	20%	31%	51%
Births in Midwifery Settings	17%	20%	25%

2. Recommendations

- **That the content of this report is noted.**

1. Background

1.1 Following the publication of the national review of maternity services (Better Births 2016) a transformation plan for maternity services in Shropshire and Telford & Wrekin has been developed through the Shropshire and Telford & Wrekin Local Maternity System. This plan sets out how transformation will be achieved by March 2021 in line with the requirements of Better Births which are to;

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 2025 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.

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)

1.2 This report sets out the progress that has been made to date and next steps in relation to the delivery of the required transformation.

2. Improving Safety of Maternity Care

2.1 The LMS trajectory in relation to reducing stillbirth, neonatal death and brain injury is provided in the table below.

	Stillbirths and neonatal deaths				Intrapartum brain injuries			
	2015 baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021
Number	30	23	22	20	11	9	8	7
Rate per 1000 births	6.15/1000	4.8/1000	4.5/1000	4.2/1000	2.2/1000	1.8/1000	1.7/1000	1.5/1000

2.2 Good progress against the 2019 trajectory has been made. In 2018, the maternity service provider is reporting the lowest ever recorded rate of stillbirth for the Trust, with a rate of 3.7/1000. This compares to a national rate of stillbirth rate of 3.9/1000 (latest figure from

2016) and the West Midlands rate of 4.3/1000 (latest figure from 2016). Neonatal deaths are also showing a reducing trend. Several initiatives are in place in order to increase pace of progress in line with the agreed trajectories. These are summarised below.

2.3 SaTH has commenced additional ultrasound scanning clinics in Sutton Hill (Telford and Wrekin). The additional scan time enables women to undergo serial scans in pregnancy close to home. This enables more women to be able to more easily access these scans and helps maternity professionals to detect fetal growth restriction in women who wouldn't otherwise have attended these scans.

2.4 In December 2018, a system was introduced on delivery suite that enables clinicians to view the heart trace and progress of fetuses during labour from outside the labour room. The advantage of this central CTG telemetry is that there can be many eyes and opinions viewing the CTG (Cardiotocography - which shows the fetal heart rate and uterine contractions). Evidence has shown that this approach improves safety for the fetus. The CTG traces are also archived enabling them to be used for teaching and audit.

2.5 Reducing the high smoking in pregnancy rates locally has been identified as a key factor in reducing the stillbirth rate. The national direction is that rates of smoking in pregnancy are expected to be lower than 11%. As an LMS we are currently reporting 16.3% overall (up to Q3) with Shropshire reporting 13.8% YTD and Telford and Wrekin reporting 19.7% YTD.

2.6 A number of projects relating to reducing smoking in pregnancy have been launched. SaTH is participating in the Maternity and Neonatal Quality Improvement Collaborative. The focus of the improvement project is on increasing the number of smoke free pregnancies. This work aims to have a positive impact on reducing stillbirths. The project includes a number of initiatives, including:

- Undertaking carbon monoxide testing at every antenatal appointment
- A pilot project in a T&W GP surgery which will mean that women who are smokers or who have given up at conception will be contacted by the Public Health Team prior to booking. They will then offer the women smoking cessation support earlier on in their pregnancy.

2.7 The LMS has commissioned a local campaign to tackle smoking in pregnancy. The organisation designing the campaign will work closely with the Maternity Voices Partnership to produce local messages that will deliver the biggest impact.

2.8 A Public Health Midwife has been in post for sixteen months, who continues to concentrate on the Telford and Wrekin pregnant smoking population to change habits and drive down the high rates of smoking in pregnancy. Through one off funding the LMS has increased the smoking cessation support for one year to help tackle this issue.

2.9 Uncertainty around the future availability of smoking cessation services for pregnant women in Shropshire is of significant concern for the Local Maternity Programme Board. A focus group has been established in order to develop a proposed new model of service. Meanwhile, it is imperative that funding is identified for the continuation of the service in the current financial year.

2.10 Raising awareness of the importance of reporting reduced fetal movements is also a key LMS campaign with regards to reducing stillbirth. The LMS has commissioned Tommy's[1] to localise some of their materials for raising awareness of reduced fetal movement. As well as an awareness raising campaign through Facebook and information cards for women and their families, banners, posters and leaflets have been disseminated across Shropshire and Telford & Wrekin and the Tommy's reduced fetal movement video is now playing in some GP practices and in Antenatal clinics in Telford and Shrewsbury.

2.11 The LMS has also provided funding to localise and implement the 'Baby Buddy' app. This app and website has been funded by the Department of Health. Baby Buddy is the multi-award winning free app that guides you through pregnancy, birth, parenting and beyond. https://www.bestbeginnings.org.uk/baby-buddy. Through the LMS funding, the Baby Buddy app is being actively promoted across the county and women will receive tailored local advice relating to a range of information for pregnancy, birth and beyond.

3. Improving Choice and Personalisation of Maternity Services

3.1 The LMS is on target to enable all women accessing maternity services to have a personalised care plan by March 2020. The hand held records are currently being reviewed to support collaborative planning between health professionals and women. Women who have recently used maternity services and maternity professionals have been working together to ensure the hand held records enable personalised care planning. A number of improvements have been identified and the updated hand held records will be ready for publication soon.

3.2 Work is also underway to develop electronic personal health records, following a successful bid by SaTH to be a pilot site for the development of maternity electronic personal health records. Once the product is available for demonstration, the pilot and implementation will need to be planned and scoped which will include the involvement of the Maternity Voices Partnership.

3.3 Shropshire, Telford and Wrekin LMS offer all four birth settings within the area (Consultant Unit, Alongside Midwife Led Unit, Freestanding Midwife Led Unit, Home Birth). This exceeds the requirements of Better Births, which requires three of the four birth settings within each LMS.

3.4 The LMS trajectory in relation increasing the proportion of women who receive continuity of carer during pregnancy, birth and postnatally is provided in the table below. Better Births requires each LMS to ensure that by March 2019 at least 20% women are booked on a continuity of carer pathway and that by March 2021, most women are booked on a continuity of carer pathway for maternity services.

[1] Tommy's is a charity that funds research into stillbirth and baby loss.

Number of women receiving continuity of carer during pregnancy, birth and postnatally			
Local baseline	**Trajectory March 2019**	**Trajectory March 2020**	**Trajectory March 2021**
0	970	1,496	2,460
0%	20%	31%	51%

3.5 Work commenced in June 2018, bringing women and their families together with health professionals to agree the actions required to take this forward. During March 2019, a continuity of carer audit is being undertaken in order to establish the proportion of women booked onto a continuity of care pathway. The 20% trajectory was met. However, the new requirement for 35% women to be booked on a continuity of carer pathway by March 2020 presents a greater challenge.

3.6 Whilst current staffing pressures on the maternity services within our LMS are presenting a challenge in taking forward the required changes in order to deliver the continuity of carer targets, the LMS has secured additional funding which has enabled a leading LMS with regards to continuity of carer to provide a bespoke support offer to help us to identify and implement solutions that will enable a greater proportion of women to receive continuity of carer across antenatal, intrapartum and postnatal care.

3.7 The LMS trajectory in relation increasing the proportion of women giving birth in midwifery led settings is provided in the table below.

Number of women giving birth in midwifery settings				
	Local baseline	**Trajectory March 2019**	**Trajectory March 2020**	**Trajectory March 2021**
Number	708	825	965	1,206
%	14%	17%	20%	25%

3.8 The projects described in Paragraph 2 with regards to reducing risk in pregnancy will contribute to increasing the number of women giving birth in midwifery led settings. The LMS also has in place a range of other initiatives aiming to increase the number of women giving birth in midwifery led settings. However, due to a number of factors – not least the staffing pressures within the service, the 2019 trajectory was not achieved. In the last financial year around 10% women in the LMS had a midwife led birth (11.5% for women from Shropshire).

3.9 The Shrewsbury Midwife Led Unit (MLU) refurbishment is now complete and the unit reopened at the end of October 2018. The refurbishment included the replacement of the roof, improvements to facilities for women, the addition of birthing couches and a more 'home-from-home' setting for our mothers to give birth and improved facilities for partners. Staff and members of the MVP worked together along with local photographers and printers to choose the murals to be displayed in the new delivery rooms, one of which has now been installed, which were funded through the LMS. The LMS has also identified funding to improve facilities in the birthing rooms at Wrekin MLU. It is anticipated that the improved

facilities will encourage more women who are suitable for a midwife led birth to choose to give birth in a midwife led unit.

3.10 In addition to the initiatives in place to reduce risk in pregnancy and the improvements to existing facilities, training has been provided to midwives in order to improve skills and confidence in caring for women giving birth in midwife led units and at home. Initiatives are also in place to improve the health of women before pregnancy, including promoting the Tommy's preconception information.

3.11 Women are now supported by their midwife to make a decision about their preferred place of birth later in pregnancy. This enables women to receive a much greater depth and range of information about the differences in birth settings and which birth settings might be appropriate for them, in order to make an informed decision. It also enables more clinical information to be gathered through the pregnancy to enable a better understanding of the women's circumstances that may impact upon her birth choice.

3.12 The LMS has commissioned an external company to undertake Motivational Interviewing (MI) training with staff. This is a technique to facilitate behaviour change by drawing out women's own motivations and goals, rather than imposing those of the health professional. It places greater importance on autonomy, and the techniques out perform traditional advice-giving in terms of improving health behaviours and adherence to recommendations. It has been shown that the effects of having a conversation in this way, persist even when used in brief consultations and is easily adapted for use by all health care professionals and non-clinicians. Additionally by ensuring that those who work together train together. We will build relationships and improve how professionals work together and learn from each other. The training will support standardisation in the way in which any information is provided but more importantly establish the woman's view and motivations for her choices, and is therefore relevant to each professional group and not subject specific.

4. Conclusion

4.1 Steady progress is being made in relation to delivering the required transformation described in Better Births. However, greater pace is required if all of the transformation targets are to be met by March 2021. The challenging context in which local maternity service is operating is having an impact upon the scale and pace of transformation achieved to date.

Fiona Ellis
LMS Programme Manager

Health and Wellbeing Board
Meeting Date: 23rd May 2019

Item Title Shropshire Care Closer to Home – Update Report

Responsible Officer Lisa Wicks Shropshire Clinical Commissioning Group
Email: Lisa.Wicks@nhs.net

1. Summary

This paper provides an update on the Shropshire Care Closer to Home programme.

2. Recommendations

The Health and Wellbeing Board is recommended to note the information and progress outlined in the report.

REPORT

Programme Phases & Progress Updates

Phase 1
Phase 1 is presently operational in the form of the Frailty Intervention team (FIT) who are based within the A&E Department of Royal Shrewsbury Hospital providing rapid frailty assessments and transferring to more appropriate care settings; with the aim of minimising unnecessary hospital admissions and ensuring the person is in the right place for their care and support. A phased launch has now commenced at the A&E Department of Princess Royal Hospital in Telford.
A short film on the work of the Shropshire Frailty Team commissioned by NHS England has also been finalised and launched.

Phase 2
The Phase 2 model of earlier identification of people's needs and proactive integrated health and social care delivered by a community based Case Management team was approved by the Governing Body in August 2018. A Pilot Implementation Group was established, made up of stakeholders spanning the whole health and social care system including CCG, Shropshire Council, GP's, SaTH NHS Trust, Midlands Partnership Foundation Trust, Shropshire Community Trust, patient and public representatives, and the voluntary & care sector; with the remit of collectively planning and implementing pilot demonstrator sites that will test the model prior to robust evaluation and wider rollout across the county. The service specifications, model, demonstrator site criteria and required outcomes were all agreed, and the providers are now taking this forward by co-ordinating the developing and shaping of the more detailed operational functionality of the pilots including locations, workforce, governance and ways of working.

The commitment is that the pilot demonstrator sites will be functional from June 2019 and will run for 9 months, including at the latter stages a 3 month robust evaluation against control sites and required outcomes.

The 8 locations for the pilot demonstrator sites of this service are:

- Albrighton Medical Practice
- Belvidere Medical Practice
- Plas Ffynnon Medical Practice
- Wem & Prees Medical Centre
- Bridgnorth Medical Practice
- Bishops Castle Medical Practice
- The Meadows Medical Practice
- Pontesbury Medical Practice

Work is still underway to develop the required IT and data elements including flow of data between providers, data sharing agreements, GDPR requirements, risk stratification or case finding using merged data, and shared electronic Care Plan meaning everyone involved in the care of that person has all of the required information and that the person has to only ever tell their story once. This will also be added to with an emergency care plan, end of life plan, and links to vital information such as allergies and DNAR notes.
While this enormous piece of work continues, automated risk stratification and data sharing agreements will be in place for the 8 named GP practices for the pilots to commence on 1st June 2019. A manual workaround process is currently being developed and agreed for the shared Care Plan as that technical development will not be in place by June.
All of this IT and data work us also fully aligned with the agenda of the STP Digital Enabling Group.

Phase 3
The design process for Phase 3, which is acute and semi-acute services but still in the community, commenced with extensive scoping and research of other similar national and international models at the end of 2018. The first draft concepts of these new models of care were then shared with stakeholders across the whole health and social care system for critique, comment and feedback.

The draft models were then also shared with the Programme Working Group, Programme Board, GP's and primary care colleagues, and a large-scale patient/public and provider stakeholder event. This ensured ongoing collaborative do-design of the new models and services by enabling us to gather as much feedback and input as possible.

The programme team then spent April consolidating all of the comments and feedback harnessed from all workshops and meetings, before undertaking thematic analysis of the core themes. This condensed feedback is now being considered and reviewed by the Programme Board in order to make any final adjustments to the model designs as part of refining and finessing them, and ensuring they are fit for purpose and sustainable.

If endorsed by the Programme Board in May 2019, the proposed models will then be taken to an extraordinary Shropshire Clinical Commissioning Committee on 11th June 2019 for consideration and approval. If agreed, planning will then commence for the implementation of pilot demonstrator sites following the same process as Phase 2.

The modelling and design has included the development of not only high level model and pathway descriptions, but also detailed robust service specifications that sets out the criteria for using the service or being discharged from it, location, conditions treated, governance, quality and safety, outcomes, and workforce.

The Phase 3 models can be summarised as follows:

Hospital at Home A model for an episode of specialist care delivered for a limited time period in person's home, or at the person's care/residential home, as an alternative to being treated in an acute hospital setting.	**DAART** A designated space that provides timely access to assessment, diagnostics, and short term intervention without the need for hospital admission; before being referred to an ongoing care setting or discharged.
Rapid Response A model that provides a Rapid Response Team of professionals who respond to a person with early signs of deterioration, or heading towards a crisis, and provide a rapid intervention and assessment that stabilises, before triaging to the appropriate setting and then departing.	**Crisis** A service that provides an emergency responsive team of professionals who respond to a person with unmanageable signs of deterioration, or who has tipped into a crisis, and provide assessment, stabilisation, similar to the Rapid Response team but also provide short term high level intensive treatment and monitoring for up to 72 hours before referring to a more appropriate care setting; whether that is stepping down if the person's condition has improved or escalating as a hospital admission of the person deteriorates.

The fifth element of Phase 3 (Step Up beds) will be revisited now that local population disease profiling and prediction information has been received and once the full written report is received.

It will be the implementation and embedding of Phase 3, along with Phase 2, that will see the full benefits realisation of Shropshire Care Closer to Home in vastly improved patient experience, whole system functionality and flow, transformed community services, enabling Future Fit, and reduction of non-elective admissions into secondary care; reflecting the recommendations also set out in the National 5 Year Forward View and the NHS 10 Year Plan.

It is worth noting that whilst these are described as individual services, they will function collectively as one cohesive model of care where the individual moves seamlessly from one service to another without handoffs, co-ordinated by the Case Manager who provides the sole consistent point of contact for the patient and their family. A high level service map of the overarching Shropshire Care Closer to Home models demonstrating these interdependencies is enclosed for information as ***Appendix A*** and ***Appendix B***.

Enablers

A dedicated Care Closer to Home Communications and Engagement Group was established to support delivery across the whole system of the communications and engagement strategy required to support the programme.

A dedicated IT Lead has now been identified within Shropshire CCG who has established a dedicated Care Closer to Home IT Group, with the remit of driving through development and delivery of the necessary IT and data work; essential for the running of the Care Closer to Home services. This includes two-way flow of data between providers, data sharing agreements, GDPR

requirements, risk stratification or case finding using merged data, and shared electronic Care Plans. This is aligned with the work underway in the background of the STP Digital Group on achieving the same agenda of work but on a broader whole system scale.

A software tool purchased by Shropshire Council is now in place which provides a wealth of information into the local population disease prevalence, profiling and predictions. Work is underway to convert this information into a written Joint Strategic Needs Analysis (JSNA) which will enable work to start on developing the fifth strand of Phase 3, Step Up Community Beds.

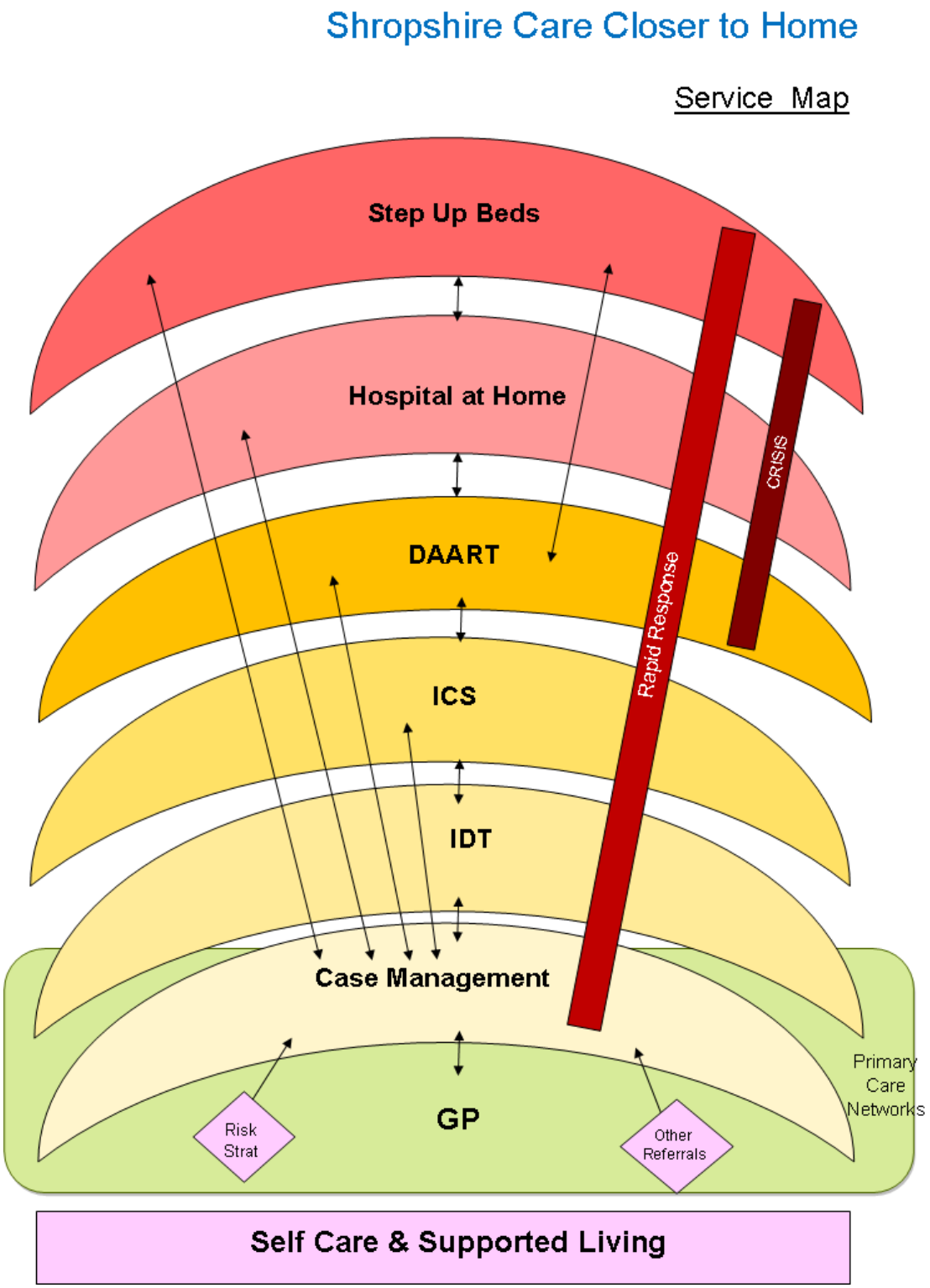
Once these phases are fully embedded and functional, there is a Phase 4 that will see an expansion to include all ages, and not just those aged 65 and over. The reason for starting with 65 plus and frailty is this group being the predominant proportion of population in the Shropshire demographic.

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

-ends-

Appendix A

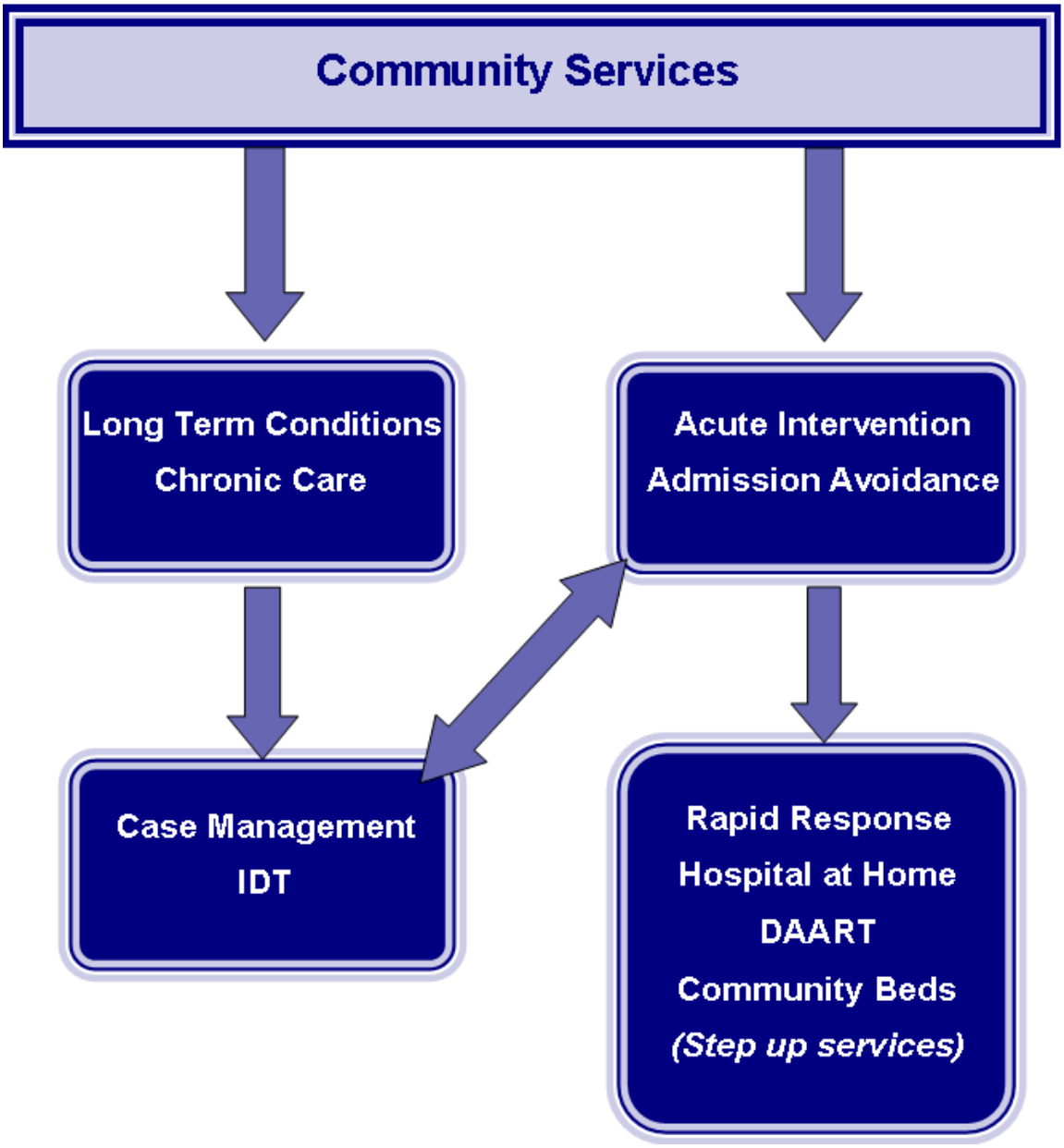
High Level Services Map



Appendix B

Shropshire Care Closer to Home

Pathways



Health and Wellbeing Board
23rd May 2019

STP Update: April 2019 19/20 System Operating Plan Narrative submission

Responsible Officer
Email: Martin.Harris7@nhs.net Tel:

1. Summary

The attached report provides the Board with an update on the progress of the Sustainability & Transformation Programme for Shropshire, Telford and Wrekin, in relation to the recently submitted NHSE & I System Operating Submission. Extensive work has been undertaken to ensure this is a collaborative submission reflecting a "system" overview of the 19/20 individual organisations operating plans. This submission is not yet signed off by NHSE & I, the STP is awaiting feedback, particularly around our predicted financial position, so some data in the attached is subject to change.
We are confident that this submission reflects a system view and would like to take this opportunity to thank Local Authority colleagues for their ongoing contribution and support.

2. For Information

The Board is invited to:

a) Note the system narrative submission, that has been developed collaboratively with all system partners

b) Note current context, challenges, system structure, governance and performance – all of which are subject to change as we as a system work towards becoming and Integrated Care System by 2011

c) Note system ambition and priorities

"The ambition of Shropshire, Telford & Wrekin STP is to deliver joined-up, transformed health and care services for local people"

d) Note timeline, delivery and enablement programmes, approach to activity and capacity planning and overall system financial position.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Not applicable

Cabinet Member (Portfolio Holder)
Local Member
Appendices STP Update: April 2019 19/20 System Operating Plan Narrative submission
Further information Please contact jo.harding1@nhs.net for any further clarification following the meeting

System Operational Plan April 2019

Shropshire, Telford & Wrekin STP

Board Version of submitted STP Plan

Our system plan has input from the following System Partners as well as wider stakeholders

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

NHS Shropshire Community Health NHS Trust

NHS Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

healthwatch Telford and Wrekin

NHS Health Education England

Telford & Wrekin Council

healthwatch Shropshire

NHS The Shrewsbury and Telford Hospital NHS Trust

NHS The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

NHS West Midlands Ambulance Service University NHS Foundation Trust

Shropshire Council

Contents

Foreword by: Sir Neil McKay, Shropshire, Telford & Wrekin STP Independent Chair

This 19/20 system operating Plan forms the first year of our refreshed STP LTP due in the autumn 2019.

The Shropshire, Telford & Wrekin STP have worked collaboratively to bring single organisational operating plans from all system partners, including **Local Authority** plans in to an aligned narrative description that captures the following:

- System Priorities& Deliverables
- System understanding of activity assumptions
- System understanding of capacity planning
- System understanding of strategic workforce planning
- System Financial understanding and agreed approach to risk management
- Understanding of efficiencies and our collective responsibility to deliver those.

In order to develop from an STP to an **Integrated Care System**, we are required to structure and manage ourselves differently going forward.

Our system will make better use of our collective data to inform the initial **Bronze Data Packs** and later in the year the **Population Health & Prevention Dashboard**, both designed to improve our system business intelligence, understanding and planning for improved outcomes.

As part of our LTP refresh, our system will be revisiting our ambitions and the expected outcomes for our population served. In conjunction with our local authority colleagues, we will focus on developing **Place Based Integrated Care**, ensuring quality services are supporting health and wellbeing, whilst improving health inequalities.

Details of these will be available in our LTP later this year.

- **System leadership capacity & capability** across all organisations is fundamental to our success and we will be completing two key programmes to support our strategic development in this area:
  - **System Commissioning Capability Programme**
  - **System ICS Development Programme**
- Transformation across all that we do to achieve ICS status by 2021/2022 is our goal. Our focus will be on system delivery and enablement to achieve high quality outcomes for our population whilst making best use of our collective system resources in order to get best value for every £ spent.
- System financial recovery is inherent in all our ambitions and plans and we are implementing a structure to support delivery of efficiencies.
- The Long Term Plan refresh is our opportunity to work as a system, to meet our challenges of a growing elderly population with increasingly complex needs. Our system expertise (health, social care & wider stakeholders) will come together via our system **Clinical Strategy Group** that will in turn inform our **System Programme Delivery Group,** this will be the engine room of our system transformation.
- This plan has the support and sign-off through all our system partners via **System Leadership Group** and corresponding individual organisational governance processes.
- Finally, this plan demonstrates how we will improve performance, quality, integrated place based working and financial recovery through 19/20.

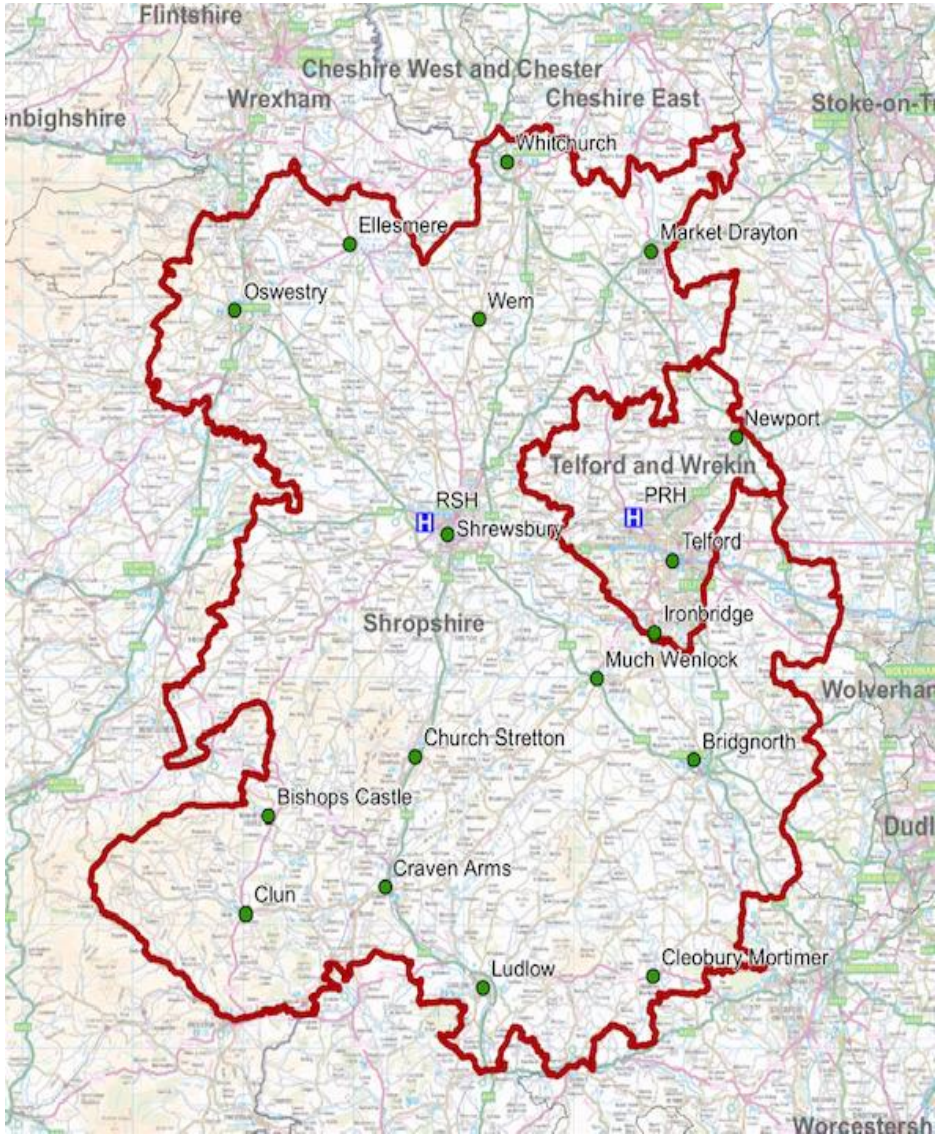
Sir Neil McKay, Independent Chair

Shropshire, Telford & Wrekin STP

2.
Context, Challenges, & ICS Development

Shropshire, Telford & Wrekin STP local context

- Shropshire, Telford & Wrekin STP can be characterised as a good place to live and work, with a good sense of community and volunteering, and the population we serve recognised as diverse, with challenges set by our geography and demography.
- Shropshire is a mostly rural county with 35% of the population living in villages, hamlets and dispersed dwellings; a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation. Telford & Wrekin is predominantly urban with more than a quarter living in the 20% most deprived nationally and some living in the most deprived areas.
- The STP sits between some of the largest conurbations in the country (Birmingham to the South, Manchester and Merseyside to the North), as well as sharing its western border with Wales.
- The STP footprint is served by one acute provider (Shrewsbury & Telford Hospital NHST), one specialist provider (The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT) , one community health provider (Shropshire Community Health NHST) and one mental health provider (Midlands Partnership FT) The ambulance provider is West Midlands Ambulance Service FT.
- There are two CCGs across the footprint; Telford & Wrekin CCG has a large, younger urban population (173k) with some rural areas and is ranked amongst the 30% most deprived populations in England. Shropshire CCG (308k) covers a large rural population with problems of physical isolation and low population density and has a mix of rural and urban ageing populations.
- There are two corresponding local authorities in the footprint; Telford & Wrekin Council, and Shropshire Council
- There are two A&E sites within 28 minutes drive time of each other (Royal Shrewsbury Hospital and Princess Royal Hospital), both with growing volumes of attendances, regularly seeing 400-430 attendances across both sites each day.
- Residents of parts of the footprint will have reasonably long drive times to access acute services.
- The nearest major trauma centre is at Stoke on Trent (UHNM), in the neighbouring Staffordshire footprint.
- There are some high prevalence rates of mental health conditions identified in Shropshire, T&W; there is one mental health provider with a full coverage of services available within the footprint. In addition to minimum Tier 3 and 4 inpatient wards, specialist beds and Tier 4 secure/forensic services are provided.
- Shropshire/T&W has a good relationship with care providers facilitated by Shropshire Partners in Care (SPIC)



System Challenges

One of the significant challenges facing our system is the cultural shift required to move from overly medical care models to ones that align with the principles of prevention, self-help and early intervention. This applies equally to mental and physical health care, as does ensuring parity between physical and mental health care. Another challenge we face is that the system has struggled to make the cultural adjustment needed toward integrated working; this has been exacerbated by insufficient access to a substantive workforce which has impacted on quality, performance and finances. There are also reducing budgets in the care sector and complex political relationships across the system.

Demographics & geography:

- Ageing population: in the Shropshire Council area, 23% of the population is 65 years and over compared to the England average of 17.6% . T&W Council area has a greater number than average of young people but a rapidly growing older population.
- A largely rural Shropshire in contrast with a relatively urban T&W provides challenges to developing consistent, sustainable services with equity of access.
- Shropshire, T&W STP area can be described as a low wage economy; consequently the wider determinants of health including education, access to employment and housing are significant issues to consider when developing services that support good physical and mental health.

Operational performance

- A&E: workforce constraints with consultant and middle tier medical and nursing staff vacancies at SaTH have affected performance, with year to date 4-hour performance at 75.87%
- Cancer: the system is failing to deliver consistently against key cancer standards in all specialties due to challenges with staffing combined with high numbers of referrals

Financial position – the system is facing in year financial pressures:

- At the time of writing this plan, there remains a material gap from the collective Control Total of £21m deficit , driven largely by financial challenges within Shropshire CCG and Shrewsbury and Telford Hospitals Trust. This represents a deficit across the system of £48.6m, with a risk to delivery of £23.2m.
- The two local authorities have been required to make significant savings over recent years, compounded by significant rising costs in delivering social care for both children and adults.

Workforce

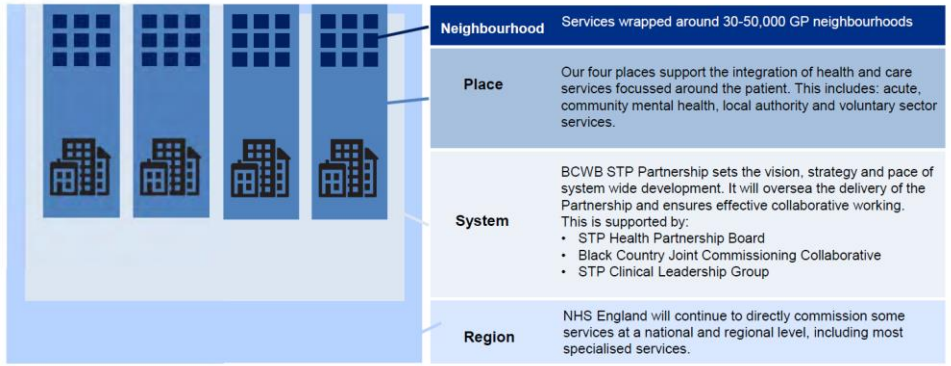
- All providers (including the social care and domiciliary sector) report issues recruiting qualified staff due in large part to the geography and demography of the area.

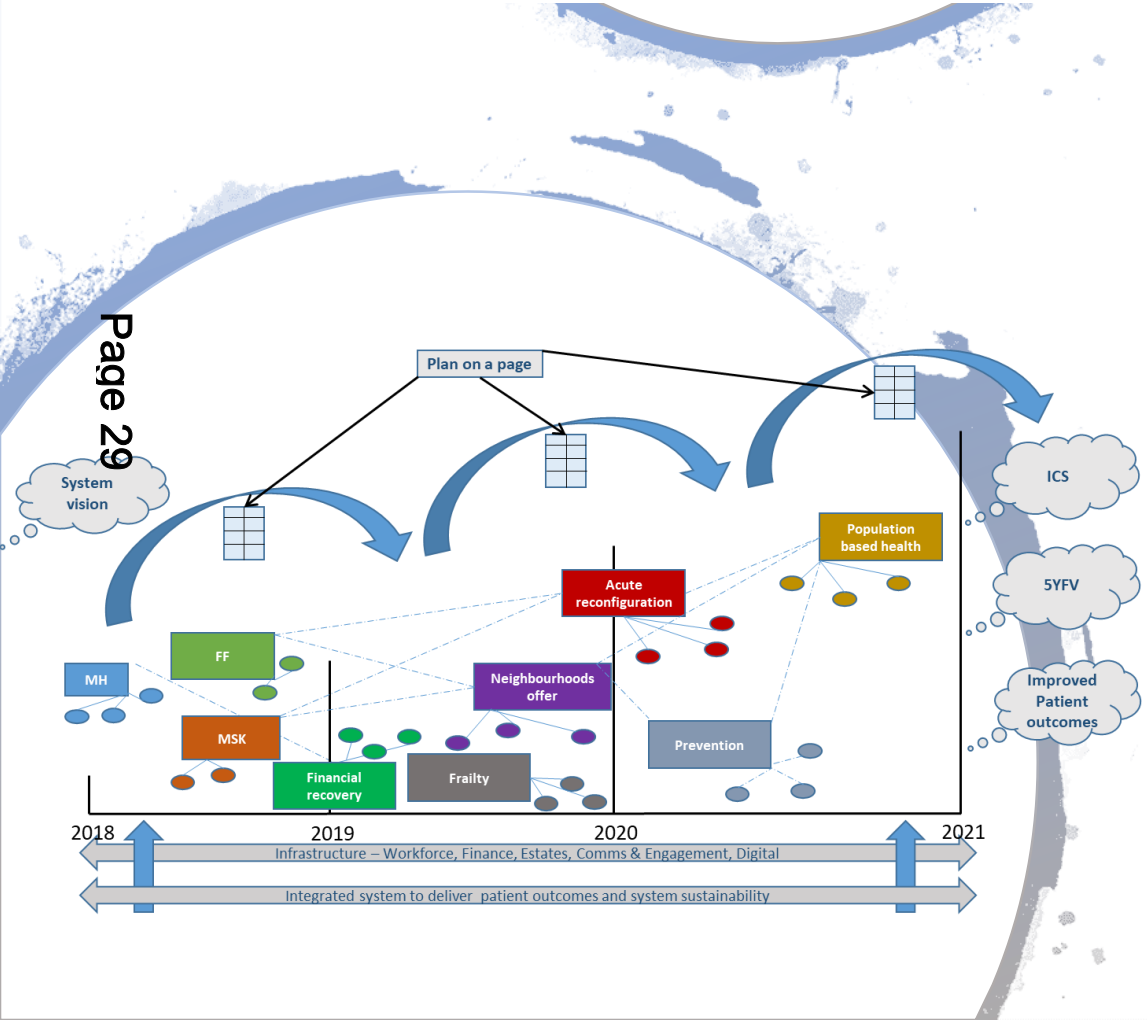
Quality

- Shrewsbury and Telford Hospital NHS Trust has recently been rated 'inadequate' by CQC and is in 'special measures', due to quality and leadership. The Trust is involved in an ongoing independent review into neonatal and maternal deaths.
- Shropshire Community Health NHS Trust is rated as 'requires improvement'. The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is rated as good.
- 88% of care homes in Shropshire are rated good by CQC, as is the mental health care provided by MPFT (Midland Partnership NHS Foundation Trust)
- Healthwatch Shropshire and T&W both work to support and identify areas for quality improvement in our STP Footprint

Reconfiguration

- Public consultation on acute services reconfiguration ('Future Fit') completed; Final Decision Making Business Case approved by Joint Programme Board January 2019. Implementation over the next 5 years, subject to NHSI approval.
- Closer joint working between the two CCGs, exploring the options to move to a Single Strategic Commissioner. Interim Accountable Officer appointment for Shropshire County CCG commenced April 2019, following retirement of the incumbent.
- Midwifery-Led Units case for change just completed NHS England strategic sense check ahead of proposed reconfiguration consultation





Development towards an Integrated Care System

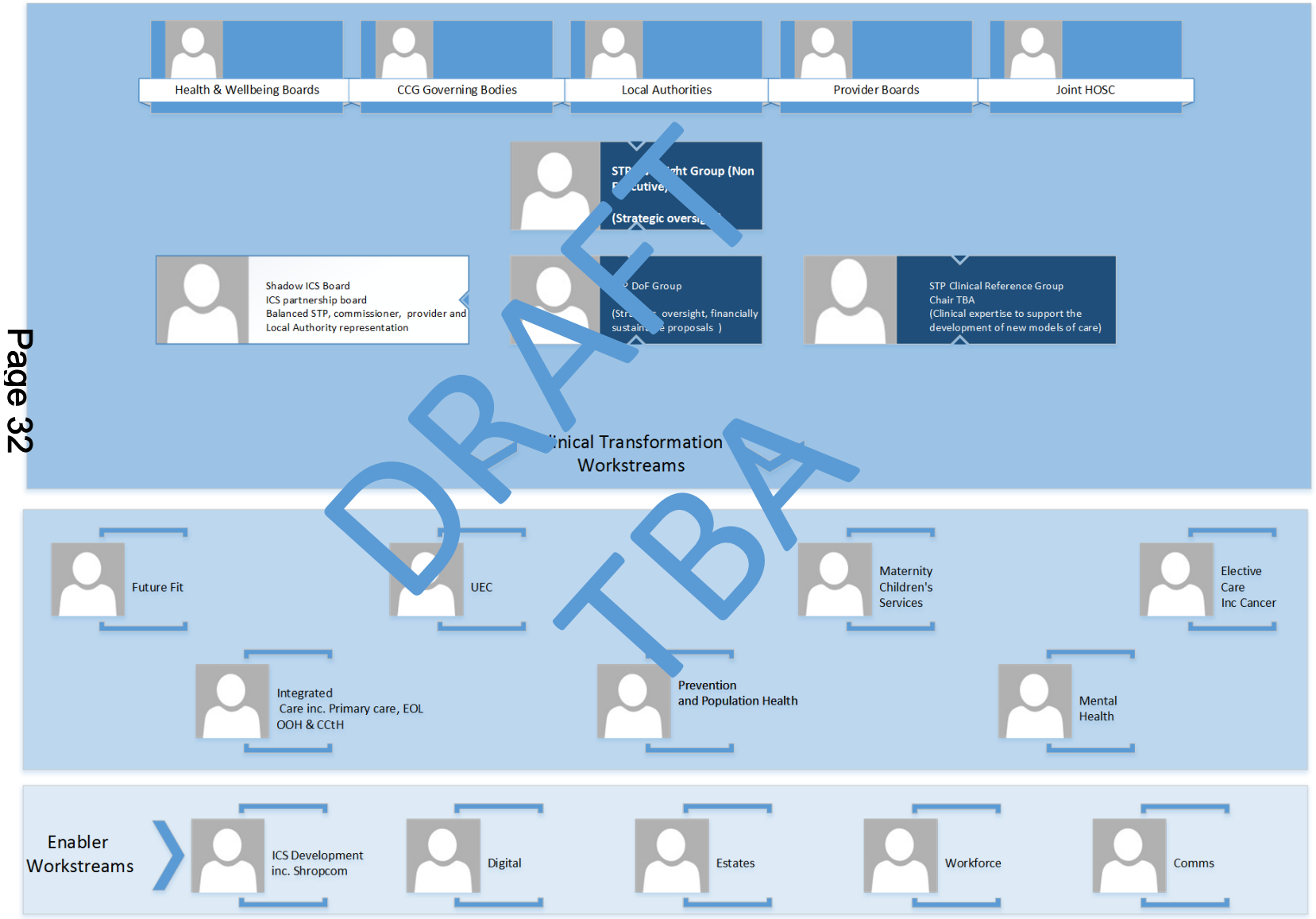
- **STP System Leadership** are progressing towards an Integrated Care System with aligned strategic thinking and delivery.
  - Shadow ICS board currently being developed
- **Renewed Governance and leadership**
  - STP governance refresh (in progress)
- **Commissioning Capability Programme**
  - Development of strategic commissioning and wider partner engagement to shape together
  - Strengthening the profile of mental health across the system
- **Integrated Care Development Programme**
  - Integrated Care System Development (ICSD) - A programme to develop long term behaviors and capabilities to progress the development of local ICS architecture.
  - Commissioning in our 'ICS System' commissioning arrangements to support our wider objectives in order to transform the quality of care delivery and improve health and wellbeing for our population.
    - Functions of the CCGs
    - Services the CCG provide
    - Teams are in the CCG and what are their areas of expertise
    - Merging STP/CCG resources where possible
- Understanding the optimal level/scale at which to commission and where greater efficiencies can be sought.
- **National Delivery Unit Data pack (Bronze Packs)** - a standard data analytical pack produced from national data sources provided to system to identify system opportunities that will contribute towards financial sustainability and improved health and wellbeing outcomes.

3.
System Structure, Governance & Performance

Future governance

- The current STP governance is a partnership between all current organisations in the system. Partners are prioritising the 2 key work programmes:-
    1. System Commissioning Capability Programme
    2. System ICS Development Programme
- We are also committed to working across the system on our **Integrated Place Based Care Programme**
- During 2019/20 we will design new system structures, including a ICS Strategic Commissioner and Place Based Alliances and the governance will evolve.
- The benefits will be:-
    - System efficiencies
    - System focus on Health AND Social Care
    - One strategic commissioner organisation able to drive improvements in performance and quality of care consistently to meet NHS constitutional and key Local Authority targets
    - Stronger local (place) arrangements to deliver care closer to home, as per Future Fit and individuals aspirations/wishes
    - Local synergy with other initiatives including development of Primary Care Networks, Population Health Management and wider prevention.

Refreshed System Governance (to be agreed)



The refreshed governance structure is currently being developed at the System Leadership Group (SLG) this will ensure a streamlined approach to our system transformation programmes this includes -

- Agreed standardised principles for each transformation workstream
    - Strategic oversight for all programmes
    - Specific Terms of Reference and membership for each workstream
    - CEO/AO lead for each programme
    - Dedicated Programme Management
    - Contributes to the LTP
    - Contributes to the implementation of the delivery plans
    - Each programme will have a clinical presence

- Quarterly Transformation checkpoint sessions
- Monthly Operational plan delivery meetings
- Quarterly Chair oversight meetings
- Monthly ICS Shadow board meetings to review and support each programme

Operational Plan Delivery Group

Governance

Delivery of the agreed Operational Plan will require robust integrated working across the whole system. To facilitate this the SLG have agreed an **Operational Plan Delivery Group**, which will be chaired by the STP Sustainability & Transformation Director and include senior Operational, Finance and Clinical representatives from each partner organisation.

This Group will:

- Monitor delivery against key milestones and performance targets
- Provide system support to collectively identify and implement mitigations required to ensure delivery of agreed plans
- Ensure balance of operational, financial and quality performance is maintained across the whole system

Implementation of this Group has been agreed in principle by SLG. We are progressing development with the support of nationally available programmes and resources.

Commissioning Capability

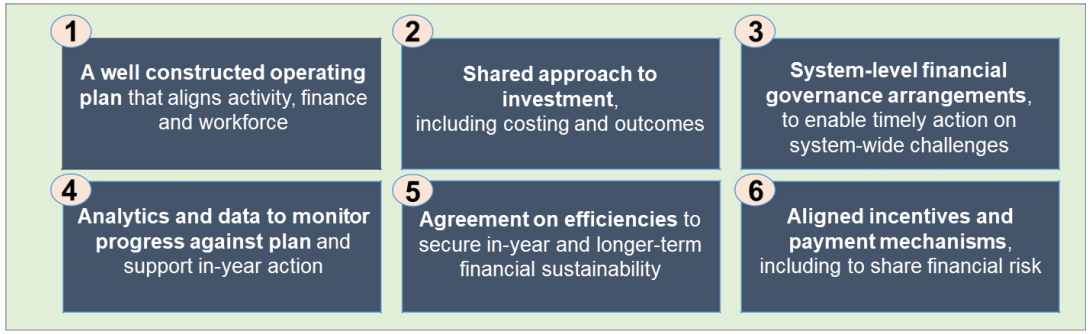
The system is currently considering the WSOA data pack (Bronze Pack) through the **System Commissioning Capability Programme** that includes health and local authority colleagues. Through this programme we are developing the skills and competencies that underpin the implementation of the **MCFR Framework.** This should position commissioners to fully support transition to the ICS.

Expected outcomes:

- All system efficiencies to be considered and actioned as agreed with system partners
- All efficiencies to be included in system financial position
- All risks to delivery to be identified and mitigated with system partners
- Population Health & Prevention Dashboard to be delivered later this year (expected Autumn 2019)

Managing Collective Financial Resources

- The Managing Collective Financial Resources (MCFR) framework has been developed to support systems to effectively manage their collective resources.
- The MCFR framework identifies six key activities that are critical to managing financial resources collectively. The framework is supported by a resource library of tools and case studies which will be updated regularly.



In addition to the six areas of system activity two additional factors have been identified as particularly important to whole system financial management.

These **factors** are:

- Implementation capacity and capability
- System leadership and culture

Shropshire and Telford & Wrekin STP Diagnostic: System Opportunity Overview – Bronze Pack

Key System Drivers / Summary Hypotheses

1 *Out of Hospital Care*

Lower social care and CHC spend, higher avoidable admissions and delayed discharged, with longer LoS for the elderly

The percentage of the **STP's population aged 60-79 (22%) is higher than the England average** (18%) and the growth rate for this segment is 6%, also higher than average (2%). **The percentage of population aged 80+ (6.2%), is higher than the average** (5%) and sees a growth rate of 2.4% against an average of 2.4% 2016.

The STP **spend on social care needs is c.£6m lower** than the national average (spend per head rate). **CHC spend is c.£0.2m higher** than the national average per 50,000 population at a STP level, **however c.£1.2m lower per 50,000 for Telford and Wrekin** CCG (2017/18).

Potentially **avoidable attendances at A&E referred from elsewhere in the system are c.45% higher compared to peers**, corresponding to a potential opportunity of 5,038 attendances compared to the best 5 peers (2016/17 Q4 - 2017/18 Q3).

Non-elective admissions per 1,000 are c.7-14% higher compared to the 5 best peers, a potential opportunity of 5,360 admissions. **Non-elective bed days are c.12% higher** for Shropshire CCG compared to peers, a potential opportunity of 19,043 bed days (17/18).

The **proportion of patients discharged to their usual place of residence is c.7% lower** compared to peers for Shropshire CCG, a potential opportunity of 758 discharges (2016/17 Q4 - 2017/18 Q3).

The **proportion of continuing healthcare eligibility decisions made within 28 days of the initial referral is below the England average** for both CCGs and lower compared to peers - a potential opportunity of 216 decisions compared to the 5 best peers (2017/18).

There has been a **decrease in the percentage of people in Telford & Wrekin (over 65) still at home 91 days after discharge** from hospital between 16/17 (71%) and 17/18 (62%).

2 *MSK*

Higher spend on MSK, widespread risk factors, higher prevalence and number of bed days/LoS

MSK is the second highest area of spend for the STP, c.£50m. Spend is c.£10m higher than the national average rate (2017/18).

Elective spend for MSK is higher compared to peers, a difference of £8.5m. c.87% of this spend (c.£7.4m) relates to Shropshire CCG (2017/18).

The STP **prevalence of obesity (18+), 10.8% is higher than the England average** (9.8%) (2017/18). The **percentage of physically inactive adults in Telford (30.3%) is higher than the England average** 22.2% (16/17).

21.5% of the STP population reports a long term MSK problem, higher than the England average of 18.5% (2018).

Shropshire CCG has a **higher number of bed days for MSK compared to peers**, a difference of 3,517 bed days (2017/18).

Shropshire CCG has a **higher number of MSK long stay patients (21+ days) compared to peers**, a difference of 17 patients (17/18).

For Robert Jones and Agnes Hunt Hospital elderly medicine the **% of day cases to all elective activity in elderly medicine is 31%**, below peer median (56%); **median LoS for elective admissions is 2 days**, below peer median (3) (Aug 18).

The **median length of stay for emergency admissions (elderly medicine) was higher than the peer median** (6 days) for Robert Jones and Agnus Hunt NHS Trust (9 days) (Aug 2018).

The **percentage of total STP elective MSK services sent to the independent sector, 9.6% is below the national average** (21.7%). There is geographical variation with **Telford & Wrekin sending a higher percentage than the average (25.7%) and Shropshire a lower percentage than the average (2.3%)** (17/18).

3 *Prevention and Detection*

Lower rates of detection, higher non-elective spend on circulation and respiratory services

Circulation and respiratory are the third and fourth highest expenditure areas in the STP (c.£84m in total). c.£3.5m more is spent on circulation and c£3m more on respiratory compared to national average rate (2017/18).

Non-elective spend on circulation and respiratory is higher compared to peers, c.£2.5m and c.£3.4m respectively (17/18).

Compared to peers, there is a potential opportunity to detect more patients with hypertension (5,640), coronary heart disease (3,128) and chronic obstructive pulmonary disease (2,279) (2016/17).

There are **opportunities compared to peers to improve circulation quality and outcome indicators** including the % of hypertension patients with BP >150/90 (2,686) (2016/17).

There are **opportunities compared to peers to improve across respiratory quality and outcome indicators including the uptake of over 65s receiving the PPV vaccine** (2,605 patients) (2016/17).

Compared to all local authorities, **Telford (123/149) is in the bottom quartile for tobacco control** (smoking prevalence and smoking status at time of delivery) and **Shropshire (103/149) is ranked "worse than average"** (2016/17).
Shropshire Council is 145th and Telford & Wrekin Council 96th out of 149 LAs for drug treatment summary (2016/17).

The number of **bed days is higher compared to peers for respiratory (6,170 days) and circulation (1,900)**. The number of **long stay patients (21 day +) for Telford CCG is higher compared to peers for respiratory** (27) (17/18).

Respiratory mortality is higher for Shropshire CCG compared to peers, with a potential opportunity of 43 patients (2012-14).

Using system data to drive system change - Bronze Pack

- **Mental health** c.£59m, c.£15m less than the 17/18 national average (spend per head rate).
  - The dementia prevalence (Shropshire CCG) 1.09% is in the highest quartile (16/17).
  - The dementia diagnosis rate for Telford CCG, 65.9% is lower than the national average (67.8%) (Aug 2018)
- **MSK** c.£50m, c.£10m more than the national average.
  - Fracture, hip and thigh, 3rd highest admission from care home
  - The percentage of STP population reporting a long term MSK problem, 21.5% is higher than the England average (18.5%) (2018).
  - The STP prevalence of obesity (18+), 10.8% is higher than the England average (9.8%) (2017/18).
- **Circulation** c.£42m, c.£3.5m more than the national average.
  - £0.73m opportunity for respiratory primary care prescribing (2017/18).
  - Non-elective spend on circulation and respiratory is higher compared to peers, a difference of c.£2.5m and c.£3.4m respectively (17/18).
  - The number of bed days is higher compared to peers for respiratory (6,170 days) and circulation (1,900) (17/18).
- **Respiratory** c.£40m, c.£3m more than the national average.
- **Gastrointestinal** c.£35m, c.£1m less than the national average.

There is lower spend for social care needs (c.£6m) and maternity and reproductive health (c.£3m) compared to the national average rate.

Public health indicators key highlights:

- **Healthy Life Expectancy in T&W significantly lower than Shropshire and lower than the national average**
- **Smoking at tine of delivery higher than national average Shropshire and T&W**
- **Obesity – adults higher than national average for both Shropshire and T&W, Children – higher than national average at reception (Shropshire), yr 6 T&W**
- **Prevalence of diagnosed hypertension all ages Shropshire higher than national average, T&W similar**
- **Alcohol harm T&W higher than national average**

CCG/Area	No. of GPs (WTE)		GPs per 10,000 Pop (HC)		% GPs over 55		% GPs over 65	
	Sept 15	Sept 18	Sept 15	Sept 18	Sept 15	Sept 18	Sept 15	Sept 18
Shropshire	194	202	8.0	8.5	21%	20%	0.5%	1.5%
Telford & Wrekin	103	101	5.9	6.4	17%	18%	0.5%	2%
North Midlands DCO	2,583	2,372	7.0	7.5	17%	18%	3%	3%

Area	Indicator	England	Shrop CCG	T&W CCG
Elderly pop %	% aged 60-79	18%	24%	19%
	% aged 80+	4.9%	6%	4%
Growth rate of Elderly pop	Annual growth pop 60-79	1%	2%	2%
	Annual growth 80+	2%	3%	3%

Using system data to drive system change - Performance

	Shropshire CCG					T&W CCG				
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-18
RTT 18 Weks	91.46%	92.20%	92.17%	91.4%		91.10%	92.30%	91.97%	91.96%	
Number of 52 Week Waits	2	0	2	4		1	0	1	2	
Diagnostic Test Waiting Times	99.3%	99.0%	99.4%	99.1%		99.7%	99.3%	99.4%	99.5%	
A&E 4Hr -LHE all types	75.47%	75.71%	72.99%	70.61%	72.85%	75.47%	75.71%	72.99%	70.61%	72.85%
Cancer 2 Week Waits	86.7%	82.15%	84.5%	88.7%		89.17%	81.55%	85.40%	91.05%	
Cancer 2 Week Waits Breast	79.8%	35.6%	55.6%	87.7%		86.36%	36.67%	59.60%	91.11%	
Cancer 31 Day Waits All Cancers	99.4%	99.5%	98.4%	96.5%		97.8%	100.0%	97.5%	98.5%	
Cancer 62 Day Waits Urgent GP Ref	81.1%	73.0%	82.7%	84.7%		86.7%	75.0%	80.0%	90.9%	
MRSA	0	1	0	0	0	0	1	1	0	0
CDIF	4	4	4	2	2	3	1	0	4	1
E coli bacteraemia	21	36	25	19	15	9	13	7	14	9
Dementia Diagnosis Rate	70.5%	70.2%	70.2%	69.5%	69.8%	65.7%	66.3%	66.6%	66.3%	65.6%
DToC - SaTH	1.32%	1.78%	1.37%	1.52%		1.32%	1.78%	1.37%	1.52%	
EIP	66.7%	50.0%	100%	100%		100%	66.6%	100%	n/a	
IAPT Access	1.1%	1.5%	1.4%	1.2%	1.4%	1.8%	2.0%	1.7%	1.4%	2.0%
IAPT Recovery	57.6%	52.6%	50.2%	59.6%	53.7%	59.8%	57.9%	59.7%	60.6%	61.0%

4.
System Ambition & Priorities

System Leadership statement – agreed April 2019
(to be further refined and built upon as part of LTP refresh)

"The ambition of Shropshire, Telford & Wrekin STP is to deliver joined-up, transformed health and care services for local people.
Our focus for the next 5 years will be to work with primary and community care, hospital services, social care, independent providers and the voluntary and community sector to deliver services at a place level; ensuring that local needs are understood and addressed with people being cared for and able to access services and support as close to where they live as possible"

To achieve this :
We will deliver our transformation in partnership across our organisations, working with our staff, engaging our population, and by setting good policy and outcomes frameworks.
Do all we can to listen to and understand the needs of our communities and staff.
Work together, utilising all our collective resources, to provide quality services and support.
Use data, evidence and insight to underpin decision making at every level

Shropshire, Telford & Wrekin, Priorities, Linked to the Long Term Plan

Programmes and Priorities:

Population health and wellbeing

- Working across health, care and the VCSE, to proactively support people to improve and maintain their health & wellbeing

Integrated Community Services

- Boosting 'out-of-hospital' care and dissolving the divide between commissioning and providing as well as primary and community health services
- Integrated working (physical, mental health and social care) working and primary care models; implementing multi-disciplinary neighbourhood care teams
- Ensuring all community services are safe, accessible and provide the most appropriate care.

Acute & Specialist Hospital Services

Redesigning and delivering urgent and emergency care, creating two vibrant 'centres of excellence'

- Delivering high quality, safe services
- Transforming and digitizing

Cancer	Outpatient care
Maternity and Paediatrics	MSK
Stroke/ Cardiology	ENT
Ophthalmology	Respiratory
Mental Health	Elective Care

Enabled by:

Strong **partnership working** across health, care, public, private and voluntary and community sector

Making the best use of **technology** to avoid people having to travel large distances where possible

Communicating with and involving local people in shaping their health and care services for the future

Supporting the **workforce** to be a highly responsive, happy, confident and capable workforce that provides excellent quality services, in the right place with the right skills, ensuring the workforce engages with local opportunities for the future

Improving and making more efficient our **back office** functions

Making better use of our **public estate**

Outcomes:

- Improved healthy life expectancy
- Improved system efficiencies
- Increased partnership working across all delivery & enablement programmes
- Living independently at home for longer

Measured by:

Quarterly Checkpoint review meetings

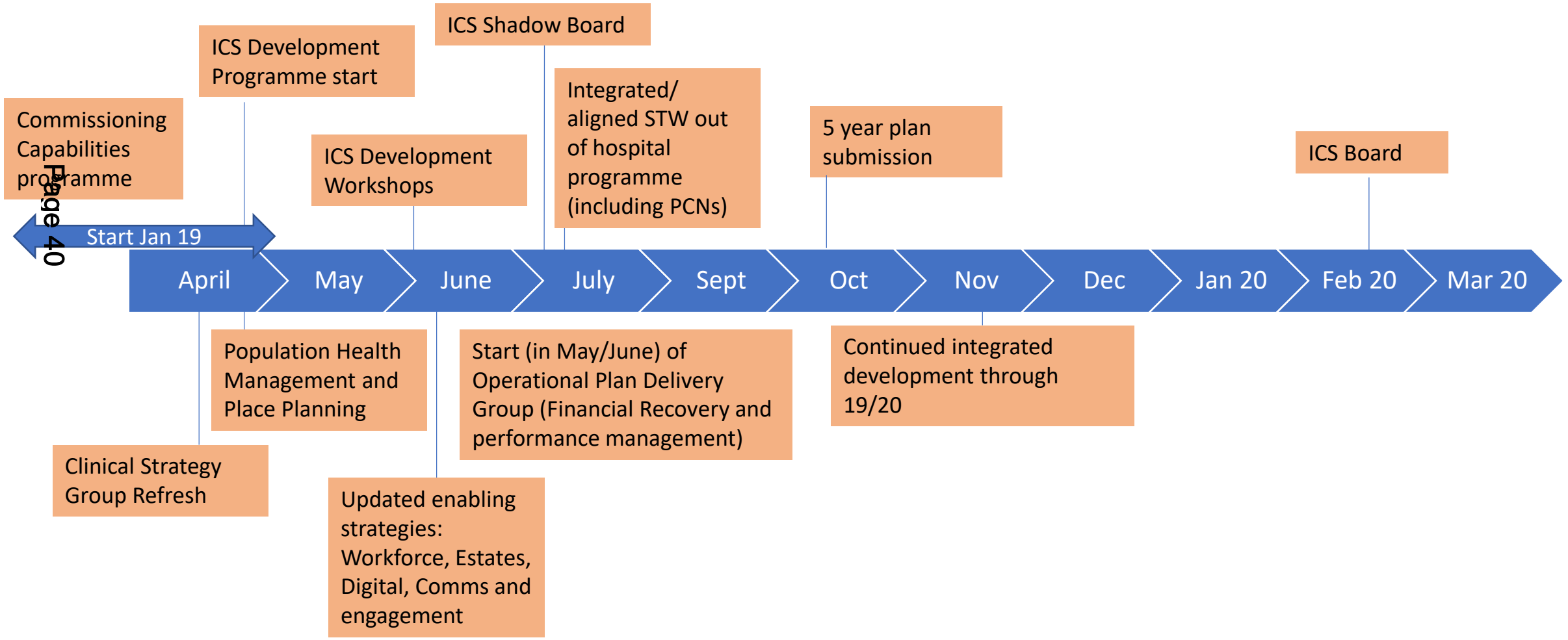
- Bronze pack/ right care
- Public Health Outcomes Framework
- Delivery Programmes
- Enablement Programmes

Governed by : *(proposed)*

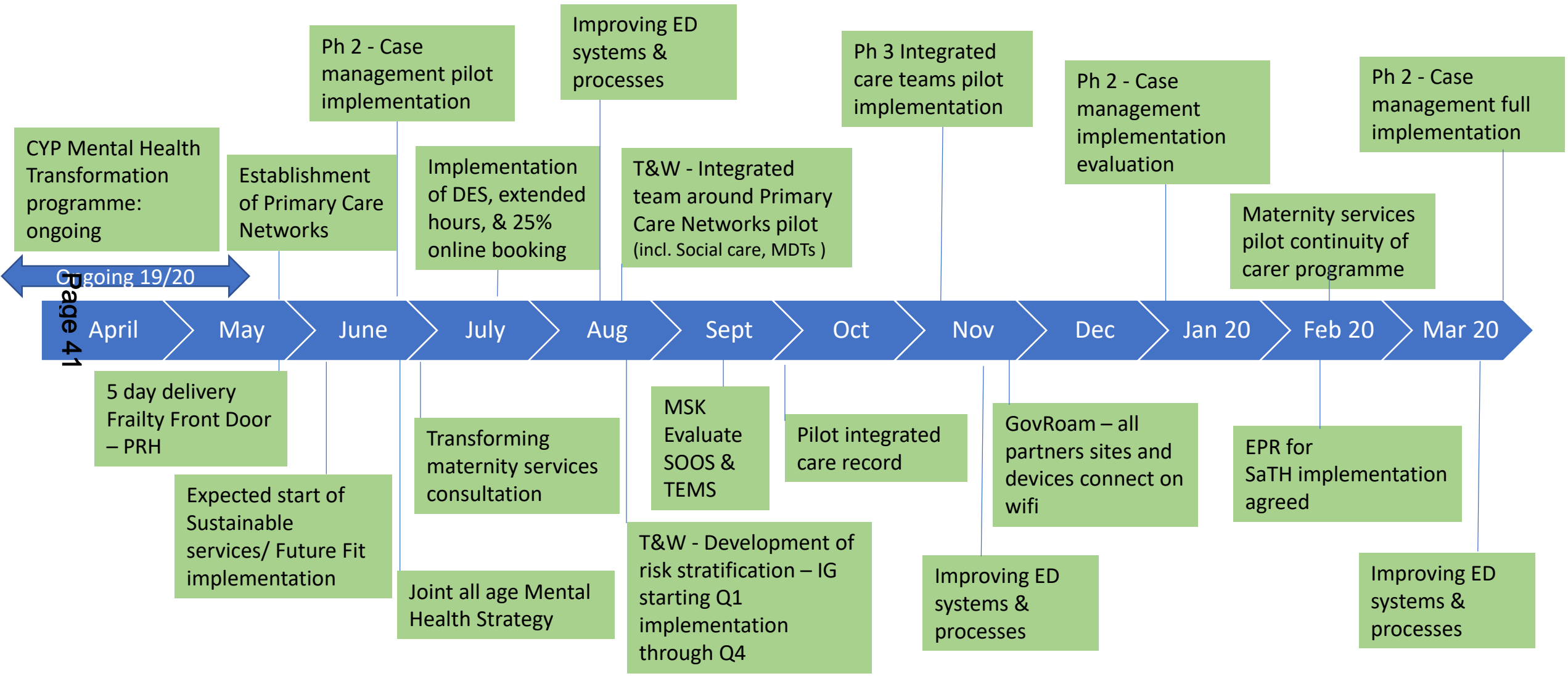
System ICS Shadow Partnership Board

- Shropshire CCG
- T&W CCG
- Shrewsbury & Telford Hospital
- Shropshire Community Health Trust
- Robert Jones and Agnes Hunt
- Midlands Partnership Foundation Trust
- Shropshire Council
- Telford and Wrekin Council

System development and governance 19/20; key highlights



System implementation timeline; key highlights



System approach to Quality

The system has a shared approach including:

- Individual Safety
- Individual & Patient Experience
- Effectiveness
- Well- Led
- Sustainability
- Equitable for all

Our Drivers for Quality include:

- Francis Report
- Berwick Report
- National Quality Board
- NHS Outcomes Framework
- Care Quality Commission Essential Standards
- NHS Assurance Framework
- CCG's Improvement & Assessment Framework
- NHS 10 Year Plan
- ASC outcomes framework
- Public Health Outcomes Framework

How we are working together as a system

Shropshire LA and T&W LA address quality across commissioned services through contract monitoring in conjunction with CQC and Healthwatch

- Shropshire CCG and T&W CCG quality teams working together to address quality across commissioned services to further increase effectiveness, integration and alignment is being planned
- Quality leads are aligned to each provider contract linked with performance, contracting and finance leads with 'buddying' arrangements in place across the two CCG quality teams
- The quality and safety of provided services is assured through quality schedules, commissioning for quality and innovation indicators (CQUIN), monitoring of the quality impact of cost improvement schemes and site visits of major providers.
- Quality exception reports are received and discussed monthly at Board.
- Quality dashboards are monitored with named quality leads aligned
- Quality leads are aligned to each QIPP and finance leads.
- Service development programme linked with performance, contracting and a programme of site visits is in place

As a system we are committed to working together to:

- Improve the issues facing quality, safety and patient experience management
- Operationalise the local quality and assurance framework across all providers
- Drive actions required to address concerns on the quality risk register
- Drive the Enhanced health in Care Homes framework
- Complete Equality, Quality Impact Assessments at the start of commissioning and decommissioning processes.
- Review Root Cause Analysis of Serious Incidents and Never Events to ensure learning is shared across all agencies to drive forward service improvements and patient safety
- Escalate quality concerns and reports to Board, QSG, NHSE and NHSI as required
- Develop a robust Quality Strategy with clearly identified priorities and that takes into account the full system, health and care
- Use all available resources including Right Care Opportunities to deliver improved quality by removing unwarranted variation and improving outcomes at a population health level

Aspiration - Creating outstanding quality by:

- Culture change within our organisations to work in an integrated way, reducing medical models of care when appropriate, and supporting people in their community, delivering the best possible care and support for our population (inclusive of Social Care, Dom Care and Private Providers)
- New dynamic that strengthens communities and individuals ability to self-care
- Patients are at the centre – to sustain and improve primary care, including strengthening integrated multi-disciplinary working ensuring people stay at home
- Streamlined care, robust pathways – to ensure we commission sufficient capacity for planned care and improve patient experience of appointments
- Support people in crisis with the right care at the right place – to make sure people can navigate a simplified urgent care system to meet both physical and mental health needs
- Aspiration that all providers to reach outstanding levels of care for our communities

System Quality Focus

Approach to improving quality at SaTH

Delivering against our Must Do actions from the CQC inspection – specific focus on ITU, ED, Maternity
Improving ambulance handover time in ED
Reducing Corridor Care in ED
Improving Ambulatory care to reduce unnecessary admissions
Improving frailty pathways
Improving discharge to reduce unnecessary Length of stay and reduce further patients that stay in hospital over 7 and 21 days
Maintaining Day Surgery capacity throughout the year in order to reduce waits for surgery
Improving workforce numbers through international recruitment for nursing and medical staff
Improving staff experience and well being through delivery of the OD plan

Seven steps to improve quality

These seven steps set out what all of us need to do together to maintain and improve the quality of care that people experience. We have strong foundations to build on – not least, the impressive improvements in care quality we have seen in many areas in recent years – but there is also much more for all of us to do if we are to close the care and quality gap.

1. **Setting clear direction and priorities** based on evidence.
2. **Bringing clarity to quality,** setting standards for what high-quality care looks like across all health and care settings.
3. **Measuring and publishing quality,** harnessing information to improve care quality through performance and quality reporting systems.
4. **Recognising and rewarding quality.**
5. **Maintaining and safeguarding quality.**
6. **Building capability,** by improving leadership, management, professional and institutional culture, skills and behaviours to assure quality and sustain improvement.
7. **Staying ahead,** by developing research, innovation and planning to provide progressive, high-quality care.

Note: Health Foundation A Clear Road Ahead (2016) developed this modified version of the NHS Quality Framework.

Workforce

- Key challenges:
  - Staff retention and recruitment
  - **Cultural challenges within existing organisations and staff groups resistant to change; preparing a workforce with no boundaries across organisations**
  - **Cultural change to support out of hospital working**
  - **Cultural change to embed prevention, self-care utilisation and health coaching**
  - Reducing dependency of bank and temporary staffing
- Key priority areas-
  - Recruitment and retention, education, training and staff development
  - Leadership, culture and organisational development
  - Workforce information, planning and intelligence

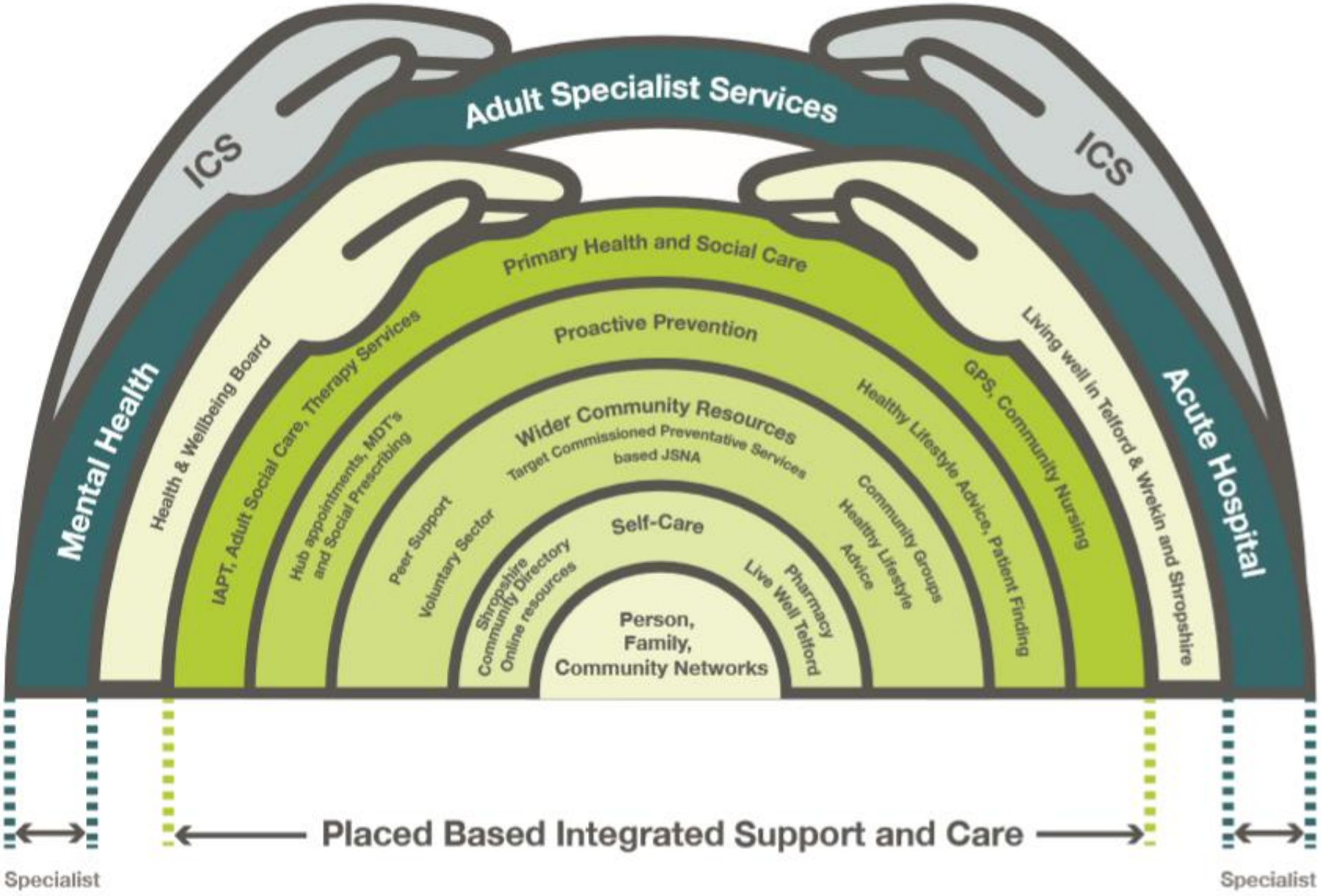
STW Process to improve quality

5.
Delivery Programmes

DRAFT - Vision of STW Integrated Support and Care Approach

As a STP we are developing a visual representation of how we are working in an place based integrated way; working in collaboration across organisations and with our communities.

This diagram is a draft of our joint vision that will be further developed for the 5 year plan.



Population health and prevention

Priorities:

1. Develop system architecture for population health, including a robust understanding of need through business intelligence and the JSNA
2. Working with the regional support offer to develop capacity and capability across Shropshire
3. Support improved working for prevention across all organisations; in particular
    - Embedding prevention through transformational work programmes, in particular Primary care and Community services
    - Develop our wider workforce in behaviour change and motivational interviewing
    - Proactively identify people at risk of ill health and behaviour change conversations, brief interventions
    - Prevent harm due to alcohol, obesity, CVD and poor mental health
    - Support culture change and new working practices that help people at the earliest opportunity
    - Support active signposting and develop a good understanding of how communities support people – linking to Social Prescribing
    - Work across organisations (including the VCSE) to prioritise support for key population groups – address inequity and inequalities by connecting with the national and regional population health management support mechanisms

Deliverables:

- Working with the regional support offer, deliver a prototype using the population health management approach to improving care
- Deliver system data repository, JSNA development and reporting processes
- Support for place based working with the local authorities (connected to primary care and community transformation);
- Deliver Stop smoking services for patients, expectant mothers, long term users of specialist mental health services and learning disabilities;
- Implement social prescribing, targeting CVD and weight loss services to people who need it most;
- Deliver greater uptake of the National Diabetes Prevention Programme;
- Ensuring children have the best start in life including access to mental health and early help support;
- Establish alcohol care teams in hospital and community

Primary care

Priorities:

1. Developing Primary Care Networks and New Models of Care (including the development of Care Closer to Home and Neighbourhood working)
2. Prevention and addressing Health Inequalities
3. Care Quality and Improvement
4. Improving Access to Primary Care – 7 days a week
5. Ensuring a workforce fit for the future
6. Improvements to technology and digital enablers
7. Ensuring high quality estate
8. Optimising workflow and addressing workload pressures in Primary Care
9. Ensuring quality and efficiency in prescribing

Deliverables:

- 100% coverage of Primary Care Networks by July 2019 including delivery of the extended hours Directed Enhanced Service
- Increase uptake of physical health checks and dementia diagnosis rates
- Meet the 7 core standard required in the extended access enhanced service including direct booking via 111
- Improvements to technology, digital enablers
- Deliver retention and recruitment programmes to secure a primary care workforce fit for the future including the enhancement of the primary care training hub
- Meet the required additional clinicians programme as outlined in the Long Term Plan .e.g social prescribing link workers and clinical pharmacists
- Deliver the requirements of use of technology e.g. 25% of appointments available online by July 2019, electronic repeat prescribing, implementation of the NHS App
- Completion of primary care estates review and full alignment with One Public Estate programme
- Delivery of the 10 high impact changes to support workflow optimisation
- Reduction in antimicrobial resistance and medication errors. Increase use of generic medicines and prescribe according to best practice

Out of hospital integrated care (including personalised health budgets and social prescribing)

Priorities:

- Developing a joint out of hospital integrated services that support the diverse population we serve; working collaboratively with Community Services, Acute Care, Primary Care, Social Care, Preventative services, and the VCS; this includes:
  - Integrated Place Programme (T&W)
  - Care Closer to Home (Shrops)
    - Phase 1 – Frailty at the Front Door (hospital service approach), Shropshire in progress, T&W in planning , delivery estimated June 2019
    - Phase 2 – Case management through demonstrator sites - Shropshire , June 2019
    - Phase 3 – Community services including admissions avoidance and delayed transfers, Autumn 2019
- Using data to drive the development of services (including case management and prevention services)
- Delivering admission avoidance , in reach and facilitated early discharge
- Developing joint personal health budgets governance and delivery with the Local Authorities
- Develop joint processes and commissioning for CHC (health and care)
- Connect social prescribing with out of hospital and primary care transformation programmes (Care Closer to Home and Neighbourhoods), and the Better Care Fund prevention strands and voluntary sector grants and contracts

Deliverables:

- Supporting the development of resilient communities, prevention and early help in conjunction with all partners
- Upscaling 'Frailty at the Front Door' to implement in PRH (already delivering in PRH)
- In collaboration with system partners, development and delivery integrated care models, including:
  1. Risk Stratification and case management
  2. Rapid Response
  3. Intermediate care/ hospital at home
  4. Care home support (including Care Home Advanced, Trusted Assessors, Care Home MDT)
  5. Social Prescribing and prevention services
- Implement an aligned programme across T&W and Shropshire
- Implement a robust system and governance for personal health budgets
- Implement new practices for jointly delivering CHC with local authority partners
- Progression of models of Social Prescribing by joining with out of hospital with additional funding, in connection with primary care and the local authorities
- Connect with data and infrastructure developments as part of Population Health Management programme

MSK Transformation Programme

Priorities:

- Ensure the model, priorities and resources relating to the vision and objectives for the MSK transformation programme
- Ensure there is strong patient and public engagement in the MSK Transformation programme
- Ensuring that an over-arching Communications and Engagement Strategy is in place and that key messages are circulated to partner organisations following each meeting.
- Ensure changes to the MSK services in Shropshire are based on clinical evidence and best practice (national and international)
- Monitor the impact of the transformation programme including unintended consequences/dis-benefits, and agree on an appropriate strategic response
- Ensure effective coordination of the planning and commissioning of services and operational delivery with a robust supporting infrastructure
- Engage with GP Clinical Directors, Academic Health Science Networks, inviting their representatives to attend Board meetings, as appropriate.
- Engage with clinical/operational teams to ensure all staff are aware of the strategy and their input required
- Review MSK services within community and secondary care;
- Transforming operational processes and developing a single service model for the whole MSK pathway, using the results of the review and the First Contact Practitioner pilot evaluation;
- Delivering referral targets;
- Delivering quality and financially sustainable services.

Deliverables:

- Establish STP MSK Programme Board
- Assess current delivery of services including TEMS (evaluation of SOOS completed with a provider review planned in the next 6 months)
- Assess resources for delivery – alignment of existing CCG and provider resource following the receipt of an agreed gap analysis
- Review current delivery board membership to ensure that the appropriate level of decision making can take place
- Scope of services to be determined within the agreed resource envelope
- Impact analysis throughout of implementation/changes
- Demand and capacity assessment of existing providers
- Development of a strategy to possibly consider the option to move to one integrated MSK provider
- Consider and support where necessary the reconfiguration and transformation programme to ensure the sustainability of services
- Review GIRFT outputs, Right Care and data sources to support changes/redesign
- Development of an agreed delivery outcome frameworks
- Completed MSK review;
- New single service model for MSK that integrates with community and secondary care;
- Continue to monitor progress and quality

Local Maternity System

Priorities:

- Improve Safety
  - Stillbirths and neonatal reduction
  - Reduction in brain injury
- Improve Choice and personalisation
  - enabling all women to have a personalised care plan and choice in the care they receive
- Increase midwife led births
  - increase the number of women giving births in a Midwife led unit
- Increasing investment in perinatal mental health
- Develop continuity of carer

Deliverables:

- Develop and progress the Midwife Led Unit Review
- Develop and implement pilot for continuity of carer programme
- Fully implement improvements in safety including Saving babies lives care bundle
- Deliver improvements in choice about maternity care, including by developing personalised care plans
- Implementing the neonatal quality improvement programme
- Develop workforce plan to improve core staffing with clear governance and reporting
- Developing a culture of learning and improvement

LMS Progress against KLOE 19 March 2019

Number of births				Key Lines of Enquiry																									
				Stillbirths and neonatal deaths					Intrapartum brain injuries					Number of personalised care plans				Number of women able to choose from three places of birth				Number of women receiving continuity of carer during pregnancy, birth and postnatally				Number of women giving birth in midwifery settings			
2015 baseline	2018/19	2019/20	2020/21	2015 baseline (and data source)	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Change in rate 2015 - 2020	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Change in rate 2015 - 2020	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021	Local baseline	Trajectory March 2019	Trajectory March 2020	Trajectory March 2021
4887	4851	4827	4824	30	23	22	20		11	9	8	7		0	0	4827	4824	4887	4851	4827	4824	0	970	1,496	2,460	708	825	965	1,206
				6.15/1000	4.8/1000	4.5/1000 (	4.2/1000		2.2/1000	1.8/1000	1.7/1000	1.5/1000		0%	0%	100%	100%	100%	100%	100%	100%	0%	20%	31%	51%	14%	17%	20%	25%

A&E performance and trajectory- 19/20 – Top Three Priorities:

1. Workforce

Options being enacted to mitigate the challenges

- Frailty at the front door at PRH
- Protect Streaming workforce
- Plans in notes and clinical criteria for discharge
- Achieve Pre-12 discharge potential on all wards
- Achieve further reductions in length of stay by:
  - Discharging patients requiring IV therapy to community slots
  - Achieving the potential in PRH stranded patient reduction
- CDU capacity created in Head and Neck theatres at RSH from the 8th of April to release bed capacity in acute medicine.
- Space Utilisation prioritisation
- Workforce models to support the current workforce challenges

2. Acute Care /Frailty Model

Options being enacted to mitigate the challenges-

- Achieve Acute Medicine and Ambulatory care potential (project group facilitated by ECIST commenced 14th March). This will require additional acute medical workforce.
- Recruitment of doctors from India and nurses from Southern Ireland
- Approval of workforce business cases for ED staffing and Acute Medicine staffing.
- Transfer of stroke neuro-rehabilitation to the community and further development of early supported discharge(Whole system approach)
- Development of cardiology SDEC /heart failure/respiratory acute (from 6 A's audit).
- Development of cardiology direct access service (from 6 A's audit).
- Development of ambulatory and 72 hour frailty service across both sites (requires workforce).
- Development of a 24 hour CDU model (requires workforce)

3. ED systems and processes

Urgent & Emergency Care

The ambition for Urgent & Emergency Care is to:
Provide enhanced system-wide urgent and emergency care that ensures our patients are cared for in the most appropriate setting by skilled workforce able to meet their needs, develop services that are based on best practice, demand and capacity analysis and the needs of our local population with an overarching ambition to support all patients Home First.

Prioritise:	Improve care:	Improve Experience:
1. ED Systems and Processes	We aim to implement standardised best practice, enhance our workforce and appropriate capacity to improve emergency care provision resulting in improved patient outcomes and satisfaction, appropriate staffing, capacity and improved recruitment and retention of skilled staff to meet the needs of our patients.	• Improved system working • Improved access to clinically appropriate services • Reduced ambulance handover time • Reduce ambulance conveyance • Reduced attendances and inappropriate admissions • Increased number of patients being treated in SDEC • Improved identification and management of frail older adults • Increased home first • Improved patient outcomes • Reduced mortality and morbidity • Improved patient and carer satisfaction • Improved team working and staff morale • Meet the A&E 4 hour quality standard to avoid waiting.
2. Frailty	We aim to have a fully functioning Frailty Front Door Service for 5 days a week at both sites by May 2019. We aim to extend this service to run 7 days a week by October 2019. We will work with the STP Out of Hospital Group to co-design a whole system frailty pathway and service model.	
3. Ambulance	We aim to ensure that we maximise the opportunity to avoid conveyance to ED so that patients arriving by ambulance to ED are appropriate, and enjoy a seamless handover to ED without delay.	
4. Acute Medical, Short-stay and Same Day Emergency Care (SDEC)	We aim to develop and implement an enhanced Acute Medical, Short-Stay and Same Day Emergency Care (SDEC) model based on national best practice and needs of the local population.	
5. Care closer to home	We aim to enhance and embed 'Home First' services to enable all our clinically appropriate patients to be offered a home first solution that meets their needs.	
6. Discharge management	We aim to ensure that patients stay in hospital for the minimum time required to manage their presenting problem while avoiding the secondary harms arising from hospitalisation and ensuring as soon as they are safe to transfer they have the opportunity to be discharged to their usual place of residence and / or access to step-down services for re-ablement which maximises independence is required.	

Urgent & Emergency Care

Priorities: *continued from last year's high impact changes

- ED Systems and processes *
- Frailty at the front door *
- Ambulance Demand *
- Same Day Emergency Care/Acute Assessment/Short Stay
- Home First (Care closer to Home)
- Discharge Management

Enabling programmes:

- Demand and Capacity
- Improvement in Informatics

Deliverables:

- Successful recruitment to the workforce
- Improved patient outcomes
- Reduced mortality
- Reduced attendances and inappropriate admissions
- Improved staff morale
- Improved patient / carer satisfaction
- Improving access to Same Day Emergency Care (SDEC)
- Improvement and development of frailty at the front door programme
- Sustained improvement in the reduction in long stays
- Improving the data available and use effectively to inform clinical decision making and future priority planning
- Improve discharge planning from moment of admission to prevent deconditioning and ensure a timely, **home first** approach for as many patients as possible
- Improve ED systems and processes to ensure efficient and effective care for patients
- Identify and manage constraints identified throughout the patient journey to ensure timely and effective care
- Effectively match capacity and demand through the use of data and intelligence
- Better use data to avoid conveyance and ensure patients are treated in the right place in the first instance.
- Decreased deconditioning . Complications of hospitalisation will reduce
- Meet the 4 hour A&E Quality standard.

Cancer & Referral to Treatment

Cancer Priorities:

Ambition – fewer people to be diagnosed with preventable cancers; improve mortality rates and improve patient experience

Priorities:

- Deliver the Living with and Beyond Cancer;
- Deliver cancer services that are accessible, timely and sustainable;
- Workforce and capacity – testing new ways of system working that will deliver more timely care;
- Improve against performance targets;
- Explore opportunities for improving urological cancer through joint working across the system
- In conjunction with the Cancer Alliance implement best practice pathways in priority areas

Deliverables:

- Implement a holistic needs assessment and care plan
- Develop treatment summaries to guide patients and GPs post treatment
- Develop and deliver the living well offer – providing advice, support and signposting
- Deliver the cancer care review – between the GP (or nurse) and patient
- Deliver person centred follow – up tailored to the patients
- Develop joint working processes for urological cancer
- Develop a system wide cancer strategy
- Implement best practice pathways for Lung, Prostate, Colorectal and Upper GI

RTT Priorities:

- Streamlined care;
  - Outpatient activity
  - Cancer treatment
  - Musculoskeletal (MSK) services
  - Neurology
  - Local Maternity Services
- Robust pathways;
  - Achieving targets
    - 18 week referral targets – consultant lead treatment
    - 6 week diagnostic test target
    - 52 week treatment target
- Commission sufficient capacity;
- Improve patient experience of appointments and treatments;
  - Outpatient redesign

Deliverables:

- Monitor the acute trusts waiting list to ensure at the end of March 2020 does not exceed the waiting list at the end of March 2018
- Work with providers to develop a process for identifying patients exceeding 6 months on the waiting list and offering them an opportunity to move to an alternative provider
- Develop a process for identifying patients approaching 40 weeks on the waiting list to ensure no patient exceeds 52 weeks

Outpatient Redesign

- The CCGs plan to undertake a programme of work in relation to outpatients redesign. A task and finish group has been established with SaTH & RJAH to look at what changes can be made. The CCGs intend to use this task and finish group to undertake the following actions:
- Identify area where non face to face appointments can be implemented
- Explore areas where patient led follow ups can be implemented
- Develop process for identifying unnecessary frequent attenders (such as mental health) and implement mitigating actions for these patients
- Align diagnostics with appointments
- Use national outpatient improvement dashboard to improve clinic utilisation
- Use the learning from the IBD app project to roll out to other areas
- Identify technology opportunities in relation to outpatient appointments

Mental Health (Children and Adults) and Learning Disabilities & Autism

Priorities:
One of the key cultural challenges for mental health services is determining what mental health conditions should be treated in secondary services and what are treated within the community and primary care. Mental health services have been successful in moving from hospital/campus models of care to helping people recover in their own homes. We want to continue this through a choice of least restrictive environments and safe environments for short term interventions which the majority of people require. Equally, for those people who experience learning disabilities or autism, these long term conditions require access to both specialist and mainstream services where reasonable adjustments have been made to enable equality of access.
Our priorities are:

1. Ensuring a great start for children and young people and appropriate services for children and young people (CYP) when needed
2. Delivering person centred care, that takes into account mental and physical health
3. Creating open door access; understanding where people can get help, support, services they need (including prevention, primary care, community, online, vcs)
4. Ensuring Mental Health is integrated into neighbourhood models of care
5. Ensuring that carers are supported as an integral part of system planning, delivery and support
6. Ensuring a joined up, confident and appropriate workforce for the STP patch including prevention, support and evidence based care for people in the communities where they live.
7. Ensuring that people with learning disabilities and autism have access to the support and services they need
8. Creating time for front line practitioners to care

Deliverables:

- Improved mental health of children and young people through the delivery of the CYP transformation plan including:
  - Delivery of the CYP Transformation Plan
  - Improved Development of local SEND partnership arrangements
  - Review and joint work on complex care needs for children and adults
- Improved access to services and community support for people with emotional and mental health issues by:
  - Developing and implementing a system all age Mental Health Strategy and embedding mental health pathways into neighbourhood models of care
  - Strengthening out of hours crisis response and reduce admission where possible
  - Increasing investment and developing an integrated model of delivery to support STP priorities (e.g. physical health, IAPT), in communities
  - Realigning the existing workforce to support the development of preventative models, and transformed secondary care (including social care)
  - Strengthening relationships and integration with community services including primary care, local authority, charities, the third and voluntary sectors
  - Expansion of IAPT services in partnership with primary care and physical health services
  - Increased access rates to IPS, IAP, EIP
  - Trauma informed pathways for adults and CYP
- Reduced number of suicides and attempted suicides by implementing the suicide prevention strategy and action plan
- Improved outcomes for people with dementia by developing and implementing a Dementia Strategy including the delivery of newly developed dementia services.

End of Life

Priorities:

- Reducing the number of people dying in acute hospital
- Supporting Care Homes (competencies, skills, confidence)
- Supporting out of hospital programmes to include end of life pathways, training and support

Partnership working with all partners including hospices and the wider the voluntary and community sector

Deliverables:

Recommended Summary Plan for Emergency Care and Treatment (Respect)

- Implementation of the national ReSPECT model of care led by the STP End of Life Programme through partnership working
- Workforce support through the development and implementation of an education programme to deliver ReSPECT training and resources for the system utilising a train the trainer model including all system partners
- This will ensure a standardised and consistent process of transition and adoption of ReSPECT
- EOLC and Swan Scheme education programmes developed and delivered across system partners supported by the End of Life Care Handbook
- EOLC Volunteers trained at SaTH and Shropshire Community Health NHS Trust (looking to scale across the social care workforce)
- System-wide access to Sage and Thyme training including communication tools and techniques for all partners acute, community, hospices, council and domiciliary care.

Contribution of carers

The contribution 'carers' of all ages make to society cannot be underestimated. Locally, we acknowledge and value what carers provide day to day and the impact this has on their own lives. We believe that supporting carers is everyone's responsibility and important in the considerations of all our strategic planning and service delivery.

We must ensure:

- Carers are recognised through all of services
- Supported to maintain their caring role and to maintain their wellbeing
- Are able to contribute to service planning and individual care as appropriate

Voluntary and Community Sector

Working with the voluntary and community sector

In Shropshire and T&W voluntary, community and enterprise sector (VCSE) exists in abundance. The people of Shropshire recognise the role, importance and power of communities and the organisations that support our local areas to thrive. The role of services is to ensure that the VCSE is supported so that it can continue to thrive. When we work together, we can achieve great things. As a partnership we will continue to work with the VCSE, communities and people to support:

- **The development and delivery of services**
- **Commissioning**
- **Delivery of services in communities**
- **Understanding of population need**
- **Wider determinants of health**

6.
System Enablement

System strategic approach to Workforce

The system workforce objectives are:

- To ensure the planning, recruitment and development of an engaged, talented and compassionate workforce for the future system

- To develop a sustainable future workforce who are equipped to meet the needs of our communities

Our **STP People Strategy** sets out how local organisations delivering health and social care services plan to work better together to ensure the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place to deliver quality and sustainable services to members of the public.

- The Strategy identifies four key areas for collective working; 1) Attract, Recruit and Retain; Agile Workforce, 2) Workforce Planning and Modelling, 3) Learning through Education, Development and Training Opportunities and 4) Organisational Development and Leadership including Equality and Diversity. The Strategy is underpinned by principles of system-wide, cooperation and collaboration, improvement and innovation, integration and redesign.

- As a result of achieving the ambition outlined in our People Strategy, we hope to succeed in:
    - Realising the vision of the People Strategy and new models of care
    - Improving outcomes for service users, families and staff
    - Building a better understanding of system workforce
    - Optimising our system workforce
    - Supporting and enabling service improvement and redesign, especially across boundaries

- Since the publication of the NHS Long Term Plan work continues to ensure the People Strategy reflects the ambitions and intentions outlined in the plan e.g. digital workforce and the volunteer workforce are new areas of focus that will be included within the next iteration of the People Strategy which remains a live document.

Primary Care

- Significant improvement in the quality of workforce data and ability to set targets and trajectories, & appointment of Primary Care workforce leads
- Success in funding proposals for running retention programmes for GPs
- Success in attracting funding for new Clinical Pharmacists
- Introduction of the Physician Associate internship with four PAs to be placed in local practices
- Significant increase in engagement with GP trainees with plans for fellowships and post-qualification support
- Improved engagement with GP Nurses via established GP Nurse Educators/Facilitators and delivery of GP Nurse 10-point action plan
- Upskilling of primary care workforce in independent prescribing, spirometry, management of long-term conditions, physical assessment and mentorship

- **Mental Health**
- Realignment of the mental health workforce to support person-centred approach to neighbourhood working
- Training delivered across services around effective care planning/ care co-ordination
- Development of system-wide mental health workforce plan which led to the establishment of an STP Mental Health Delivery Group
- HEE investment to support delivery of the mental health workforce development plan by upskilling the workforce to achieve Five Year Forward View for mental health
- Health awareness and first aid training made available across the system including health, social care, domiciliary care, fire service, police, ambulance
- Targeted recruitment for Shropshire area, focussing on selling Shropshire as a lifestyle and good place to work
- Focus on developing a new pathway for 0-25 (CYP) mental health including a workforce model

Our Local Workforce Challenges:

Fragility of workforce for acute provider across medical, nursing and therapies
Recruitment challenges and high vacancy rates, related to factors such as national workforce shortages, varying terms and conditions, geographical rurality, levels of morale
Cultural challenges within organisations, with some staff groups or individuals resistant to change
Morale and retention of staff as a result of major change or retendering within the system
An ageing workforce and a reduced community of suitable people to seek to attract
An uncertain future supply of staff, with difficulty attracting students to some courses, placements and recruitment to jobs upon qualifying
Different expectations of the younger workforce, e.g. increased part-time and flexible working
The image of health and social care in the general population

System People Strategy

Shropshire, Telford & Wrekin LWAB People Strategy

STP Workforce Leaders and Groups

Attract, recruit, retain

Retention Strategy
Collaborative **Recruitment**
'Team STW'; Employment Offer and Branding
Health and Wellbeing of our people
Agile Workforce; integrated, rotational and new roles
Collaborative Bank
System-wide **People Development Plan**
Widening Participation

Planning & Modelling

System-wide **workforce profile** (baseline)
Service/pathway specific **workforce plans**
Longer term collective planning and **forecasting**
Supply improvement
Workforce **modelling** tools
Benchmarking

Education

Redesign roles and skills
EDT needs for system
Current **EDT offer**; gaps & duplication
Develop **'core' system EDT offer**
System-wide approach to **induction**
Standardise statutory and mandatory training (**skills passport**)
System-wide approach to **Preceptorship**

OD & Leadership

Leadership; shared leadership development approach
STW STP **leadership offer**
Managing **talented people**
Service / Quality **Improvement Methodology**
Culture and values
Equality and diversity

Our Values

system-wide engagement, involvement and leadership; working in co-operation with all our stakeholders; stimulating continuous improvement and innovation for high quality person-centred delivery; driving forwards prevention and the integration of health and social care to create a more holistic approach for our people and communities; and supporting the redesign of roles and skills

OUTCOMES

- Realise the vision
- Improved outcomes for service users, families and staff
- Better understanding of system workforce
- Ability to optimise system workforce
- Support and enable service improvement and redesign, especially across boundaries

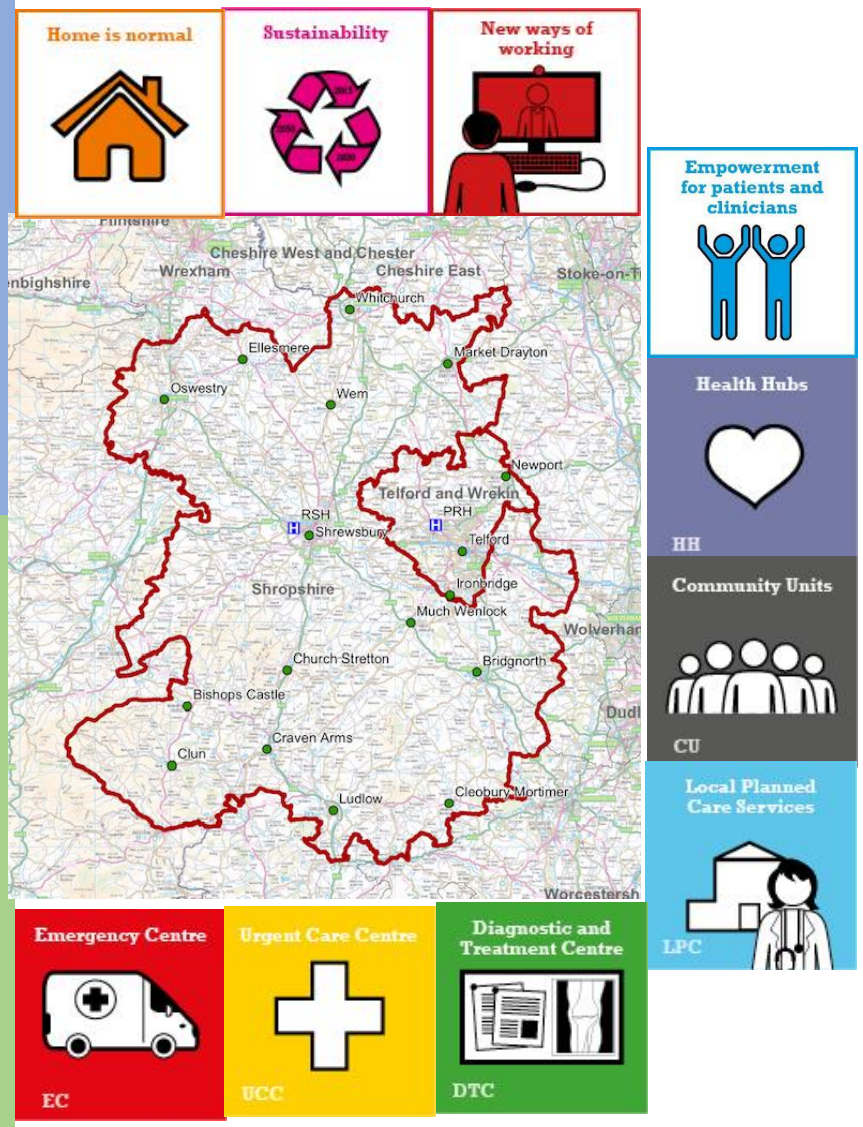
System Strategic Estates

Priorities:

- Put people rather than buildings first, with population need at the heart of our estate focus
- Develop **'Place'** based integrated & co-ordinated healthcare estate, relevant to redesigned person, patient, service user and staff delivery pathways, embedded with decisions based on a wider system view; supported by hub solutions, backed up with One Public Estate philosophy, rather than organisational self-interest
- Ensure best system use of estate assets which are relevant, accessible, efficient, safe, fit for use & purpose
- Collaborate with system partners; examine & challenge organisational estate strategies and plans to identify all of the potential opportunities for improvement and rationalisation
- Support system delivery programmes leads in articulating & translating their system need into estate requirements
- Ensure capital plans & asset management align with clinical strategies
- Future proofing of GP services through closer working with Council planning teams to negate future planning problems down the line
- Establish a virtual STP estates team, based on supporting STP, rather than individual organisations

Deliverables:

- Submit Estates Strategy Checkpoint template by June 2019
- Resubmit the STP Estate Strategy Autumn 2019 for further assessment – must be rated as 'Good' in order to receive future STP estate capital
- Progress project pipelines with 'Place' health and social care hub concept as the driver, including the acute reconfiguration aspects associated with 'Future Fit' Wave 3 capital funding, co-ordinated by Sustainable Services Programme, Paul's Moss Whitchurch health and social care hub development, and primary care at scale projects
- Produce the refresh of the Estates Chapter for the STP Long Term Plan
- Improve system-wide potential disposal information, through creation of a system-wide occupancy planner, sharing of disposals, with a disposal plan and timetable to include an understanding of associated capital investment to release assets and lead to efficiency savings
- Support efficiency programmes, estate rationalisation strategies and utilisation plans to maximise the opportunity to create a system-wide capital plan
- Support the drive to make more efficient use of space and deliver the Carter metrics, with better use of void, shared and bookable space
- Create a matrix of existing leases, marking the break clause etc. to enable system planning to take place and better manage occupancy



STW STP Estates Implications

Better use of void, shared and bookable space; focusing on collaborations with NHS property companies, Councils, Providers, and Landlords

Improving financial transparency between ST&W STP partners' strategic capital investment plan's

Opportunities to reduce footprint & release capital proceeds and reinvestment needs identified

Estate aligning with One Public Estate, including opportunities to develop key worker housing

Reviewing primary & community service locations, including community bed provision

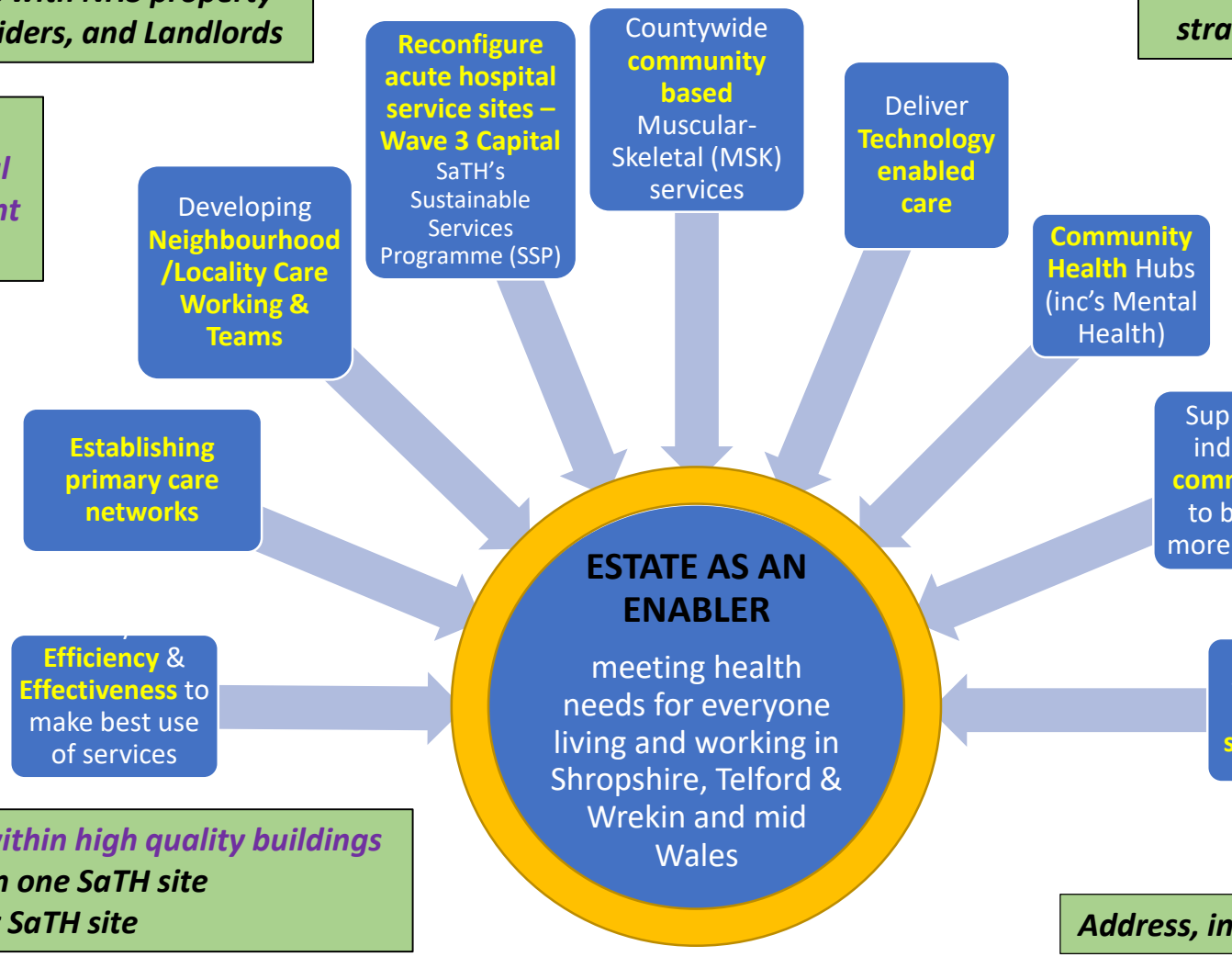
Joint and better use of clinical & non-clinical space

Facilitating Community and Clinical Hubs

Review maternity services, locations, consultant & midwife-led care & related estate

Two urgent care centres within high quality buildings
Emergency Department on one SaTH site
Planned Care on the other SaTH site

Address, in part, the backlog maintenance



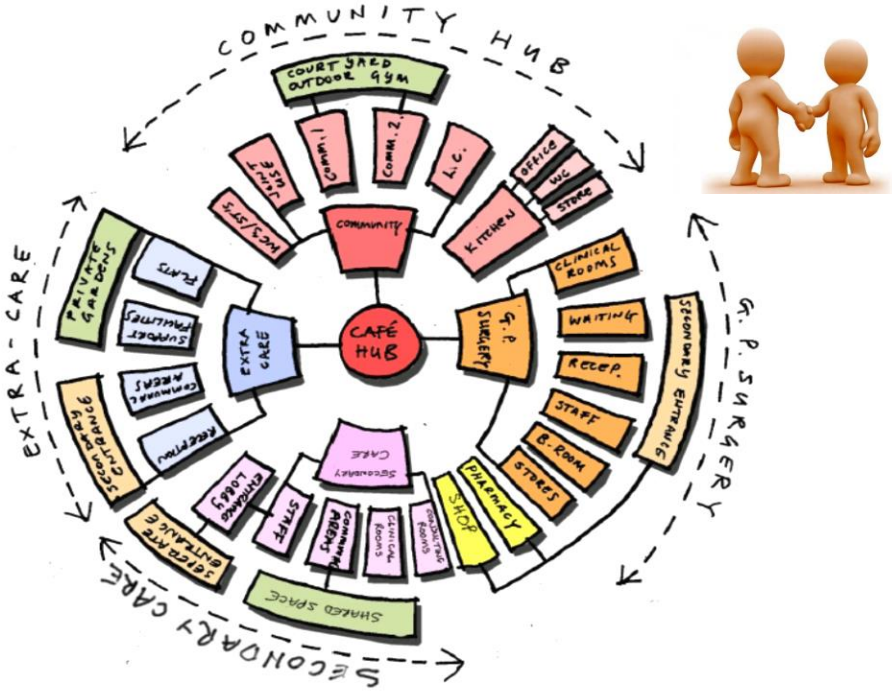
'People' and 'Place' not 'Building' focused

Estates focusing on long-term service transformation and efficiencies

- Fit for purpose, community hubs, based on community need
- Programme of opportunities, across patch, which will transform service delivery, deliver efficiencies and enable inward investment
- The proposed approach is one of prevention and wellness, building up communities, developing resilience and reducing the future cost of care with a clear focus on housing. Reduction in packages of care costs, less stress on future finances
- Increased self sufficiency through community support and independent living – housing type is hugely important
- Long term, generational change will reduce reliance on public services

How this can be delivered

- Through creating independent living opportunities and appropriate housing to give people the lives they want
- Enabling people and organisations to integrate, work together, share problems and solutions, all in one place – collaborative working across estates function, look at shared procurement
- Allowing generational change to occur whereby people look to their own community for support, not to the public services
- Bespoke financial model for each opportunity
- Funding opportunities through grants
- Recycle any capital receipts through identified surplus buildings



Principles of our community centric approach

- To put people at the heart of decisions
- Understand the needs of the people in each area
- Empowering the community to support its self
- Enabling a change in community culture
- Supporting people through social action
- Building capacity within the voluntary sector offer space to deliver
- Targeting the specific needs of individual communities
- Providing new models of ‘wrap around care’
- Developing the ‘Community Hub’
- Up-scaling and enhancing the primary care offer
- Providing joined-up public services delivered at a local level
- Incorporating specialist housing
- Developing housing models for step down care

System Digital Enablement

Priorities:

1. Developing and delivering an Integrated care record (MCR)

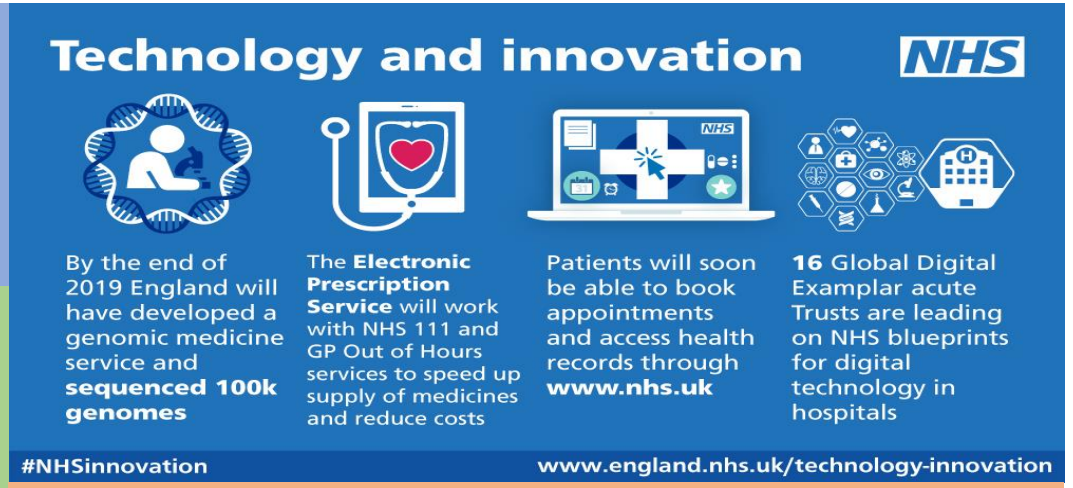
2. One approach to Information Governance and data sharing for our system

3.Business Intelligence and data sharing with a focus on one system-wide view and support for population health management and prevention

4. System wide approach to infrastructure & security.

Deliverables:

- Digital sufficiently embedded as enabler in all transformation programmes
- System data is available from all partners and informs integrated working and population health management
- Improved IG and data sharing
- Local Digital Roadmap for 2019; focussing on:
- People empowerment ("All people")
- Processes – workflow and efficiency
- Pace
- Digital shared care record available for appropriate use.
- Initial plan to include organisations already having Electronic Patient systems, to obtain early benefits. Other orgs to phase in later.
- A standard of infrastructure across all partner sites and devices to enable digital transformation.
- Early stages focussing in improving system access for mobile staff.
- Mobile enabled workforce.
- Progression towards Electronic Patient Record in Acute.
- Electronic patient management system in UEC to replace use of paper.
- Remove use of faxes across the STP area.



Next Steps:

- Deliver refreshed Local Digital Roadmap for 2019.
- Engage with out of hospital programmes to support and enable transformation.
- Continue to engage with Maternity Services to support and enable transformation.
- Create local digital infrastructure.
- Define plan to deliver shared care record.
- Investigate options for shared care records, including discussions with STP neighbours
- Communicate and disseminate information about system digital capabilities.
- Liaise with Academic Health Science Network (AHSN) to connect with proven digital transformation.

First GovRoam sites and devices go live (April) → LDR agreed (May 2019) → Pilot Integrated care record specified and out for funding (Sept 2019) → GovRoam – all partners sites and devices connect on wifi (Nov 2019) → EPR for SaTH implementation agreed (Feb 2020)

System Communication & Engagement

Priorities:

- Establish an initial infrastructure and operating arrangements to ensure that opportunity to build confidence and engagement are not missed
  - A refreshed visual identity, new website, twitter account and a regular Stakeholder Bulletin
  - Further developing our single, shared narrative and clear briefing to help inform stakeholders' understanding of the work underway
  - The new appointment of a C&E SRO for the C&E Workstream to represent the health and care system, allowing co-ordination and dissemination of communications messages and joint working on issues and challenges
  - Ensure continuous stakeholder engagement including seldom heard groups
  - Presence at events, speaking opportunities and networking events where appropriate
- To further develop the communications and engagement approach using the C&E Workstream
  - Manage communication and engagement capacity and support for STP programmes
  - Facilitate discussion between communication and engagement colleagues and effectively manage change
  - Ensure key messages are focused at a public and staff level and answer the question that audiences are asking
  - Produce communication materials to allow managers/stakeholders to communicate the key STP priorities and themes to include toolkits, website copy, social media tools, leaflets, videos and other specific materials as required for internal and external communications
  - Ensure a consistent approach, understanding and messaging across the system internally and externally
  - Share resources, best practice and share thinking to deliver effective campaigns for change
  - Cascade clear decisions and leadership messages to staff and partners
- Engage in the development and delivery of our refreshed system wide plan following the publication of the Long Term Plan
  - Utilising existing engagement channels/relationships such as Healthwatch, to continue to engage and use insights to inform decision making – undertake the work, share the findings, and act on it
  - Ensure wider stakeholder engagement and involvement in every delivery and enablement programme
  - Build awareness of the partnership working amongst the local voluntary and community sector organisation so that they can be closely involved in shaping strategy
  - Inform and involve all stakeholders in the development of the ICS and our emerging vision for health and care partnership in Shropshire, Telford & Wrekin so that the plan is best for our patients

Deliverables:

- Delivery of STP communications & engagement strategy
- Establish communications & engagement network
- Evidenced engagement within every programme of work
- Every organisation has increased awareness of system understanding of the transformation programme
- Increased understanding amongst Shropshire, Telford & Wrekin residents, staff and stakeholders of the challenge we face, our health and care partnership and our vision for future health and care services
- Increased understanding that we all have a role to play in developing how services may change and the importance of engaging in the debate about the future of health and care services in Shropshire, Telford & Wrekin
- Support consultations on service change

NHS
Long Term Plan
#NHSLongTermPlan

7.
Activity & Capacity Planning

System Approach to Capacity Planning

- The system is working together to understand shared capacity across collective resources
- Significant amount of work was undertaken across the system to model the capacity requirements for winter 2018/19 and this learning is being used to plan for 19/20
- Real time activity data has been used to develop this model given the significant, unpredicted growth in demand
- Further work is being undertaken to determine capacity requirements in acute and community settings
- Significant work is being done by the system to improve models of admissions avoidance, such as the ambulance conveyance reduction work. Improvement in ambulatory care models also being undertaken to minimise bed utilisation.
- The system are reviewing their assumptions and then reviewing for impact on workforce and finance to then create the plans for 2019/20
- Significant changes predicted and improvement in patient management by direction to out of hospital services will need to be profiled, in order to accurately forecast demand, e.g. 111, urgent treatment centres and Future Fit
- Use **valued care in mental health**; and **improving for excellence** to improve the emergency care of people with mental health

System Winter Planning Approach

- The Plan has been developed through robust engagement of all key system partners overseen by the A&E Delivery Group.
- In parallel, system demand and capacity modelling has been undertaken to determine predicted winter demand and required acute bed capacity to inform the bed bridge calculations.
- All Providers are asked to share their understanding of their demand and capacity over the winter months and provide an organisational winter plan which includes:
    - Additionally, and phasing of escalation
    - A workforce model to support 7-day working, senior decision making and escalation capacity
    - 7-day working
    - Christmas, New Year and Easter period
    - Options for further surge capacity if required

System Capacity Planning Modelling - Based on 92% occupancy

	April	May	June	July	August	Sep	Oct	Nov	Dec	Jan	Feb	Mar
beds available (core)	642	642	642	642	642	642	642	642	642	642	642	642
Total beds available for +1 day	589	589	589	589	589	589	589	589	589	589	589	589
BEDS REQUIRED with LOS 6 days	633	625	664	645	624	637	628	688	654	654	634	676
8% to reduce occupancy to 92%	683	675	717	697	674	688	678	743	707	706	685	730
BED GAP	-94	-86	-128	-108	-85	-99	-89	-154	-118	-117	-96	-141
Improvement schemes to bridge bed gap												
This Varies by month and includes schemes such as Acute medicin (Front door), frailty, Stranded Patients/Los Improvements												
Total Improvements	10	15	24	38	37	36	37	38	38	38	38	38
RESULTING BED GAP	-84	-71	-104	-70	-48	-63	-52	-116	-80	-79	-58	-103
Capacity schemes to bridge bed gap												
winter beds open all year	30	30	30	30	30	30	30	30	30	30	30	30
RSH ward 35				28	28	28	28	28	28	28	28	28
RESULTING BED GAP	-54	-41	-74	-12	10	-5	6	-58	-22	-21	0	-45
Additional solutions that can be in place as currently utilised as additional winter capacity												
care home beds	11	11	11	11	11	11	11	11	11	11	11	11
Hospital full protocol (without day surgery or AEC)	8	8	8					8	0	0	0	8
RESULTING GAP	-35	-22	-55	-1	21	6	17	-39	-11	-10	11	-26
Potential solutions that currently don't exist e.g. PRH additional capacity (from November), additional care home beds												
?additional community capacity	20	20	20									
PRH additonal capacity								28	28	28	28	28
rehab out of hospital				10	10	10	10	10	10	10	10	10
Potential GAP if these are accepted	-15	-2	-25	9	31	16	27	-1	27	28	49	12

System Capacity Planning Modelling - Based on 95% occupancy

	April	May	June	July	August	Sep	Oct	Nov	Dec	Jan	Feb	Mar
beds available (core)	642	642	642	642	642	642	642	642	642	642	642	642
Total beds available for +1 day	589	589	589	589	589	589	589	589	589	589	589	589
BEDS REQUIRED with LOS 6 days	633	625	664	645	624	637	628	688	654	654	634	676
5% to reduce occupancy to 95%	664	656	697	677	655	669	659	723	687	686	666	710
RESULTING BED GAP	-75	-67	-108	-88	-66	-80	-70	-134	-98	-97	-77	-121
Improvement schemes to bridge bed gap												
This Varies by month and includes schemes such as Acute medicin (Front door), frailty, Stranded Patients/Los Improvements												
Total Improvements	10	15	24	38	37	36	37	38	38	38	38	38
RESULTING BED GAP	-65	-52	-84	-50	-29	-44	-33	-96	-60	-59	-39	-83
Capacity schemes to bridge bed gap												
winter beds open all year	30	30	30	30	30	30	30	30	30	30	30	30
RSH ward 35				28	28	28	28	28	28	28	28	28
RESULTING BED GAP	-35	-22	-54	8	29	14	25	-38	-2	-1	19	-25
Additional solutions that can be in place as currently utilised as additional winter capacity												
care home beds	11	11	11	11	11	11	11	11	11	11	11	11
Hospital full protocol (without day surgery or AEC)	8	8	8					8	0	0	0	8
RESULTING BED GAP	-16	-3	-35	19	40	25	36	-19	9	10	30	-6
Potential solutions that currently don't exist e.g. PRH additional capacity (from November), additional care home beds												
?additional community capacity	20	20	20									
PRH additonal capacity								28	28	28	28	28
rehab out of hospital				10	10	10	10	10	10	10	10	10
POTENTIAL POSITION if these are accepted	4	7	-5	29	50	35	46	19	47	48	68	32

8.
System Finances

System Financial Position

£m	SCCG	TWCCG	SaTH	RJAH	SCHT	TOTAL
2019/20 Control Total	(12.3)	0.0	(17.4)	2.0	0.0	(27.7)
2019/20 Plan Surplus / (Deficit)	(23.8)	0.0	(24.3)	(0.5)	0.0	(48.6)
Variance to Control Total	**(11.5)**	**0.0**	**(6.9)**	**(2.5)**	**0.0**	**(20.9)**
Risk to Delivery:						
Unidentified CIP/QIPP	0.0	(4.9)	(7.8)	0.0	(2.0)	(14.7)
High/Medium Risk Schemes	(7.0)	(2.0)	(4.8)	(3.3)	(1.5)	(18.6)
Transformational Change Programmes	1.1	0.9	2.5	1.3	0.2	6.0
Contingencies/Reserves/Other	1.3	2.5	0.0	0.8	(0.5)	4.1
Total Risks to Delivery	**(4.6)**	**(3.5)**	**(10.1)**	**(1.2)**	**(3.8)**	**(23.2)**

Note:

- *All figures exclude PSF, FRF and MRET*
- *Issues referred for national resolution to NHSI/E have been included in the plans:*
  - *Resolution of national tariff (RJAH) - £2.5m*
  - *GP indemnity delegated budget adjustment (SCCG) - £1.5m*

  Favourable resolution of these issues would reduce the variance to Control Total
- *Confirmation of national solution required from NHSI/E regarding pay award funding for LA services (SCHT) - £0.5m*

- Delivery of current plans require total cost-out savings of £51.6m across the system. All organisations in the system continue to review QIPP/CIP plans to maximise deliverable savings in 2019/20 and to manage internal organisational cost pressures.
- Our transformational change programme identifies a pipeline of opportunities that can deliver up to £53m over the next four years. We are committed to accelerating the work on these programmes but this is unlikely to address in full the gap identified in 2019/20
- In recognition of the financial situation we continue to review a number of additional potential cost savings. However a number of these areas would impact on organisational performance and the delivery of constitutional targets and would therefore require full commitment from commissioners, providers and regulators.

Shropshire Council

NHS
Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
Meeting Date

Responsible Officer: Steve Trenchard, STP Mental Health Programme Director

Email: steve.trenchard@nhs.net **Telephone:**

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1. Summary

This report outlines the feedback from the period of engagement to support the development of an all-age mental health strategy for the Sustainability and Transformation Partnership.

2. Recommendations

The Health and Wellbeing Board is asked to note the contents of the report and in particular the endorsement for a strategic push towards integrated, place-based models of mental health care with easy access to effective, personalised recovery support. The role of the Shropshire Mental Health Partnership Board is endorsed within the report to continue to support the STP on the development of placed based models of mental health care, and in the ongoing development and implementation of the MH Strategy.

REPORT

The engagement report is attached for the H&W Boards attention.

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 for people experiencing poor mental health.

4. Financial Implications

The financial implications for the full implementation of a longer term mental health strategy to support the implementation of the Mental Health 5 Year Forward View and to meet local needs has yet to be fully costed.

5. Conclusions

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **Mental Health Strategy Engagement Report**
Cabinet Member (Portfolio Holder) **Cllr Lee Chapman**

Local Member n/a
Appendices

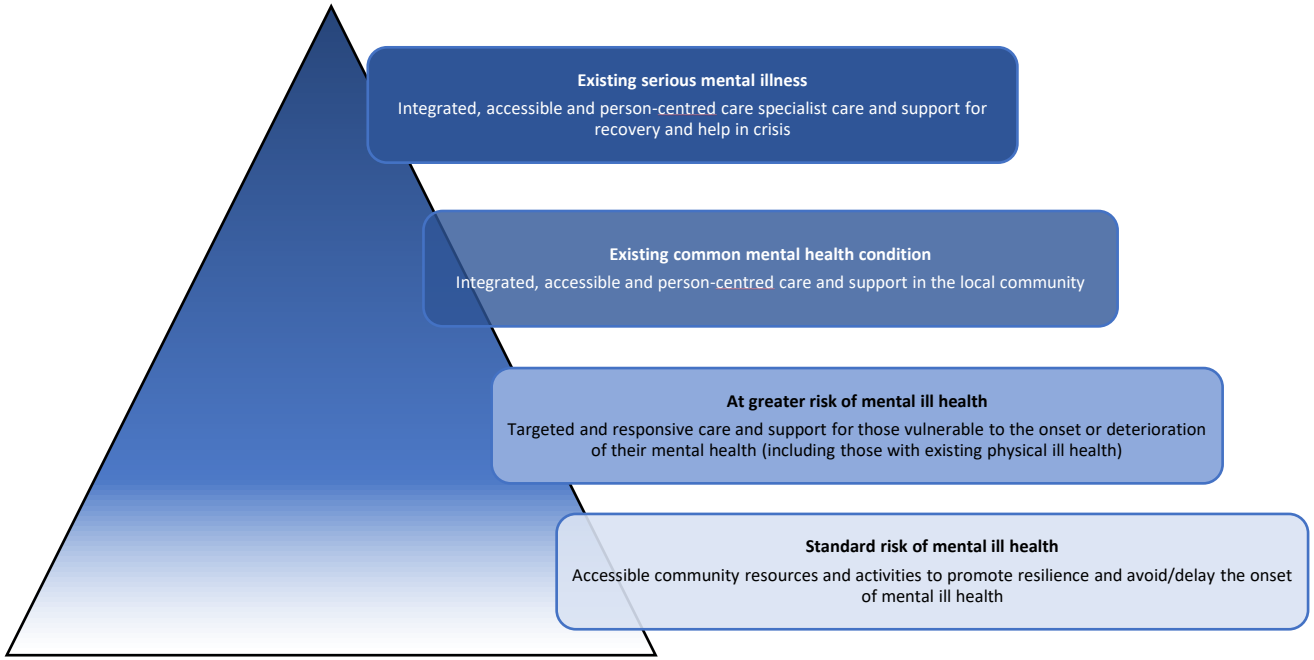
Mental Health Strategy - Engagement Report

Introduction

The strategic aim of the STP Mental Health Strategy is to transform mental health and wellbeing in Shropshire, Telford and Wrekin. There are already many positive aspects to the services provided by the voluntary sector, the NHS and Local Authority partners in our STP which we aim to build upon. A number of improvements continue to be implemented and outlined nationally (not least in support of NHS England's *Five Year Forward View for Mental Health).*

There is also compelling evidence from innovations across the country that there is a real opportunity to achieve a step-change in the health and wellbeing of those who are at risk of or who are already living with mental health. The nature of the step-change that citizens need to experience will vary with their underlying need and associated risk factors. So, the strategy will be population-centred and aims to address appropriately the specific needs of each cohort (see Figure 1 below).

Figure 1: Broad Cohorts of Mental Health Need



The mental health strategy will stand a better chance of being implemented if it speaks to, and reflects the wishes, preferences and experiences of the people for whom it is meant to make a difference, i.e. service users, family members, friends and those too who deliver services across the county.

This report builds on previous work undertaken in 2017/18 to inform the Shropshire Mental Health Needs Analysis, through which feedback from individual service users and provider organisations including a mix of drop-in centres, counselling services, employment services, charities and advice and advocacy services was received. 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

The key findings from these interviews at the time are summarised below:

Overarching Themes	Emerging Trends
▪ 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	▪ 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

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 young 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.	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

To inform the development of a new whole system STP Mental Health Strategy additional meetings and workshops were held between October 2018 and April 2019 to capture the views of people receiving care, family members and professionals working within services across health, care and voluntary sectors. In addition to service users and families, approximately 200 people from across primary care (GPs), local authorities (social workers, housing, public health, children's services and commissioners), health (mental health and acute), police, fire service and voluntary and community sectors have engaged with the process.

Events held included:

- Meetings with service users in local settings – e.g. MIND Shrewsbury, Designs in Mind (Oswestry), Redwoods.
- Primary Care locality meetings with GP's (across Shropshire)
- Listening event with Telford and Wrekin Mental Health Forum
- Listening event with Shropshire Mental Health Strategy Forum
- Listening meeting with Shropshire Suicide Prevention Group
- Meetings with leaders from Shropshire MIND, Samaritans, Men in Sheds, Compassionate Communities
- Meetings with social worker and mental health managers from across Shropshire, Telford and Wrekin
- Meeting with Shropshire Patient Involvement Group
- Discussion at Shropshire Health and Wellbeing Board
- Regular meetings with a small group of service users and family members who openly shared their views of service provision.

The findings from these meetings are presented below and reflect the three questions asked at the meetings which were:

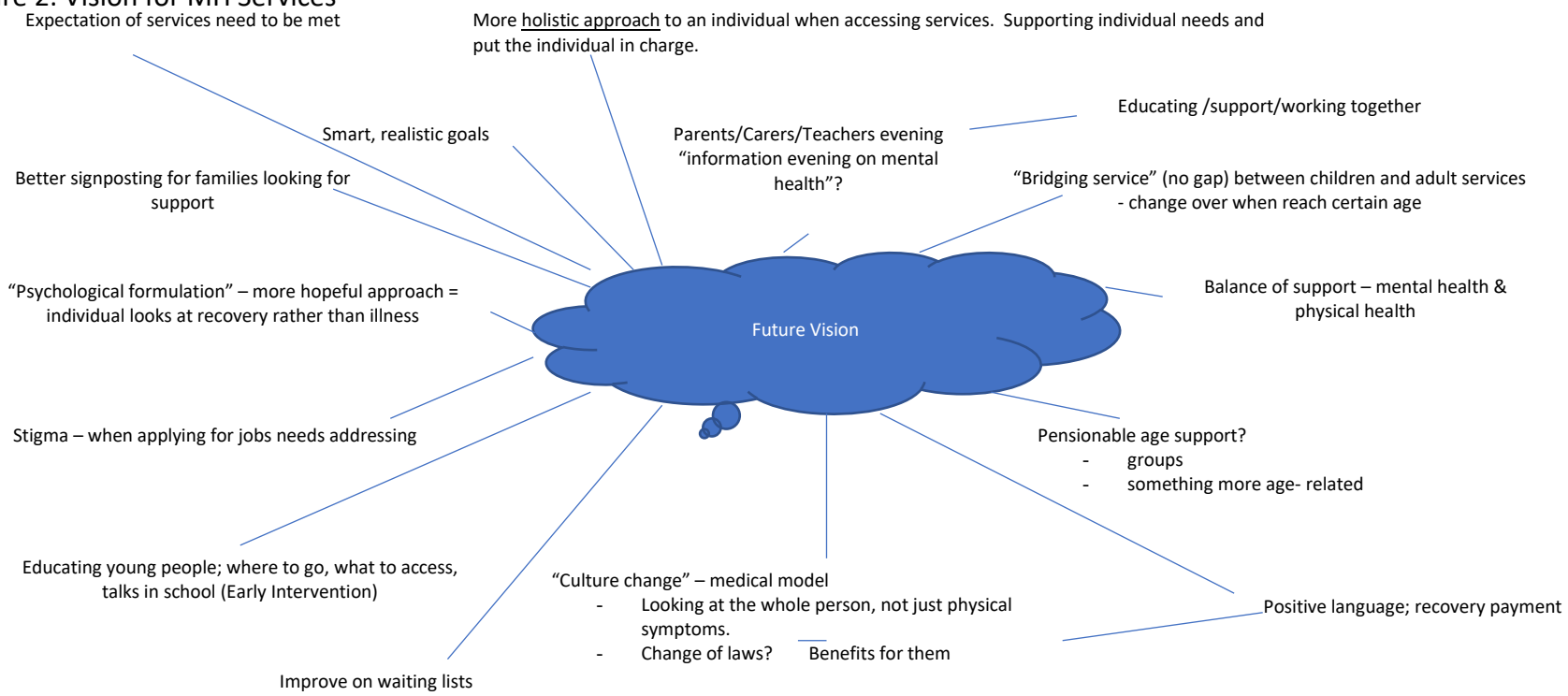
- What is your ideal future vision for the mental health support in Shropshire, Telford & Wrekin?
- In getting to your ideal future, what are the three things you'd most like to fix?

- What would the Trust, Local Authorities, Voluntary Sector and the CCG's need to do to help you and your colleagues reach this ideal future?

Question 1: What is your ideal future vision for the mental health support in Telford & Wrekin and Shropshire?

There was a consistent message from across the Sustainability Transformation Partnership (STP) in relation to what people wanted from mental health services. All comments have been included to capture the full breadth of views. These are then themed and summarised at the end of the document to reflect high level themes and priorities. Figure 2 below illustrates a typical visioning diagram.

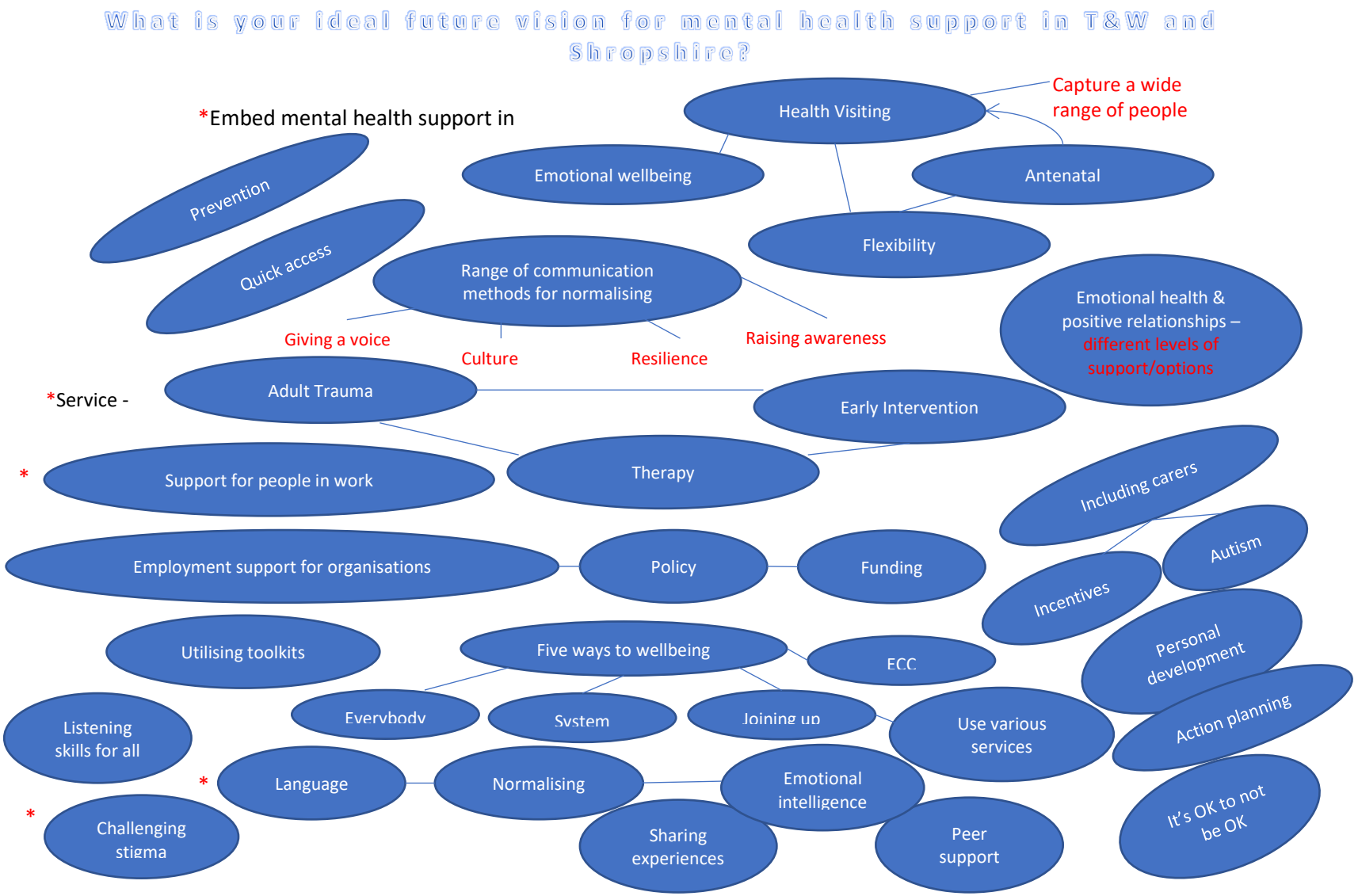
Figure 2: Vision for MH Services



Feedback in this question has been captured and shown in the format below - services would be joined up, easy to access and locally available. The whole workforce would be knowledgeable about mental health issues and the impact of trauma and the impact of childhood adversity.

Figure 3: Future Vision Word Cloud

Figure 4: Vision for Mental Health Services



Question 2: In getting to your ideal future, what are the three things you'd most like to fix?

The table below highlights the main issues from the feedback:

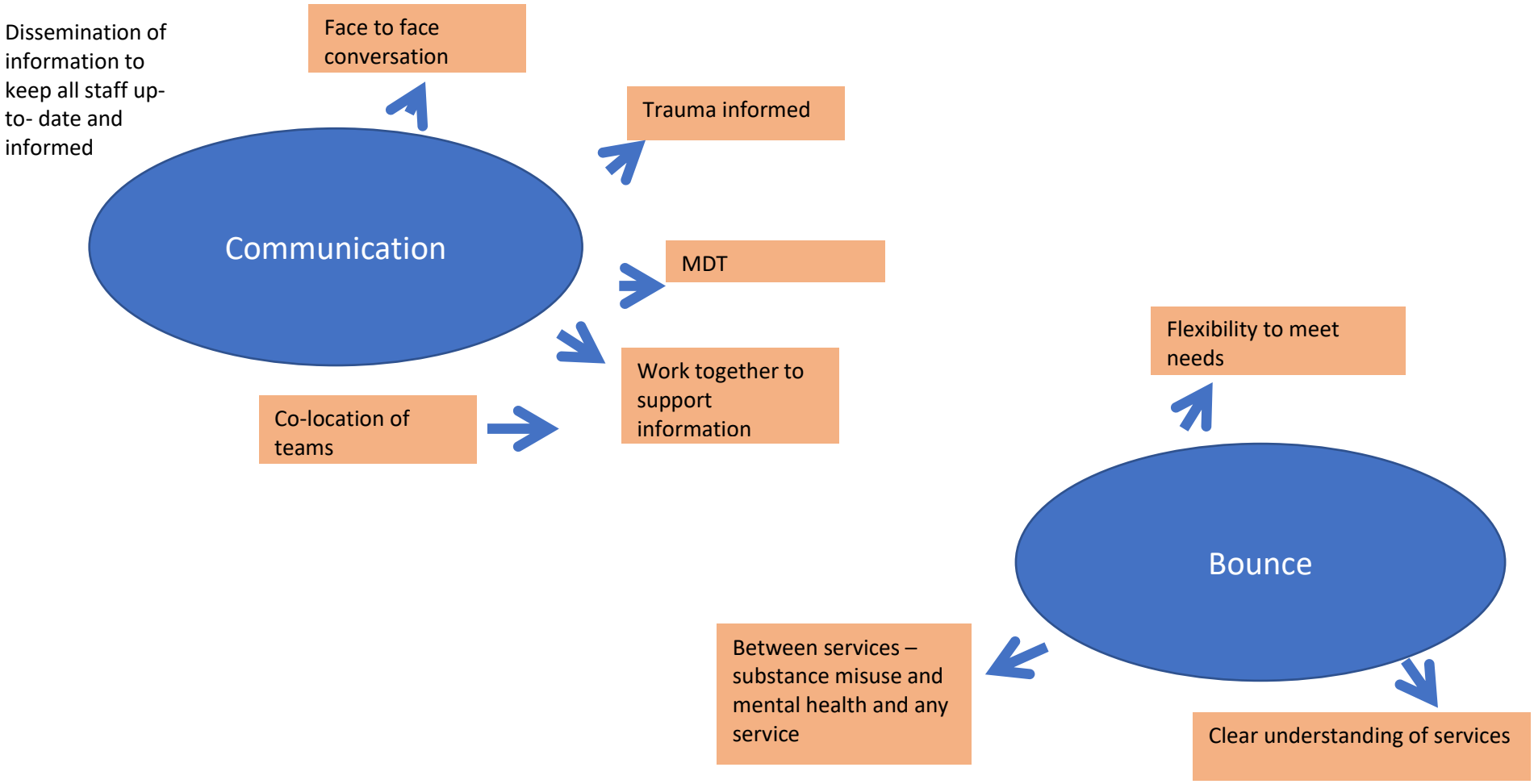
Communication	• Communications – voluntary sector (social media) use it well • Communication – remove silos • All relevant agencies working and communicating together (information sharing/ access to care plans)
A mental health aware workforce delivering person-centred care working together	• Cultural shift in attitude • Involvement from all, ownership • Cooperation and collaboration • More cohesive working – taking time to understand who can do what / sharing ideas • Agencies working together – passionate about the 'person' • Staff spending less time writing notes, meaning they have less time to spend with patience • Education about MH in wider teams
Locally available	• Practices within a primary care network offering consistent, multi-faceted approach to support emotional wellbeing and mental ill health. • Consistent response in primary care – GP champion, clear pathways, local • Extended opening hours for listening, CBT, suicidal ideation. • Easy access when in distress or before – not climbing over the wall to get it. • IAPT at Primary Care Level (Dudley and Walsall already to this)
Better access to services for all	• Alternatives to A&E – child and adult – prevention. • More money • Emotional, health and wellbeing assessments and support for children on the edge of care and their families. • Better support for people in social crisis i.e. homeless

Establishing integration across the system to support place-based working	• Do we fully understanding the problem, are we offering the right services? Can we describe the full cost now? How could this improve through joining up? • Appropriate level of resources • Design of the system (mix of all partners) • Commit to long term funding • Dynamic adjustment • Mental health systems • Putting expertise in one place – organisations letting go – not being precious • Less bureaucracy

"Stop the Bounce"

Some people with lived experience shared their experiences of the negative impact of multiple referrals, repeating their stories time again, and even after many months still not being able to receive the right service. They named this phenomenon 'The Bounce'. Their solution to fixing it is illustrated in Figure 5 below.

Figure 5: Stop the Bounce



Question Three: What would the Trust, Local Authorities, Voluntary Sector and the CCG's need to do to help you and your colleagues reach this ideal future?

The major feedback from this question centred on whole system working, integration and localised accessibility. The levers for this were suggested to be integrated commissioning, one budget for the system, easier and earlier access to localised services where there was parity of esteem for mental health. The confusion surrounding the current mental health model would no longer exist, and there would be excellent communication and knowledge of the new model on offer. All groups spoke of their frustrations about current arrangements and they expressed full support for system wide commissioning, strong mental health leadership to bring about change and help to develop compassionate cultures where teams could work more closely together. This would be facilitated through access to high quality data about

local needs and made available to communities to ‘solutionise’ their own unique models aligned to population and community needs. People spoke of courage, taking a longer-term view of assets and strengths-based approaches and aligning systems together to make the most of available resources. All of the above should be based on an ambition to be the best.

Summary

This document only represents the beginning of the work needed in the continual involvement and engagement of people in the ambition of improving mental health and wellbeing services for all.

Much greater engagement is now required with all our stakeholders but especially those of all ages with lived experience of using mental health services. We will ensure that services users are engaged fully in the design of services and that they have maximum choice and control in the care and support they access. As an immediate first step, the ongoing focus of the work of the Shropshire Mental Health Strategic Partnership Board and the Telford and Wrekin Mental Health Forum should be fully supported. Whilst recognizing that there are overlapping areas of interest and learning for both groups in an STP approach the local knowledge and understanding of place which both groups have will be vital in steering future localized mental health prevention and wellbeing strategies can most effectively be merged with community asset based approaches aligned to primary care networks.

More detailed planning work must now be undertaken to translate this feedback into a full strategy which will be in line with the NHS Plan and the STP Integrated Plan. This will include testing out the initial mental health priorities against this feedback, and considering the national priorities from the Mental Health Five Year Forward View (Appendix 1) and implemented through the NHS Long Term Plan such as mental health support teams in schools, integrated community mental health teams for people with serious mental health conditions and increasing access to psychological interventions for all mental health conditions.

The mental health strategy needs to be factored into all relevant aspects of other STP workstreams if true integration is to be enabled. This includes the parallel clinical strategy work around acute, community and primary care services. This strategy represents our system's commitment to the reshaping of services and other interventions so that they better respond to the needs of our population. The STP MH Group will plan together how to achieve this, including where to focus our combined efforts in the short, medium and longer term. It needs to interlace with the other elements of the clinical services strategy to ensure that the whole works as one seamless service.

Recommendations

1. Note the feedback from engagement and support the inclusion of this in the strategy.
2. Note the view that local engagement groups at LA level have an important function for ongoing place based mental health developments.

Appendix 1:

National policy context

The 5YFV for mental health identifies 3 areas of priority which contribute to the development of the strategy for the STP. They are broadly consistent with the themes from local engagement and are:

1) 7-day NHS -locally accessible

Action	**Outcome**
People in crisis should have access to MH care 7 days per week, 24 hours per day	by 20/21 CMHT 24/7 crisis response
Services adequately resourced to offer intensive home treatment as an alternative to acute admission	Compliant with CRHT fidelity criteria
Liaison Mental Health in acute hospitals	by 20/21 all age MH liaison service in acute
	by 20/21 @ least 50% acute meet 'core 24'
People experiencing a first episode of psychosis should have access to NICE approved care package <2weeks of referral	by April 2016 50% should have access to early intervention in psychosis services
	by 20/21 60% should have access to early intervention in psychosis services
Expand proven community-based services to people of all ages with severe Mental Health problems who need support to live safely as close to home as possible	Guidance to be issued May 2019 for Wave 1 sites.
More step down from secure i.e. residential rehabilitation, supported housing and forensic or assertive outreach teams	No prescribed targets but in STW this is an area for developmental work.
Out of area placements for acute care should be reduced and eliminated as quickly as possible	No out of area placements by 20/21
Reduce suicide rates	by 20/21 reduce by 10%

2) Integrated mental and physical health approach

Action	Outcome
More women with access to evidence-based specialist Mental Health care during perinatal period	By 20/21 increased care provision for at least 30,000 more women nationally.
People living with severe Mental Health problems should have physical health needs met	By 20/21 at least 280,000 offered screening and secondary prevention reflecting the higher risk of poor health.
Mental Health inpatient services should be smoke free	by 2018 smoke free
Increase access to evidence based psychological therapies to reach 25% of need - adults with anxiety and depression (IAPT)	By 20/21 600,000 more adults each year (350,000 complete treatment).

3) Promoting good Mental Health and preventing poor Mental Health

Action	Outcome
Children and young people are a priority groups for mental health promotion and prevention	By 20/21 at least 70,000 nationally more children and young people should have access to highest quality MH care.
More people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to individual placement and support (IPS)	By 20/21 each year up to 29,000 nationally more helped to find or stay in employment.

The national planning guidance for 2018/19 sets out the following requirements in addition to the requirement to deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages:

- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;

- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;
- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral;
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and
- Reduce suicide rates by 10% against the 2016/17 baseline
- CCGs are also required to meet the minimum investment standard in Mental Health in 2018/19 (where mental health spending grows faster than its overall funding growth)

Shropshire Council

NHS Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
Meeting Date
Shropshire Alcohol Strategy 2016 -2019 update and next steps.

Responsible Officer: Jayne Randall

Email:jayne.randall@shropshire.gov.uk **Telephone: 01743 253979**

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1. Summary

1.1 This report provides the Health and Well-being Board with an update of progress on the implementation of Shropshire Alcohol Strategy 2016-2019 and next steps.

1.2 The implementation and delivery of the Shropshire Alcohol Strategy 2016-2019 has been overseen by the Alcohol Strategy Group (ASG) formed by key stakeholders. Meetings have been held quarterly with the main purpose of reviewing the action plan and refining as necessary. The ASG is accountable to Shropshire Community Safety Partnership.

1.3 Progress in a number of areas has been achieved to support structural change to the management of alcohol related harm within communities. This has included the revision and publication of the Licensing Policy Statement providing a blueprint for the day and night-time economy; revision of the joint working protocol between children and family services and substance misuse services and the development of an evidence based school programme and policy on managing drug and alcohol related incidents.

1.4 Since 2016 there have been a number of national initiatives to promote improved management of alcohol related harm. Shropshire was one of 42 areas that supported the Local Alcohol Action Area initiative supporting improved data sharing between police, the hospital and local authority. In 2017, Shropshire Community Health Trust adopted the national CQUiN for the *Prevention of ill Health* through the delivery of identification and brief intervention to reduce alcohol related harms.

1.5 Nationally, alcohol consumption remains a key risk factor for ill-health and premature deaths. In Shropshire alcohol related hospital admissions for people aged 65 and over is above the national average for both men and women using the narrow measure (where admission was wholly attributable to alcohol). Fewer adults in Shropshire abstain from drinking alcohol than other areas within England and alcohol related road traffic accidents remain above the England average (Appendix A).

1.6 Following a review of this strategy it was agreed by the Shropshire Community Safety Partnership that the synergies between interventions to reduce alcohol related harm and drug misuse warranted a joint approach. A Shropshire Drug and Alcohol Strategy is currently been developed and is due to be published in April 2020. It is proposed the HWBB receive regular reports on the progress of this strategy which will support a range of activities to reduce drug and alcohol related harm across the County.

1.7 An interim alcohol strategy plan has been agreed by the Shropshire Community Safety Partnership to support continued delivery of the Alcohol Strategy for 2019 -2020.

2. Recommendations

It is recommended the Health and Wellbeing Board (HWBB):

a) Note the progress to date.

b) Agree to receive the consultation document in the autumn and provide feedback through the consultation process.

c) Support implementation on the future drug and alcohol strategy 2020 by ensuring activities to reduce alcohol related harm are implemented within the organisations they represent through both policy and procedure.

d) Agree to receive regular reports on the progress of the future drug and alcohol strategy once it has been agreed by the Shropshire Community Safety Partnership..

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1 A key risk to delivery of the strategy is the financial implications and continued reductions in the Public Health grant and the financial constraints of key partners to support delivery. Whilst the public health grant only supports part delivery of the strategy, it is key in the delivery of specialist drug and alcohol services and supporting local work on public protection. Going forward the continued funding of public health generally and activity for drug and alcohol services is not clear.

3.2 The budget to support the delivery of specialist alcohol and drug services was substantially reduced in 2019/2020 as part of the Council's saving plan and further reductions will compromise delivery and level of reach the service will have.

3.3 A further risk is the implementation of the interim plan and the capacity to deliver on the key areas without full stakeholder involvement.

3.4 There are no Human Rights, or environmental consequences contravened through the implementation of this strategy. Its overall aim is to improve the health and well-being of people by introducing measures to reduce alcohol related harm at both a community and individual level.

3.5 Alcohol can cause problems across the social scale however, health harms from alcohol are more pronounced in communities that suffer higher levels of deprivation despite the fact they usually have lower levels of consumption (based on affordability). This phenomenon is known as the alcohol paradox, recent studies have found poor nutrition and higher rates of smoking may amplify the risks of alcohol related harm within deprived communities. The impact of the alcohol paradox and other associated health harms in more deprived communities is considered within its implementation and targeting of resources within key communities

3.6 Delivery of the strategy is dependent on the buy-in from partners to support the objectives and direct activity to achieve outcomes. It is important to have identified leads within key stakeholder organisations to achieve this and utilise opportunities to reduce alcohol related harm through the day to day business of organisations.

3.7 The STP plan provides the opportunity to increase prevention of alcohol related harm across the system.

4. Financial Implications

4.1 The level of Public Health ring fenced grant allocated to support delivery of specialist treatment interventions has been substantially reduced in 2019/2020. The new contract will deliver the service utilising through efficiencies and new ways of working.

4.2 There is still the expectation the new contract will deliver on the key public health outcomes for improving sustained recovery from drug and alcohol misuse and reducing the spread of blood borne viruses through the delivery of harm reduction services.

5. Background

5.1 Alcohol is the third most significant risk factor for ill health and premature death after smoking and obesity[1]. In England, for people aged 15-49 years old, alcohol is now the leading risk factor for ill health, early mortality and disability, and the fifth leading risk factor for ill-health across all age groups[2].

5.2 In 2016 the Shropshire Alcohol Strategy was published. Ambitious in its vision, the aim of this strategy was to galvanise key stakeholders to adopt approaches within their working environment that would support harm reduction and promote sensible drinking to achieve the key outcomes:

- Promote Safer Communities.
- Improve Health and Well-being
- Protect Children and Young People
- Create Capacity

5.5 It was agreed the Health and Wellbeing Board would receive regular updates on the implementation of the Shropshire Alcohol Strategy 2016 -2019 across its life course.

5.6 Progress has been made in most of the outcome areas, and below is a summary of activities undertaken to support delivery.

Promote Safer Communities

- Publication of the Statement of Licensing Policy for Shropshire Council 2019 -2024, setting out the expectations of the Council's on applicants and licence holders to promote the four licensing objectives.
- Continued delivery and development of Alcohol Treatment Requirements (ATR) as part of a community sentencing plan to reduce alcohol related crime and disorder.
- Development of an integrated community management approach was not achieved. Although a successful pilot was undertaken in Shifnal it was resource intensive and partners felt it could be adequately managed through the usual mainstream pathways.
- Improved screening and management of victims of domestic abuse within drug and alcohol treatment services following review and implementation of NICE guidance PH50
- Improved management of perpetrators of domestic abuse through a pilot perpetrator programme.

Improve Health and Well-being

- Roll out of Identification & Brief Advice (IBA) in Community Hospitals, Mental Health residential units, Shrewsbury and Telford Hospitals (achieved through the national CQUIN programme *Prevention of ill Health*).
- 72 Shropshire Community Health staff trained in IBA.
- A twelve month IBA pilot is currently underway with Job Centre Plus as part of this initiative to support identification to improve job readiness and remove barriers to work for people with alcohol problems. All staff at the Shrewsbury Job Centre have been trained to provide brief advice and people are being followed up at 3 months to review impact of intervention.

For those identified at drinking at higher risk levels they are referred to treatment through a local booking process. The pilot will be evaluated in the summer.

- Supporting people with co-occurring mental health and substance misuse through a no-wrong door approach is progressing through the eider work on the NHS Five Year Forward View.
- A dedicated outreach worker has been appointed to support homeless populations as part of the new commissioned specialist drug and alcohol service.
- Promotion of national campaigns, including alcohol awareness week and Dry January through a range of social mediums.

Protect Children and Young People

- Development and delivery of the Shropshire Respect Yourself Relationship and Sex Education Programme. The programme also won a prestigious national award 'Children and Young People Now Award 2017.
- Strengthening pathways to specialist substance misuse services, following NICE guidance for young people who present to A&E.
- Review and implementation of the Joint Working Protocol between Children and Family Services and Substance Misuse services, to improve identification and support for families affected by drug and alcohol misuse.
- Development and dissemination of the *Schools Drug and Alcohol Policy* providing guidance for schools on managing incidents using the evidence base.
- The expansion of brief interventions into children's services following NICE guidance PH24 was not achieved.
- Strengthening commissioning arrangements between children's services, mental health and domestic abuse was not achieved.

Create Capacity

- Development of the Public Health Licensing Tool to support decision making.
- Improved recording of data within A&E setting to support crime and disorder locations as part of the Local Alcohol Action Area programme 2 initiative.
- In total 501 staff trained (includes 72 from Shropshire Community Health Trust) in IBA, working with parents who misuse substances; autism and the use of substances and alcohol; safeguarding and substance misuse; alcohol in the community and an introduction to substance misuse.

Challenges to delivery

5.2 The HWBB should note a fundamental element of this strategy was the commitment and adoption to the principles of the strategy within organisations. At times it has been difficult to engage key stakeholders in its implementation due to conflicting priorities and capacity of the teams involved slowing progress.

Measuring Impact

5.3 Measuring impact is difficult to assess within a short time frame, due to the nature of the problem. Measures to reduce health related harm using IBA methods will not be visible within a three year strategy due to the fact symptoms of health related harm are slow in presentation. Liver disease can take up to 20 years of regular higher risk drinking levels to become symptomatic, as can the identification of cancers where alcohol is a contributing factor. Preventative measures with young people will not be realised until well into adulthood, although there is some national indication fewer young people are drinking than they did ten years ago[4].

5.4 Alongside measures at an individual level there does need to be other measures to reduce availability and therefore consumption. The new licensing statement published by the local

authority is part of the environmental approach to shaping both the night-time and day-time drinking economy and the availability of alcohol within the county.

5.5 All of the preventative measures undertaken have been underpinned by the evidence based providing some assurance that activity undertaken now will help to slow the rate of alcohol related harm in the future.

Next Steps

5.6 The Shropshire Community Safety Partnership have agreed that in the future strategies to reduce drug and alcohol related harm should be delivered through a joint strategy due to the synergy that exists between the two agendas.

5.7 A new drug and alcohol strategy is due to be published in April 2020, this coincides with the completion of the Crime and Disorder Reduction Strategy for Shropshire 2017-2020.

5.8 In the interim it has been agreed by the Shropshire Community Safety Partnership the following activities will be undertaken:

- Continue the roll out of IBA
- Develop a Responsible Authorities Group
- Undertake a review of Alcohol Treatment Rehabilitation requirements
- Explore responses to children affected by parental alcohol misuse
- Develop a systematic response to those identified as Treatment Resistant' using blue light methodology.

6 Additional Information

6.1 There is a close relationship between levels of alcohol consumption and the prevalence of alcohol related harm and dependence. Since 1980 sales of alcohol has risen by 43%, peaking in 2008, the increase in sales is driven by affordability, increased consumption by women and a shift in drinking location, the majority of alcohol is purchased from shops to be drunk at home. Research has suggested more recently there is a decline in alcohol consumption and an increase in levels of abstinence, although it is unclear whether much of the decline is due to people drinking less or more people choosing not to drink.

6.2 Alcohol related mortality has increased by 400% since the 1970s. The average age of those dying from a specific cause is 54.3 years compared to the average age of death from all causes is 77.6 years[2].

6.3 It is estimated that 68.6% of dependent drinkers in Shropshire are not in treatment, this is an estimated 1,977 individuals (Appendix A).

6.4 The rate of admission episodes for alcohol-related conditions among females aged 40 – 64 years in 2016/17 rose above the England average (Appendix A).

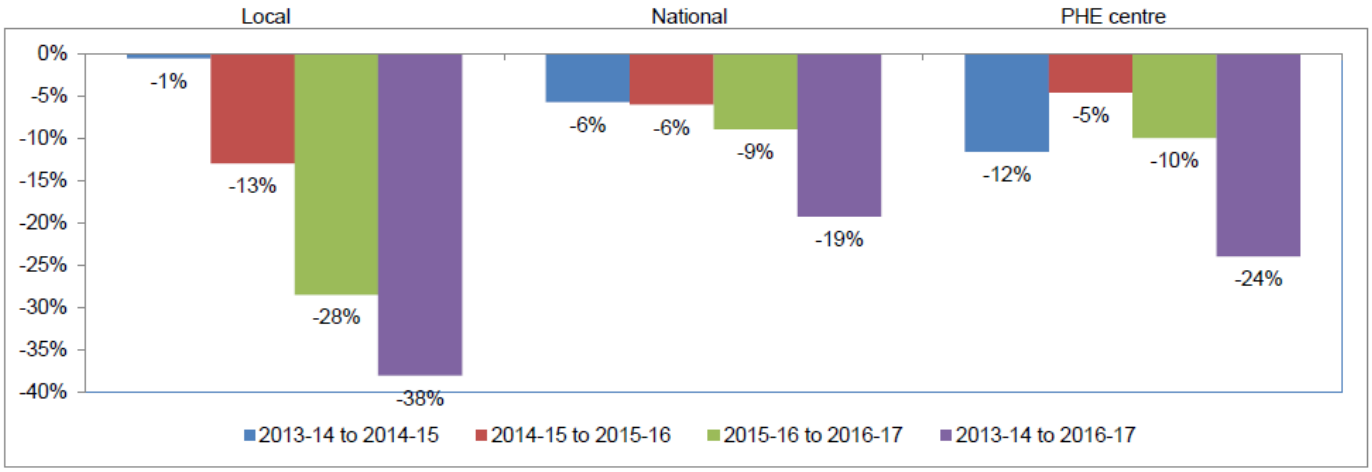
6.5 In Shropshire there is a higher proportion of people aged 65 and over admitted to hospital for alcohol related conditions than the England average, this rate has been increasing since 2014/2015[3].

6.6 Alcohol can cause problems across the social scale however, health harms from alcohol are more pronounced in communities that suffer higher levels of deprivation despite the fact they usually have lower consumption (based on affordability). This phenomenon is known as the alcohol paradox, recent studies have found poor nutrition and higher rates of smoking may amplify the risks of alcohol related harm within deprived communities.

6.7 For the period from 2011 to 2014, 8.6% of Shropshire's respondents to Health Survey for England aged 18 years and older said they were abstainers. This is significantly less than the percentage for the West Midlands (16.6%) and for England (15.5%). Shropshire is the third worst area in the West Midlands region for this measure (Appendix A).

6.8 Data from the National Cancer Registration and Analysis Service for 2014 -2016 found that women suffer the highest amount of harm for alcohol related cancers, both nationally and within the county. For men in Shropshire, the data shows rates of alcohol related cancer in the county is at higher harm levels than rate for men nationally.

6.9 Since the strategy was published there has been a decrease in the number of people presenting to alcohol services for treatment. This is a national issue and as Shropshire was one of 8 areas that had experienced a significant drop, a deep dive was undertaken by PHE to understand what was happening. The overall findings by PHE could not find one conclusive reason, but the integration of drug and alcohol services, reduction in alcohol only workers and reduced funding was all cited as possible causes. In Shropshire, the removal of the alcohol clinics from key GP practices was identified as a possible contributing factor to the 28% reduction in presentations for the period 2015 -2017 as this coincided with the providers decision to remove the clinics.



7 Conclusions

7.1 The Shropshire Alcohol Strategy 2016-2019 has started to lay the foundations to tackling alcohol related harm through a range of activities, including the development of PHSE programmes, the blueprint for future licensing through the latest Statement of Licensing Policy and the roll-out of IBA within key areas of the system. Fundamental to reducing alcohol related harm is the delivery of evidence based interventions throughout the system and acknowledgment of its role in causing a range of societal and individual harm when developing new policies and interventions.

7.2 Though work at the local level supports reducing alcohol related harm, the health and social care gains will not be achieved through local action alone. A new national alcohol strategy is anticipated within the next few months which will provide the direction of travel over the coming years in the national response to reducing alcohol related harm.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

1. (2019) Public Health England: Health Matters https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

2. (2016) the public health burden of alcohol and the effectiveness and cost effectiveness of Alcohol Control Policies: An evidence review: Public Health England.

3. (2019) Local Alcohol Profiles for England

4.(2018) Investigating the growing trend of non-drinking among young people: repeated analysis of cross sectional surveys BMC Public Health

Cabinet Member (Portfolio Holder)

Cllr Dean Caroll
Cllr Rob Gittens (Deputy Portfolio Holder – Public Health)

Local Member

Appendices

Needs Assessment for Substance Misus

Appendix A. Needs Assessment for Substance Misuse

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Health and Wellbeing Board
Meeting Date
Community Drug and Alcohol Treatment Service New Provider Update
Responsible Officer: Jayne Randall

Email:jayne.randall@shropshire.gov.uk **Telephone: 01743 253979**

1. Summary

1.1 In May 2018, Shropshire Council agreed to retender the specialist community drug and alcohol treatment. This report provides an update on the retender process and the new community drug and alcohol treatment model for Shropshire.

1.2 Following the retender the specialist community drug and alcohol treatment service contract was awarded to Addaction, a national treatment charity. Addaction had been the sub-contractor to the outgoing provider, providing clinical interventions, the young people's service and data management.

1.3 The retender process was led by the local authority and involved a multi-agency project team across health, local authority, police, and the national probation service.

1.4 As part of the overall council savings plan the contract value was reduced prior to advertisement of the retender. The contract was awarded within the advertised budget of £6,886,170.

1.5 The procurement was an open process and around seven providers initially showed interest in the contract, with four submitting final bids.

1.6 All bids were evaluated separately by members of the evaluation team and then moderated, first within small groups based on areas of expertise and then within the full project team. Clarifications was sought as appropriate and bidders were asked to respond before the full moderation.

1.7 The new Provider aims to improve quality and performance through a hub and spoke delivery model that will utilise staff, volunteers, peer mentors and new technology.

1.8 Key areas for improvement contained within the contract:

- Increase the numbers entering specialist treatment, especially for people who are alcohol dependent.
- Increase the proportion of successful completions and non-representations rates across all cohorts,
- Improve screening, vaccination and take-up of treatment for blood-borne viruses (BBV) for Hep B and Hep C, supporting the national target to eradicate the Hep C virus in England by 2025.
- Reduce drug related deaths.
- Further joint working arrangements with children and family services to improve outcomes for families.

2. Recommendations

It is recommended the Health and Well-being board note the contents of this report and the new service model for the treatment of drug and alcohol dependence.

3. Risk Assessment and Opportunities Appraisal

3.1 There are no human rights, environmental consequences, community or quality issues in delivery of this service, its overall aim is to improve the health and well-being of people and their families affected by drug and alcohol misuse and dependence. Delivery of the service will be underpinned by NICE guidance, clinical guidelines and good practice guidance.

3.2 All risks associated with the retender process have past, and no legal challenge was submitted during the process.

3.3 The level of Public Health ring fenced grant allocated to support delivery of specialist treatment interventions was reduced for 2019/2020 prior to the retender process. This contract has been negotiated based on the saving made in 2018-2019, further required saving may impact on the ability to deliver the service using the current model.

3.4 Other potential risks to service delivery is capacity, staffing levels may fluctuate during mobilisation as staff reconsider their positions within the new service structure.

3.5 The hub and spoke model submitted by Addaction includes the opportunity to integrate the service through the Early Help hubs and to support a holistic family approach through co-location of frontline workers, bringing improvements to the management of families affected by drug or alcohol misuse. This integrated model with co-location has already proved successful within criminal justice and the Integrated Offender Management (IOM) team.

3.6 There are, however, some risks to service delivery. The availability of suitable premises within the county and the willingness of landlords to support delivery of this service has always been difficult and may prove challenging in the future. In Shrewsbury the current lease is due to expire within the next 18 months. Plans are already in place by the provider to identify a new premises for the central area and it is hoped the new premise will provide opportunities to develop a recovery style café.

4. Financial Implications

4.1 The contract was awarded within the advertised budget of £6,886,170.

4.2 Additional efficiency savings will be required in 2019/2020.

4.3 Annexe A of the Public Health Grant conditions requires local authorities to have regard for the improvement in outcomes from drug and alcohol treatment services, when using the grant.

4.4 Future national funding beyond 2020 of public health functions is still unclear.

5. Background

5.1 A pre-requisite of successful recovery from drug or alcohol dependence is the quality of the support available through the treatment system to promote recovery through evidence based treatment interventions.

5.2 The local authority is responsible for commissioning local drug and alcohol service to meet the needs of the population. Under the conditions of the public health grant the local authority is required to have regard for improving the uptake and outcomes from its drug and alcohol misuse treatment services.

5.3 In May 2016, Shropshire Council agreed to the retender of the community drug and alcohol treatment service. A full tender process was orchestrated and was supported by a number of stakeholders from health, social care and criminal justice agencies.

5.4 Initially around seven providers showed interest in the contract through the Council's procurement system DELTA, with four organisation placing formal bids

5.5 The winning bid was submitted by Addaction, a national charity, specialising in drug and alcohol treatment. Addaction was the sub-contractor to the previous contract. This is the first time an organisation is solely responsible for the delivery of drug and alcohol treatment service in Shropshire.

5.6 Utilising a hub and spoke model, Addaction will deliver a range of drug and alcohol treatment using clinical and psychosocial interventions to support stabilisation, treatment and recovery.

5.7 The service model includes

- Utilisation of a range of technologies to support treatment, for example all service users will have access to Breaking Free Online,
- Dedicated alcohol only workforce to improve access and take-up of treatment.
- Dedicated post to support outreach provision.
- Key workers located within Early Help hubs.
- Clinical, psychosocial and brief intervention using best practice and NICE guidance.
- Hospital Liaison service
- Young Addaction – specialist young people's drug and alcohol team.
- Single Point of Contact (SPOC).
- Criminal justice team.
- Community assisted withdrawal or ambulatory assisted withdrawal.
- Service user co-production
- Dedicated worker to support families affected by drug and alcohol misuse.
- Training for partners organisations in substance misuse.

5.8 On entry to service people will be triaged and depending on need will receive either a comprehensive assessment to determine treatment required or brief intervention. The service will also work with the inpatient assisted withdrawal service and residential rehab services as part of a personalised support plan.

5.9 Due to the nature of drug and alcohol misuse and the promotion of recovery the service will also form strong links with housing providers and Job Centre Plus.

5.10 The workforce is made up of paid staff, volunteers and experts by experience. All staff have a personal development plan and there is a calendar of training to support implementation of the new model, which includes the training of volunteers and peer support volunteers.

5.11 Addaction have incorporated the 'Breaking Free Online' web based programme within its delivery model. A clinically robust treatment and recovery programme it directly targets 39 types of substances, including alcohol, opiates, novel psychoactive and non-opiate substances. The programme can be accessed 24/7 and can be used as part of the key work session or as additional work to be completed at home.

5.12 Addaction have also subcontracted out part of the contract to Intuitive Thinking Skills to deliver a range of recovery based programmes to support work readiness and increase entry to employment or voluntary work from the treatment service.

6. Additional Information

6.1 All drug and alcohol service providers are required to provide data to the National Drug Treatment Monitoring System (NDTMS). This allows tracking of individuals through the system and is used to provide performance management information.

6.2 Monthly and quarterly reports on the local drug and treatment system and its performance are provided through NDTMS by Public Health England.

6.3 A number of quality standards still provide a good measure on the accessibility and effectiveness of drug and alcohol treatment services.

6.4 A key measure is the Public Health Outcome Framework (PHOF) indicator to improve successful completions and non-representation rates for opiate, non-opiate and alcohol treatment cohorts. This is the key performance indicator for the contract. Representation rates are counted for six months from successful completion.

6.5 Addaction will also be required to meet the national three weeks waiting time from referral to first intervention.

7. Conclusions

7.1 For the first time, the local drug and alcohol treatment service is under the single management of Addaction, which in turn should improve the service user experience.

7.2 It is anticipated the experience and expertise of Addaction within the drug and alcohol treatment agenda will bring improvements to local recovery rates.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767140/DHSC_allocations_circular_template_final_1.pdf
Cabinet Member (Portfolio Holder) Cllr Dean Caroll Cllr Rob Gittens (Deputy Portfolio Holder – Public Health)
Local Member
Appendices **None**

Shropshire Council | NHS Shropshire Clinical Commissioning Group | Shropshire together

Health and Wellbeing Board
Meeting Date Thursday 23rd May 2019

Responsible Officer: Anne-Marie Speke

Email: anne-marie.speke@shropshire.gov.uk **Telephone:**

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1. **Summary**

The Healthy Child Programme Partnership Board was set up in 2015 following the transfer of commissioning responsibilities for the Healthy Child Programme (HCP) to Local Authorities. This paper outlines the work undertaken as part of the Board in the last 12-18 months. It is important to note that the Board did not meet during the time that the procurement process was taking place for the 0-19 (25) Public Health Nursing Service but reconvened in October 2018.

The Healthy Child Programme Board has historically reported directly to the Children's Trust but with the anticipated changes to the Children's Trust it is anticipated that reporting will be received directly by the Health and Well-Being Board going forward.

The purpose of this report is therefore to provide the Health and Well-Being Board with an update of the Healthy Child Programme Board activities and next steps.

2. **Recommendations**

For the Health and Well-Being Board to receive and note the content of the report and support the Healthy Child Programme Board in its key priorities for 2019/20

REPORT

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 Human Rights, Environmental Consequences, Community or Equality issues identified with the provision of these updates.

4. **Financial Implications**

There are no financial implications that need to be considered with this update.

5. **Background**

The Healthy Child Programme Partnership Board was set up in 2015 following the transfer of the commissioning responsibilities for HCP to Local Authorities. The purpose of the group was to have an overview/oversight of the HCP delivery and work in partnership with key stakeholders to ensure effective delivery across agencies to meet the outcomes for children, young people and their families and to identify work that was required to improve or monitor effectiveness.

In March 2018, the responsibility for chairing the HCPPB changed to the Healthy Child Programme Coordinator in Public Health. This change took place as the previous Chair had

left her post. At this point in time the Board reviewed the terms of reference and membership (see appendix 1 for updated TOR).

During the past 12-18 months, key areas of work have included Adverse Childhood Experiences (ACE), school readiness and emotional health and well-being as well as the implementation of the new 0-19 (up to 25 where SEND identified) Public Health Nursing Service.

5.1 Adverse Childhood Experiences

Following a successful ACE conference in June 2017 a task and finish group was set up to look at how ACE work can be embedded in practice across the system. The task and finish group has only a small membership which is challenging as not all services are represented, however plans have been overseen by the Early Help Partnership Board. An action plan has been developed and shared. The priority area for this was identified as being a way for services to self-assess against key ACE criteria which would then enable them to produce a development plan. However, to do this effectively a training matrix is needed to identify the appropriate competencies and training required dependent upon role. An initial basic awareness raising presentation was developed by the group and disseminated for comments. It proved to be a challenge to find further recommended training beyond that. NHS Scotland and Wales have published a number of supporting resources but there are no comparable resources in England. Public Health England were therefore approached to support this development to ensure that there is a consistency of approach across organisations and areas. The Healthy Child Programme Coordinator has been invited to be part of a regional group to scope this development and the learning will be shared once available. An initial meeting took place in October to explore the challenges and begin to develop the approach. It is also possible that the resources from Scotland and Wales could be adopted with some regional variations. A report on Evidence Based Early Interventions has also been submitted to the House of Commons which identifies the need for this work.
https://publications.parliament.uk/pa/cm201719/cmselect/cmsctech/506/50602.htm

5.2 School Readiness

Following a publication from Public Health England and local anecdotal evidence, a multi-agency task and finish group was set up to map services and identify gaps in relation to improving school readiness. An action plan has been worked through and a leaflet produced to provide parents with information on how to support their child's development (see appendix 2 draft leaflet). The leaflet will be available electronically on various platforms but funding for any printing costs need to identified. A web page has also been developed to support the key messages within the leaflet offering parents signposting to activities and sources of information.

The 2 year review data collected now also provides information on the percentage of children who have had an ages and stages questionnaire completed and meet the required developmental milestones in each of the identified domains; communication, gross motor, fine motor, problem solving and personal-social skills. This may enable us to identify any areas of need going forward.

The task and finish group along with other groups put together a bid for the Early Outcomes project which also includes a maturity matrix. Although we were unsuccessful with the bid, we will continue to work through the maturity matrix and local action plan to develop the work further. There is also the option to request a peer review as part of this work.

5.3 Emotional Health and Well-Being

Shropshire have been involved in the Anna Freud Schools and Mental Health link project, a report for which had already been received by the Children's Trust. This has been a successful start to enhancing communications between schools and services that support children and young people's mental health. Future plans are to continue this work by developing networks that professionals can come together to share experiences and good practice and develop support for children and young people as well as developing a sustainable multi-agency continuous professional development programme based on needs identified within the network. This will be supported by Targeted Mental Health Support (TaMHS) and the Children and Young People Team.

The TaMHs training programme has continued with the main focus being on Mental Health First Aid. The TaMHS Training and Development Officer also offers support to individual schools, offering in-house training as required.

Board members continue to be involved in the Suicide Prevention Group, providing a children and young people's focus as well as the All-age Mental Health Strategy and the local transformation plan refresh.

The Personal Health Social and Economic Education (PHSEE) Mental Health curriculum continues to be shared with schools and through the wider partners along with statutory PHSEE curriculum. Work is on-going in relation to Lesbian Gay Bisexual Transgender (LGBT).

5.4 0-19 (25) Public Health Nursing Service

As part of the new service specification in place this has been restructured and incorporates Health Visiting, School Nursing and Family Nurse Partnership with a greater skill mix within the service. Lead roles for emotional health and well-being and SEND have been developed to support these areas of work.

A single point of access is available for professionals and families as well as a texting service which has enabled easier access to information and support.

5.5 Achieving a Healthy weight and increasing physical activity

Unfortunately, due to funding cuts the Fit Families programme for children identified as being overweight has been decommissioned. An exit strategy has been identified with signposting to support as required. An application was submitted for the Childhood Obesity Trailblazer project but unfortunately we were unsuccessful.

Healthy eating and physical activity continue to be promoted through the curriculum and other contacts with Children and Young People (CYP) and their families. We also propose to extend the National Child Measurement Operational Group and alter the remit to become a Healthy Weight Partnership group to look at how we can work together across the age groups to achieve a healthy weight and increase physical activity.

Representatives from the Board are also involved in the Local Maternity System Transformation Board and work streams which include the Early Maternal Health workstream which has decreasing obesity as a key priority.

5.6 Next Steps

Currently there is no forum for joint commissioning of services for children and young people and this is felt to be a gap and therefore it is recommended that this is explored through the Health and Wellbeing Board.

Plan on a Page- As part of the work being undertaken with the Partnership Boards a plan on a page for the coming year has been developed (see appendix 3) enabling other Boards to see the key priorities which are:

 Teenage Pregnancy to review and update the teenage pregnancy care pathway and monitor the teenage pregnancy data. Map services and make recommendations for improving service delivery/effectiveness.

 Monitor, review and where appropriate incorporate recommendations from Public Health England, NHS England and other appropriate bodies.

 Monitor Public Health Outcomes associated with the HCP and highlight any concerns and/or recommendations to the Health and Wellbeing Board.

6. Additional Information

Key documents
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/492086/HCP_5_to_19.pdf

7. Conclusions

The Healthy Child Programme Board provides an effective forum by which to monitor and review public health outcomes, explore new initiatives and information from Public Health England and NHS England and disseminating this information and where appropriate embedding through other Boards and organisations.

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) Rob Gittins
Local Member
Appendices Appendix 1 Terms of Reference Appendix 2 Draft School Readiness leaflet

Appendix 1 TOR

SHROPSHIRE HEALTHY CHILD PROGRAMME (HCP) PARTNERSHIP BOARD

Background

From 1 October 2015, the commissioning responsibilities for the "0- 5 Healthy Child Programme" transferred to local authority Public Health Departments. This includes:

- health visiting services (delivery of the service vision, four stage model including universal, community and targeted services) and
- Family Nurse Partnership services (targeted service for teenage mothers).

The Child Health Information System (CHIS) and 6-8-week GP check remains the responsibility of NHS England (to be reviewed 2020).

The Healthy Child Programme is available to all families and aims to:

- help parents develop a strong bond with children;
- encourage care that keeps children healthy and safe;
- protect children from serious diseases, through screening and immunisation;
- reduce childhood obesity by promoting healthy eating and physical activity;
- encourage mothers to breastfeed;
- identify problems in children's health and development (for example learning difficulties) and safety (for example parental neglect), so that they can get help with their problems as early as possible;
- make sure children are prepared for school;
- identify and help children with problems that might affect their chances later in life.

Commissioning responsibilities for the "5-19" elements of the Healthy Child Programme, through school nursing, transferred to Public Health Departments on 1st April 2014.

In October 2017, health visiting, family nurse partnership and school nursing in Shropshire was commissioned as one service covering 0-19 and up to 25 where there are special educational needs and/or disability.

In order to ensure an approach across Shropshire that is comprehensive, cost- effective and sensitive to local community needs, an overarching Partnership Board was set up. This Board will provide a link to regional networks; oversee the work of the Healthy Child Programme' including any task and finish groups that are developed from the Board and ensure appropriate governance through the Children's Trust and the Health & Wellbeing Board by providing timely updates against local priorities and national targets.

The Board will develop a strategic approach to the commissioning of services encompassing health visiting, school nursing, nursery education and children's centres.

Purpose

- To provide leadership for the Healthy Child Programme in Shropshire
- To oversee effective implementation of the Healthy Child Programme, encompassing pregnancy - 19 years.
- To maximise the delivery of the Healthy Child Programme through effective strategic partnership working, both within the local authority and other partners.
- To prioritise the plans and activities of task and finish groups that are developed from the Boards priorities, strategy and action planning.
- To ensure robust commissioning and monitoring processes are in place for the Healthy Child Programme.
- To oversee and ensure rigour in performance in relation to the Healthy Child Programme public health outcomes and targets.
- To ensure effective delivery of the Healthy Child Programme within available resources.
- To ensure implementation of national and regional guidance/policy.
- To provide assurance and/or exception reports to The Children's Trust and Health & Wellbeing Board in relation to performance against national targets.

Accountability and Responsibility

- The Chair of the Shropshire HCP Partnership Board to provide regular reports on the strategic development and achievement of targets of the Healthy Child Programme to the Children's Trust and the Health & Wellbeing Board.
- Partnership Board members to align their organisation's activities to the Healthy Child Programme priorities, as appropriate.
- Partnership Board members to attend and actively contribute to meetings and act as champions for the Healthy Child Programme within their agency/organisation.
- To work in partnership to meet the needs of the Healthy Child Programme, including sharing (non-identifiable) information and data, as appropriate.
- To identify and agree co-commissioning or joint funding opportunities as appropriate, including bid funding opportunities.
- To attend quarterly meetings or provide alternative representation.
- Declarations of any conflicts of interest to be declared at the beginning of each meeting.

Chairing arrangements

Chair: Anne-Marie Speke Healthy Child Programme Coordinator, Children & Young People Team, Shropshire Council, Public Health.

Vice Chair: David Coan Designated Nurse for Safeguarding Children for Shropshire CCG.

Representatives may be identified, on occasion, to act on behalf of the Chair and Vice Chair.

Quoracy and Decision making

A minimum of 6 members must be present in order for the Board to be quorate, including at least one member from each of the commissioning organisations.

As far as possible, decisions should be made on a consensual basis. Where consensus cannot be achieved, the matter will be referred to the Children's Trust and/or the Health & Wellbeing Board.

Frequency of Meetings

Meetings will be held once every quarter from June 2015.

Support Arrangements

HCP Partnership Board Administration: Hayley Barnett-Hook, Health and Wellbeing Administrator, Shropshire Council Public Health

Distribution of Minutes

Group Members

Children's Trust Chair

Health & Wellbeing Board Executive Team

Health Portfolio Council Member

Children's Services, Transformation & Safeguarding Portfolio Council Member

Director of Public Health

And members to distribute through their own networks and governance structures, as appropriate.

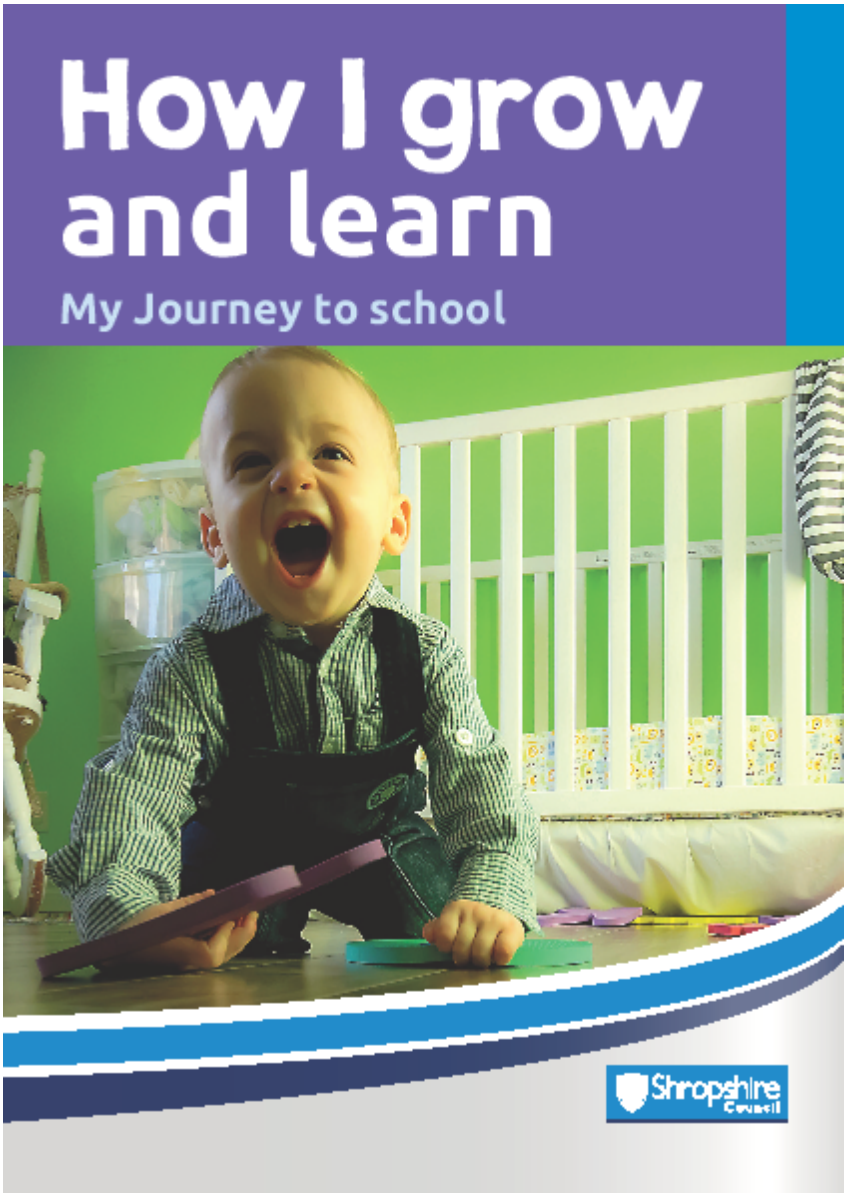
Shropshire HCP Partnership Board (proposed) Membership:

NAME	ROLE	ORGANISATION
Lorraine Laverton	Business Manager, Shropshire Health & Wellbeing Board, Mental Health Partnership Board and Children's Trust	Shropshire Council

Emma Dodson	Matron, Paediatrics	SATH
Karen Saunders	Health & Wellbeing Programme Lead/Public Health Specialist	Public Health England
Stephanie Cook *for information only?*	Public Health Commissioner	NHS England
Sarah Jamieson *Anthea Gregory Page*	Head of Midwifery	SaTH
Jane Randall-Smith *Adelle Wilkinson*	Chief Officer	Healthwatch
Fran Doyle	Head of Early Help, Partnerships & Commissioning	Shropshire Council
Neville Ward	Early Years and Childcare Manager	Shropshire Council
Sarah Rock	Family Nurse Partnership Supervisor	Shropshire Community Health NHS Trust
Caroline Hatton	Service Delivery Group Manager, (Children, Young People and Families)	Shropshire Community Health NHS Trust
Phil Wilson *Christine Kerry*	Commissioner for Education Improvement and Efficiency	Shropshire Council
David Coan/ Fiona Ellis	Safeguarding/ Women and Children's Commissioner	Shropshire CCG
Mark Trenfield	Public Health Analyst	Shropshire Council
Anne Marie Speke	Healthy Child Programme Lead, Public Health.	Shropshire Council
Julian Povey	GP	Shropshire CCG
Penny Bason	Health & Wellbeing Board Business Manager	Shropshire Council
Irfan Ghani *information only*	Consultant in Public Health Medicine, Community Safety & Health Protection Team	Shropshire Council
Kevin Lewis	Director of Help2Change	Help2Change

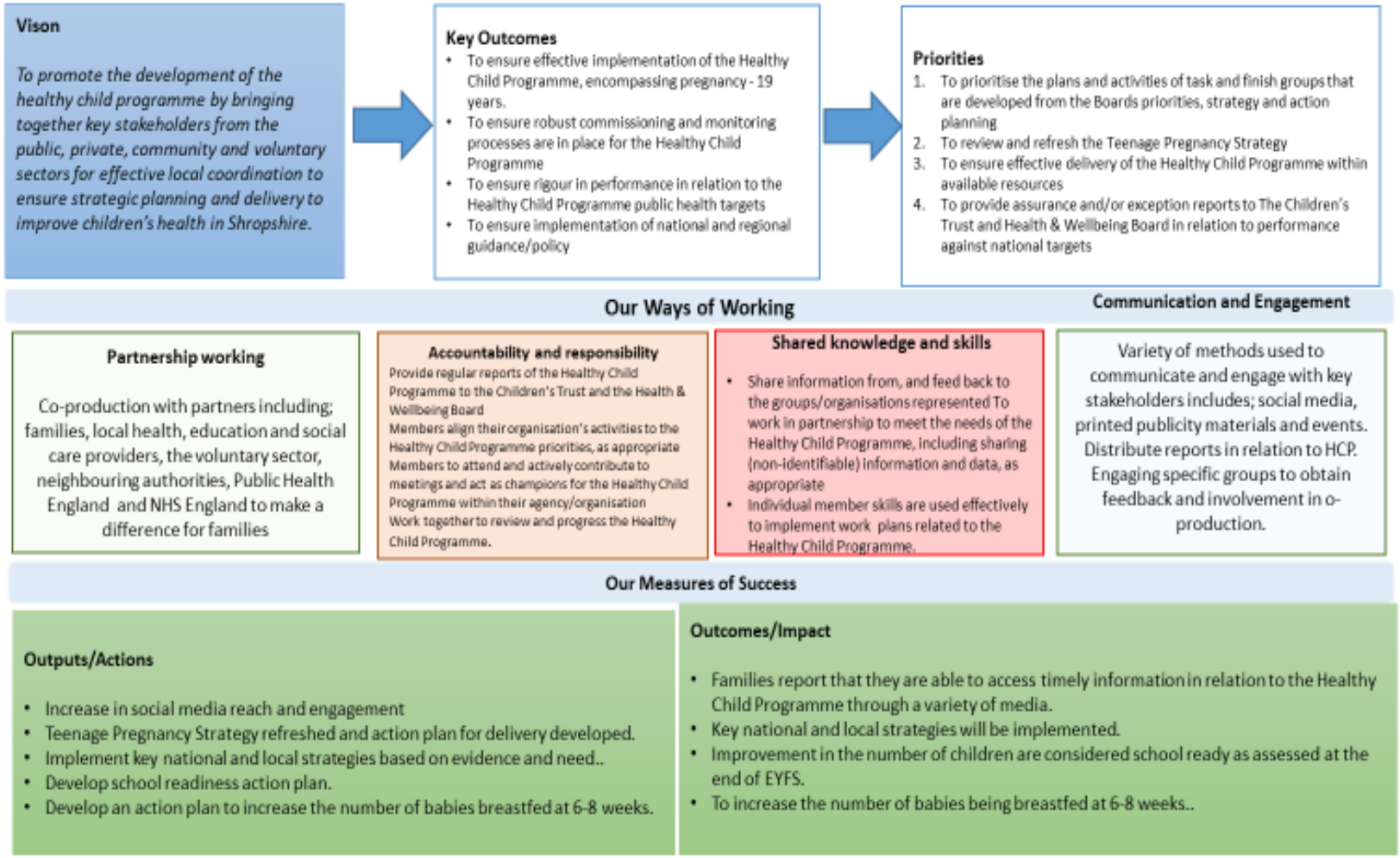
Sam Anderson	Safeguarding Boards Business Manager	Shropshire Council
Val Cross	Health & Wellbeing Officer, Public Health	Shropshire Council
Graham Moore		Shropshire Council
Naomi O'Hanlon	0-25 Development Officer, Public Health	Shropshire Council

Appendix 2


How I grow and learn
My Journey to school
Shropshire Council

Appendix 3 Plan on a Page

Healthy Child Programme Partnership Board 2018/19



Focus of work at the moment / work plan:

School readiness

Development and implementation of Adverse Childhood Experiences (ACE's) and routine enquiry

Teenage pregnancy

Who we report to and how often:

Children' Trust quarterly

Health & Wellbeing Board as required

Meeting dates:

26th June 2018

10th October 2018

Working links with other partnership groups:

Children's Trust

Health & Wellbeing Board

Early help Partnership Board

LMS Transformation Board

Mental Health Partnership Board

Board membership

Anne-Marie Speke Chair, Acting CYP Team Lead Shropshire Council Public Health

David Coan Vice Chair Designated Nurse for Safeguarding Children for Shropshire

Naomi O'Hanlon 0-25 development officer Shropshire Council Public Health

Neville Ward Service manager Early Years and Childcare, Shropshire Council

Francean Doyle Head of Early Help Partnerships and Commissioning, Shropshire Council

Emma Dodson Matron Paediatrics, Shrewsbury and Telford Hospitals NHS Trust

Sarah Rock Service Delivery Group Manager – Childrens & Families Services Shropshire Community Health Trust

Sarah Jamieson Head of Midwifery, Shrewsbury and Telford hospitals NHS Trust

Adelle Wilkins Healthwatch Shropshire

Karen Saunders Health and Wellbeing Programme Lead, Public Health England

Irfan Ghani Consultant in Public Health, Shropshire Council

Kevin Lewis Director of Help2Change, Shropshire Council Public Health

Lorraine Laverton Business manager, Shropshire Health & Wellbeing Board, Mental Health Partnership Board and Children's Trust

Julia Dean Service manager Special educational Needs and Disabilities

Chris Mathews Commissioner for Education Improvement and Efficiency

Alice Cruttwell PSHE Curriculum Advisor, Shropshire Council Public Health

Mark Trenfield Public health Analyst, Shropshire Council

Val Cross Health and Wellbeing Officer Shropshire Council Public Health

Sam Anderson Safeguarding Boards Business Manager, Shropshire Council

Graham Moore

David Ellis

Health and Wellbeing Board
Thursday 23rd May 2019

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 focuses on proposals for a new way forward for the Children's Trust and its sub groups.

2.0 Recommendations

The Children's Trust recommends that the Health and Wellbeing Board agree to:

- **have the Early Help Partnership Board report directly to the Shropshire Safeguarding Children Board (SSCB)**
- **have the 0 – 25 SEND Strategic Board and Healthy Child Programme Partnership Board report directly to Health and Wellbeing Board**
- **support a collaborative approach utilising the Partnership Board's SharePoint**

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.

REPORT

1.0 Background

On an annual basis the Shropshire Children's Trust considers its priorities and ways of working. In preparation for this consideration a questionnaire was sent out to the 20 members of the Trust. 5 Members responded to the questionnaire.

2.0 Questionnaire responses

Of the responses; all understood the role of the Children's Trust and their role as a member of the Children's Trust while most of the respondents thought it is a useful way to share information and promote partnership working, only 1 respondent felt the Children's Trust effects positive change.

The limited engagement from Members and the responses to the questionnaire led me to consider the most effective way forward for the Children's Trust. As a result of that consideration a proposal was put to the members of the Children's Trust that the Children's Trust as it stands now be replaced by an annual Children's Summit.

3.0 Children's Summit proposal

The landscape of partnership working is evolving and the three groups that currently report to the Children's Trust; Early Help, 0 – 25 SEND Strategic Board and the Healthy Child Programme are Partnership Boards in their own right with their own governance structures.

Each of these Partnership Boards has demonstrated their effectiveness in delivering positive outcomes for children and families in Shropshire whilst the Children's Trust is seen as a useful way to share information. The proposal put to the CT Members sees this continue. However, the proposal included that the 0 – 25 SEND Strategic Partnership Board and the Healthy Child Programme Partnership Board report directly to the Health and Wellbeing Board whilst the Early Help Partnership Board reports directly to the Shropshire Safeguarding Children Board (SSCB). The information element of the Children's Trust will not be lost but focussed on an annual consideration of the work of the Partnership Boards, to share learning and collaborate in time limited Task and Finish Groups as appropriate.

In summary:

- Children's Trust replaced with annual Children's Summit
- Early Help Partnership Board report directly to SSCB
- 0 – 25 SEND Strategic Board and Healthy Child Programme Partnership Board report directly to Health and Wellbeing Board
- All Partnership Boards to utilise the Partnership Board's SharePoint to collaborate as appropriate.

4.0 Children's Trust Response

The Children's Trust agreed the changes outlined in section 7.0 above, with the first Children's Summit to take place 24th October 2019, with a review to this approach scheduled for the Autumn 2021.

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) Ed Potter
Local Member
Appendices None

NHS England and NHS Improvement - Midlands

Commissioning Directorate

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Recipient's name
Ms V Cross
Shropshire Health and Well Being Board
Shirehall
Abbey Foregate
Shrewsbury
Shropshire
SY2 6ND

12 April 2019

Dear Ms Cross

Notification to Change Supplementary Opening Hours:
St Martins Pharmacy, Stans Superstore, St Martins, Shropshire SY11 3AY

The above pharmacy has notified a change to their supplementary hours. This notification has been ratified by Committee and the pharmacy will now open from, Monday 15 July 2019 , with the amended hours detailed below.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
09:00 – 17:30	09:00 – 17:30	09:00 – 17:30	09:00 – 17:30	09:00 – 17:30	09:00 – 13:00	Closed

Please take the appropriate action to update your files.

Yours sincerely

Julie Rawlinson
Primary Care Support Officer

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