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

Date: 8 January 2020

Committee:
Health and Wellbeing Board

Date: **Thursday, 16 January 2020**
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 Evans – 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

Interim Chief Executive, Shrewsbury & Telford Hospital Trust

Ros Preen - Shropshire Community Health Trust

Nicky Jacques – Chief Officer, Shropshire Partners in Care

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

Martin Harris – STP Programme Director

Laura Fisher – Housing for Shropshire

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

AGENDA

1 Apologies for Absence and Substitutions

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

2 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.

3 Minutes of the last meeting (Pages 1 - 10)

To confirm as a correct record the minutes of the meeting held on 14 November 2019.
Contact: Michelle Dulson Tel 01743 257719

4 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. The deadline for this meeting is 9.30am on Tuesday 14 January 2020.

5 System Update (Pages 11 - 26)

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

Shropshire Care Closer to Home

Report attached.
Contact: Lisa Wicks, Deputy Director of Performance & Delivery, Shropshire CCG

STP Update

A presentation will be given.
Contact: David Stout, Accountable Officer, Shropshire CCG

Better Care Fund, Update and Performance

Report attached.

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

Healthy Lives Update

Report attached.
Contact: Val Cross, Health & Wellbeing Officer, Shropshire Council

6 0-25 Emotional Health and Wellbeing Service update (Pages 27 - 108)

Report attached.
Contact: Steve Trenchard, STP Programme Director (Mental Health), Shropshire STP

7 Wellbeing Award (Pages 109 - 116)

Report attached.
Contact: Kerry Simmonds, Deputy Headteacher, Market Drayton Infants School

8 Single Strategic Commissioner programme (Pages 117 - 120)

Report attached.
Contact: Alison Smith, Telford & Wrekin CCG

9 Dementia update (Pages 121 - 150)

Report attached.
Contact: Cathy Davies, Shropshire Clinical Commissioning Group

10 Homelessness and rough sleeping provision

Report to follow.
Contact: Laura Fisher, Housing Services Manager, Shropshire Council

11 Immunisations update

Report to follow.
Contact: Rachel Robinson, Director of Public Health, Shropshire Council

12 Chairman's updates

13 AOB

Shropshire Council

Committee and Date

Health and Wellbeing Board

16 January 2020

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 14 NOVEMBER 2019
9.30 AM - 12.05 PM

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

Present

Councillor Lee Chapman (Co-Chair)	PFH Organisational Transformation and Digital Infrastructure
Councillor Rob Gittins	Deputy PFH for Public Health
Councillor Ed Potter	PFH Children's Services
Mr David Evans	Accountable Officer, Shropshire CCG
Rachel Robinson	Director of Public Health
Andy Begley	Director of Adult Services
Karen Bradshaw	Director of Children's Services
Lynn Cawley	Chief Officer, Shropshire Healthwatch
Jackie Jeffrey	VCSA
Ros Preen	Shropshire Community Health Trust
Nicky Jacques	Chief Officer, Shropshire Partners in Care
Laura Fisher	Housing Services Manager

Also in attendance:

Val Cross, Tanya Miles, Penny Bason, Cathy, Riley, Anne-Marie Speke, Wendy Bulman and Stewart Smith.

36 **Apologies for Absence and Substitutions**

The following apologies were reported to the meeting by the Chair:

Martin Harris, STP Programme Director
Councillor Dean Carroll, PFH ASC, Housing and Climate Change
Bev Tabernacle, Director of Nursing RJ&AH Hospital
Dr Julie Davies, Director of Performance and Delivery Shropshire CCG
Gail Fortes-Mayer, Director of Contracting and Planning Shropshire CCG

The following substitutions were also notified:

Councillor Rob Gittins substituting for Councillor Dean Carroll

37 **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.

38 **Minutes**

It was noted that Councillor Lee Chapman's Job Title was now the Portfolio Holder for Organisational Transformation and Digital Infrastructure and that Megan Nurse's Job Title was Managing Director, Midlands Partnership NHS Foundation Trust.

RESOLVED:

That the Minutes of the meeting held on 12 September 2019, be approved and signed by the Chairman as a correct record, subject to the above.

39 **Public Question Time**

No public questions were received.

40 **System Update**

i. Shropshire Care Closer to Home

The report of the Shropshire Clinical Commissioning Group which provided an update on the Care Closer to Home programme was received for information only (copy attached to the signed Minutes).

RESOLVED: That the report be noted.

ii. Healthy Lives Update

Val Cross, the Health and Wellbeing Officer introduced and amplified her report (copy attached to the signed Minutes) which provided the Board with an update on the Healthy Lives programme.

The Health and Wellbeing Officer updated the Board on the following areas:

- Cardio-Vascular Disease (CVD) risk prevention
- Physical Activity – Elevate
- Social Prescribing
- Carers

In response to a query, the Health and Wellbeing Officer reported that the impact on both the lives and wellbeing of children was indeed being considered and that All-Age Strategies were starting to be produced eg All-Age Mental Health Strategy and All-Age Carers Strategy. She informed the Board of a Social Prescribing event taking place on 5 December with a focus on young people.

In response to a query in relation to the future roll out of AF (Atrial Fibrillation) devices, the Director of Public Health explained that costings and the outcomes of roll out were currently being worked up and that this would be reported to a future meeting of the Board.

The Accountable Officer reported that each PCN (Primary Care Network) would have a mandatory social prescribing function. The Director of Public Health informed the Board of a workshop taking please on 12 December where partners had been invited to look at rolling out the social prescribing model across the County including how to link in volunteers. A clearer picture would therefore be presented to the next meeting of the Board setting out the current position and what happens in Shropshire. Invitations would be cascaded widely the following week.

RESOLVED: That the report be noted.

iii. Better Care Fund, Performance

Penny Bason, the STP Programme Manager introduced her report (copy attached to the signed Minutes) which set out the Better Care Fund (BCF) Plan for 2019/20, along with the variation to the Section 75 Partnership Agreement for endorsement by the Board.

The STP Programme Manager reported that the BCF Plan had kept the same focus as previously which matched the national Eight High Impact Model to keep people out of hospital for as long as possible. The BCF Plan still had to go through the assurance process but in terms of expenditure and narrative, the BCF Plan matched that in the STP Plan.

The STP Programme Manager explained that variations to the Section 75 Partnership Agreement were around changes within the scheme in relation to pooled budget amounts, risk sharing and how to work together.

The Chairman congratulated the STP Programme Manager for pulling the Plan together which had been a huge amount of work.

The Chairman then highlighted the risks around the continued reliance on grant funding and the ability to plan in the longer term for Adult and Children's Social Care and he urged Members to lobby their MPs and Central Government for a longer-term solution.

RESOLVED:

A. That the BCF plan attached at Appendix A be endorsed.

B. That the variation of the Section 75 Partnership Agreement attached at Appendix B be endorsed, prior to final approval by Shropshire Council and Shropshire CCG.

C. That the risks associated with continued reliance on grant funding to pay for system initiatives to support transfers of care and admission avoidance be noted.

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

David Stout, the Interim Transformational Director gave a presentation on the STP Long Term Plan, which gave a high-level overview and timeline of the system Long Term Plan (LTP) submission (copy of slides attached to the signed Minutes). He reported that the LTP was due for submission the following day, Friday 15 November 2019. He commented on the phenomenal amount of engagement that had gone into producing the LTP and was confident that it contained no great surprises.

The Interim Transformational Director then gave a brief update on the individual Chapters contained within the LTP, as follows:

- Chapter 1 – sets out how the Plan was pulled together; the vision of working together more collaboratively and blurring the boundaries between commissioners and providers; plans for an Integrated Care System; the approach to system development, including the establishment of a shadow ICS Board which would start meeting in early 2020 to help drive forward implementation of the Plan; person-centred approach to system development.
- Chapter 2 – Provided an overarching view of the health and wellbeing of the population for which the two JSNA documents feed into.
- Chapter 3 – Population Health Management (PHM), ensures services are based on data and evidence to ensure that the delivery of health and care services achieve the best outcomes.
- Chapters 4, 5 and 6 are the service transformation elements of the Plan.
- Chapter 4 – to ensure enough effort was put into prevention to keep people healthy for as long as possible and ensure that people only go to hospital when they really need to. This was a key part of the Plan and focused on how to stop the increase in non-elective admissions.
- Chapter 5 – addressed Mental Health prevention and its impact on A&E attendance.
- Chapter 6 – focused on people who most need acute care.
- Chapter 7 – sets out the plan to transform the workforce.
- Chapter 8 – looked at clinical and non-clinical support services and working together to drive efficiencies.
- Chapter 9 – sets out the vision for digital support and utilising technology more effectively.
- Chapter 10 – sets out the estates strategy and opportunities to improve/use more effectively.
- Chapter 12 – sets out the next steps in delivery of the Plan.

The Interim Transformational Director informed the Board that although the LTP did not financially balance, it set out a reasonable, plausible plan. The LTP was due to be signed off mid-December so they had from now until April 2020 to develop an implementation plan. He confirmed that the delivery plan would come back to this Board at a future meeting.

Concerns were raised about whether the Plan was ambitious enough to deliver prevention, particularly for young children and families and the impact on children's health and wellbeing. In response, the Accountable Officer felt that

the LTP needed to be as ambitious as possible and that this would be tested as it was implemented. It was confirmed that children were a key priority and were addressed in all sections of the LTP rather than having a separate section for them.

The Chairman noted that a lot of ambition had been invested in the expectation of delivery and that this ambition needed to be translated into what the technical requirements would be. He urged caution not to underestimate the difficulty and time required to achieve a culture change and new ways of working.

RESOLVED: That the update be noted.

41 **MMR Vaccination, Uptake and Action**

The Board received the report of the Healthy Child Programme Co-ordinator (copy attached to the signed Minutes) – which set out the requirement to introduce an MMR Elimination Strategy.

The Director of Public Health gave some background and context in relation to vaccinations and immunisations. She informed the Board that 330 children die each day from Measles but that 30m have been saved due to vaccination. She explained how vaccination programmes provided 'herd immunity', and that, depending how contagious a disease was, this required approximately 90-95% coverage. When coverage dropped below 95%, that had an impact on communities and the 'herd' immunity. The Director of Public Health confirmed that although Shropshire did very well and were above national rates, the coverage had started to drop with uptake of the second dose of MMR at approximately 88%. The reasons for this drop was less about confidence in the vaccine but more around timing, access, childcare and supply issues etc.

The Healthy Child Programme Co-ordinator informed the Board that in 2016 the World Health Organisation had declared that the UK had achieved elimination of Measles however, following uptake of the second dose dropping to 88%, elimination has not been sustained so the status has been withdrawn. As well as concern for vulnerable populations, further NHS England analysis suggests that immunity in those aged 15-20 years old and also possibly those aged 10-15 years old had fallen below 95%. Although there had not been any major outbreaks in the UK, there had been some in Europe and it was important to be aware that the risk was higher when travelling abroad.

The Healthy Child Programme Co-ordinator reported that Public Health England had produced an MMR Elimination Strategy and that each Local Authority had been asked to create an Action Plan to raise awareness of the importance of vaccination. There were four main components, set out on page 18, which included provision of a catch-up programme for those aged between 15-20 and 10-15. To this end, there was currently a GP catch-up programme under way, information had been sent to schools to encourage them to share the information with parents and check the immunisation status of children when starting school. She then drew attention to the Action Plan, set out at Appendix 1, and the recommendation on page 17.

In response to a query, the Healthy Child Programme Co-ordinator confirmed that partner organisations had liaised around getting the message out and were taking responsibility to raise awareness within their own organisations. The Chairman commented that Councillors often attended School Governor meetings, and, as such, could raise awareness of this issue with schools. A general update on immunisation was requested for a future meeting.

RESOLVED:

1. That the contents of the report be noted and that the action plan and work being carried out to improve awareness be supported.

2. That Members of the Board act as champions within their services and communities to raise further awareness and encourage immunisation uptake.

42 **Healthwatch NHS Long Term Plan Report**

The report of the Chief Officer, Healthwatch Shropshire was received (copy attached to the signed Minutes) which set out the key messages that emerged following the engagement programme undertaken jointly by Healthwatch Shropshire and Healthwatch Telford & Wrekin to inform the STP Long Term Plan.

The Chief Officer informed the Board that the engagement programme had taken place between March and May this year and was the largest piece of engagement work they had been asked to do thus far. A total of 641 comments had been heard and they had been assured that the findings would be considered in the Long Term Plan. The Chief Officer commented that respondents wished to receive feedback on the impact of their responses and how they had been implemented. She thanked STP partners for their assistance in promoting events, local groups, 1:1s with carers, dementia sufferers etc.

The Chief Officer drew attention to some of the findings, as follows:

- Clear/consistent communications were really important;
- Consistency of staff, knowledgeable about other services available as well as their own, including in the voluntary sector;
- Supporting carers and recognising the role they play;
- Call for more staff/money;
- Concern around the roll out of digital technology going forward – record sharing, may have to become more IT literate;
- Services communicating clearly with each other;
- Prevention should be the key work in the Long Term Plan.

The Chairman congratulated the Chief Officer for a tremendous piece of work. He commented that the voice of the people should be the prime focus and stressed the importance of having the opportunity to capture and ground the STP in what was important to people. He was interested to learn that out of the top ten priorities the top four were the same for everybody. He cautioned that although data sharing was important, some people did not want to use technology and that service design should ignore this at their peril.

In conclusion, the Chief Officer stressed the power of face to face engagement and the importance of regular communications with the public about what was happening and how it affected them.

RESOLVED: That the contents of the report be noted.

43 Health & Wellbeing Board workshop - update on the first workshop

The report of the Health and Wellbeing Officer/Healthy Lives Co-ordinator was received (copy attached to the signed Minute). The Health and Wellbeing Officer/Healthy Lives Co-ordinator explained that the focus for the day was Place Based Working and Priority Setting. She drew attention to the aims and outcomes of the workshop and gave a summary of the key discussion points and the themes that emerged (set out at paragraphs 3.2.1 to 3.2.4 of the report). She informed the Board that a further workshop had been arranged for 5 December 2019.

The Director of Public Health reported that the JSNA (Joint Strategic Needs Assessment) had been discussed at the workshop. She explained that the JSNA needed to be updated every three years but that Shropshire had been using a rolling process. Also, the following Individual Needs Assessments required updating; Care Closer to Home, Older People, Musculoskeletal and that these should come to the Board in the New Year for sign off.

The Chairman requested that a representative from education be invited to the workshop on 5 December 2019 and he questioned to what extent they could, as a system, commission their way out of certain inequalities, he also suggested that members of the Board had the opportunity to influence their organisations to deal with the wellbeing of their workforce and to influence behaviour to challenge the system.

RESOLVED: That the report be noted.

44 Domestic Abuse contract. New initiatives and overview of the work done in Shropshire

The report of the Shropshire Domestic Abuse Service was received (copy attached to the signed Minutes). Wendy Bulman introduced this item and gave a presentation (copy attached to the signed Minutes) which covered the following areas:

- History
- Accommodation
- Children – who do we support
- Outreach
- Shropshire Domestic Abuse Service (SDAS)
- Survivors Empowering and Educating Domestic Abuse Services (SEEDS)

She gave a brief history and informed the Board that the service had been around for 20 years and that since 2017 the Service had sat within South Shropshire Housing

Association (Connexus). She reported that the service had 20 bed spaces across the county and, following a change to the contract, stock could be increased as needed. Ms Bulman highlighted the 10 bed refuge accommodation and drew attention to the Children in Need contract which provided funding for three years to support children. She went on to discuss the support offered to children which included talking about how they felt, understanding healthy relationships and helping to change their own futures. They also worked in partnership with schools.

Ms Bulman then discussed the outreach services, what was offered, who could access the services etc. She highlighted a number of courses offered, including weekly education programmes, parenting courses and a pilot for male perpetrators and female victims which was also being offered, which demonstrated the impact each were having on the other, in order to help the couple stay together going forward in a safe relationship.

Ms Bulman drew attention to the work of Shropshire Domestic Abuse Service (SDAS) which was a Multi-Agency service which ensured users being supported could access support from other agencies. The service had Leading Lights Accreditation, which ensured that it was fit for purpose and delivered against recognised standards. She then explained that the service had its own Management Group to ensure scrutiny of the service was undertaken.

Finally, Ms Bulman explained about Survivors Empowering and Educating Domestic Abuse Services (SEEDS) which was a monthly drop-in group for survivors of domestic abuse. The Chairman felt that it was important for the Health and Wellbeing Board to have awareness of this service as it impacted across the system. The Director of Adult Services thanked Ms Bulman for her presentation and reported that wider work was taking place which would be reported to the Board. The Director of Public Health explained that domestic abuse was a priority within the JSNA.

The Chief Executive welcomed the report and stressed the importance of bringing the Police and the Community Safety Partnership to the table and to encourage more police involvement. In response, Ms Bulman confirmed that the police did have involvement for those high-risk cases.

RESOLVED: That the contents of the presentation be noted.

45 **Direct Payments Workshops**

The Chairman introduced Stewart Smith, the Personalisation Development Officer, Tanya Miles, Assistant Director Adult Social Care, Chris Roberts, the Development and Project Manager and Mary Hastings, a recipient of Direct Payments who gave a presentation following the recent Direct Payments Workshops held at the Guildhall. The presentation highlighted personal experiences, occasions when Direct Payments helped/when it hindered and why there was a need for the system to change.

The Board were informed that a Direct Payments Board had been set up by staff and people in receipt of Direct Payments, of which Mary was the Co-Chair. Mary explained the need for change and how being Co-Chair had challenged her to step up. She found it very empowering to be contributing alongside a team of

professionals, being the voice for other vulnerable people and, most importantly, being seen and valued as another human being.

The Personalisation Development Officer then discussed the two workshops that had been held which focused on 'Tell our story' which was intended to reframe thinking around Direct Payments. The workshops highlighted a desire to improve and work together alongside health services.

The Development and Project Manager then set out the next steps and the work required to move forward. This included the use of technology, to allow more creativity and flexibility for those in receipt of Direct Payments who should be involved in the development of their own care plans. Work would also be undertaken around creating a pool of Personal Assistants, pre-payments would be looked at in the future and a Task and Finish Group had been set up to start looking at work around support planning.

The Chairman thanked everyone for their informative presentation and for sharing their personal experiences. He had found it very powerful and inspiring and he looked forward to further updates. In response to a query, the Development and Project Manager confirmed that best practice would be shared within the NHS going forward. The Director of Adult Services felt that the results that came out of the workshop demonstrated the power of engagement and spoke to the wider agenda of a shift in the whole landscape of Health and Adult Social Care.

46 **Chairman's updates**

- The Chairman drew attention to the new combined Drug and Alcohol Strategy. It had been proposed that the strategy be consulted upon. It would therefore be sent to members of the Board towards the end of the month.
- At the request of the Chairman, Laura Fisher the Housing Services Manager gave an update on arrangements for cold weather provision and she reported that an update would be presented to the Board at its next meeting in January which would include the Annual Rough Sleeper Count.
- The Chairman informed the Board that its response to the Green Paper consultation had been acknowledged.
- The Chairman informed the Board that a report on Dementia had been requested for the16 January 2019 meeting.

47 **AOB**

The Chairman informed the Board that NHS England had granted an application for a change of ownership for Rowlands & Co (Retail) Ltd at 5 Cross Street, SY12 0AW by Day-Night Pharmacy Ltd.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

Health and Wellbeing Board
Meeting Date: 16th January 2020

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
The Frailty Intervention Team (FIT) is based within the A&E Departments of both Royal Shrewsbury Hospital and Princess Royal Hospital in Telford and the service runs 5 days per week at both sites. Recent recruitment to the teams has improved the staffing issues previously identified, including the recent appointment of a substantive Consultant Geriatrician, however adequate levels of support to the teams remains a concern, through Matron support at RSH and Rapid Response input to the PRH team. Both teams are reporting positive results around reducing length of stay, improving discharge and avoiding emergency admissions to the acute hospitals.

Phase 2
Case Management has been underway at the eight pilot sites since mid-August and 463 patients have been contacted to gain their consent to take part in the pilots. As at the end of November, 43% of patients had consented to be Case Managed. A small number declined consent and the remainder are yet to respond. Initial assessments have been taking place to develop holistic care plans which will be co-ordinated by the Case Manager and delivered by a multi-disciplinary team including health, mental health and social care colleagues.

In terms of system impact, for the risk stratified cohort of individuals from the GP practices involved in the pilots, in the first 2 months across 8 practice locations, the teams have prevented:

- 30 ambulance conveyances;

- 46 A&E attendances;
- 44 acute admissions;
- 12 acute readmissions.

Feedback from both staff and patients involved in the pilots has been very positive so far and the Case Management teams have captured a number of case study examples of how earlier identification of needs and provision of proactive preventative care via joined up working is improving lives, conditions and outcomes and demonstrating the positive impact of this new model of care.

Monitoring of the progress of the pilots will continue until the end of March 2020 when the pilots are due to end although discussions are taking place with partners around potentially extending the pilot period to test out the model more fully and evaluate the impact over a longer period.

Risk stratification data is being drawn in early January 2010, combining primary and secondary care data before applying a number of criteria and filters that are used to identify individuals who may be at risk of hospital admission and who could benefit from earlier support and intervention. At this stage the data is only being drawn to give the team an idea of numbers from each practice who would potentially be referred into Case Management to help inform wider workforce modelling for the system that is underway.

Phase 3
The Programme Team have been working with partner and provider organisations over several months to impact assess the Phase 3 models of care which were approved by Shropshire Clinical Commissioning Committee in June 2019. A number of workshops have taken place with colleagues in the various organisations to identify any unintended consequences of implementing the new models and pathways. Where impact or risk has been identified further assessment has taken place with input from the CCG Quality Team to plan mitigation. The process is now almost complete with an outcome report expected around February 2020 which will go to the CCG Clinical Commissioning Committee who will agree next steps.

Enablers
Work continues with partner and provider organisations to implement a Shropshire Council system, Liquid Logic, as an interim IT solution allowing data flow from partner organisations and enabling Case Managers to have an overview of the people they are working with. The task and finish group are working through the technical aspects of the data transfer and are also involving Information Governance colleagues to ensure all data protection requirements are considered and met at an early stage in the project.

Whole system workforce transformation planning is now underway with all partner and provider organisations and is being driven by Health Education England and the STP at a system level. This work will map out the shift required in terms of workforce to deliver the new models of care in Shropshire Care Closer to Home.

Next Steps
Public Health colleagues are now refining the draft Joint Strategic Needs Assessment document following input from stakeholders across the whole system. This document will establish the general direction of travel for the county in terms of what health and social care

needs will be required over the coming years and will shape the services provided in Shropshire. An easy read version of the JSNA is also being developed that will be released for public information.

A public and provider event to explore the JSNA findings was due to take place in December 2019 but due to guidance received from NHS England on purdah restrictions surrounding the general election the event was deferred until Wednesday 26th February 2020. This workshop will be an opportunity to discuss in detail what the data in the JSNA indicates for the people of Shropshire and following this event work will begin on developing the requirements for step-up community beds in Shropshire.

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

Health and Wellbeing Board
Meeting Date: 16th January 2020

HWBB Joint Commissioning Report – Health & Wellbeing Board 'Place Based Working and Priority Setting.' Second Workshop report

Responsible Officer: Val Cross, Health and Wellbeing Officer/Healthy Lives Co-ordinator

Email: val.cross@shropshire.gov.uk

1.0 Summary

1.1 Following a half-day Health & Wellbeing Board (HWBB) workshop held on the 22nd October 2019, for which the focus was 'Place Based Working and Priority Setting', a further workshop to discuss, agree and conclude the interventions and outcomes was held on the 5th December 2019.

1.2 The workshop was well attended with 20 people represented from; the Voluntary and Community Sector, Adult and Childrens' Services, Shropshire CCG, Shropshire Community Health Trust, Shropshire STP, Education, Elected Members and Public Health.

1.3 Participants were mixed across three tables, to enable a good cross section of discussion and balance of views.

1.4 This report provides the findings from that workshop.

2.0 Recommendations

Based on the evidence and workshop outcomes, the Health and Wellbeing Board is asked to endorse the key identified key priorities of;

- Adverse Childhood Experiences
- Workforce
- Healthy Weight and Physical Activity

The board is also asked to recognise the ongoing prioritisation and work happening which includes; Smoking in Pregnancy, Social Prescribing, Domestic Abuse, Dementia, Alcohol, Mental Health - wellbeing support, suicide prevention, County Lines and Air Quality.

REPORT

3.0

3.1 The aims of the workshop remained the same as the October workshop:

- To discuss and agree the role of the Health & Wellbeing Board in place based care/working, drawing in the 10 areas of the STP, Long Term Plan and cross-pollinating good practice happening across both
- Use intelligence from the JSNA to agree ongoing priorities

- Embed agreed priorities from the workshop in the refreshed Health & Wellbeing Strategy

3.2 The outcome of the workshop was that the role of the Board in place based care/working and priorities would be agreed, and embedded in the refreshed Health & Wellbeing Strategy

3.2.1 A recap of the previous session was provided including key themes which had emerged;

- *Workforce:* including elements such as: a healthy informed workforce, who have an awareness of prevention and looking at embedding behaviour change (a technique which help to put people back in control of their own lives, through making positive choices around their own health and wellbeing).
- *Children and young people:* Adverse Childhood Experiences (ACE); starting early and building ambition.
- *Weight Management/Diabetes*

also

- *Wider determinants of health* - use of green spaces, planning policy and housing etc.
- *Role of the VCSE* as a core element of our system
- *meeting the needs of seldom heard groups* and those of the nine protected characteristics
- *How Place Based Working and Priority Setting* is part of developing our integrated working, trusting, developing and designing collectively.

3.2.2 As requested at the October workshop, more data and detail from sources was provided which included;

- Public Health England (PHE) Fingertips data
- Draft JSNA prioritisation matrix (see appendix 1) which: evaluates level of need and strength of evidence; attempts to be more transparent, robust and objective on a subjective issue; has criteria outlined based on information available and has weighting for level of need and economic cost. This had started to be populated with the different priorities including; weight management, smoking in pregnancy, ACE, school readiness and alcohol. The draft, which will need to be discussed and ratified by the Joint Commissioning Group (JCG) can be seen in appendix 2.
- The PHE 2019 Prioritisation Framework process for health and wellbeing "interventions" (see appendix 3) which supports making the most of budgets and reviews programmes that could offer the greatest value. Use of this framework links to work with the Commissioning Support Unit (CSU) and to the STP System Design and Prioritisation and Quality Assurance Groups.
- Shropshire Council data, Place based data, Office of National Statistics (ONS), and specific sources such as www.adversechildhoodexperiences.co.uk.

3.2.3 Following the presentation of data, workshop participants were asked to work in smaller groups to answer the following;
'Based on the evidence and our organisational/own knowledge, do we agree these are our priorities'? Information which included; HWBB strategy and priorities, ACORN and place based data was placed on the tables to aid discussion.
Participants were also asked to consider:

- A life course approach - Starting Well, Living Well, Ageing Well
- The needs of our vulnerable communities
- Using a Place Based approach
- The Wider determinants of health

3.2.4 The PHE 2019 Prioritisation Framework (appendix 3) was provided, and participants were invited to score the priorities against this, and discuss potential enablers for change.

3.3 The table below provides a summary of the table discussions:

Scoring for key priorities

N.B. two of the three groups specifically scored the criteria as below. The third group did not. The discussion captured however, demonstrates a similar scoring to the other groups and can be considered as valid.

Adverse Childhood Experiences (ACE)

Criteria	High score – 10	Medium Score 6	Low Score 3	Weighting
Strength and quality of evidence	(Score from 2 groups) - good evidence of importance of work - good evidence that supports need for trauma informed workforce			
The size of the health benefit	(Score from 2 groups) - Potential to address 50% of the population -Opportunity to support specific families			
The prevention of future illness	(Score from 2 groups) - Good evidence to support prevention -Intervening early can break the cycle - Life course approach			
Addresses health inequality or inequity	(Score from 2 groups) Good evidence to support this			
Delivers national or local priorities or targets	(Score from 1 group) STP Mental Health, Early Help, HWBB	(Score from one group)		
The financial costs and benefits	(Score from 2 groups) Significant return on investment			

Potential enablers for change	
System wide approach	Champions, informed about trauma, holistic approach
Prevention	• Using opportunities throughout a person's life journey, and intervening earlier to break the cycle. • Pilot interventions to enable measurement • Understand why children are behaving as they are and put in place appropriate support
Targeting	Consider if prioritisation should be on poor outcome areas, or on impacts/actions that could improve outcomes across multiple areas.
Training	Develop trauma informed workforce
Data	• Understand the data – risk stratify • Identify parents – work with troubled families and all services

Policy development	• Should be firmly in the HWBB strategy
Involving everyone	• Create peer support (like compassionate communities but for younger people) • Consider role of grandparents and friends • Understand what is needed in communities that will help • Connect schools (including nursing service), voluntary and community sector and families together

Workforce

Criteria	High score – 10	Medium Score 6	Low Score 3	Weighting
Strength and quality of evidence	(Score from 2 groups) - Good evidence. Skills, lower employment, sufficient workforce			
The size of the health benefit	(Score from 2 groups)			
The prevention of future illness	(Score from 2 groups) Healthy workforce. THRIVE model.			
Addresses health inequality or inequity	(Score from 2 groups)			
Delivers national or local priorities or targets	(Score from 1 group)	(Score from 1 group)		
The financial costs and benefits	(Score from 2 groups) Immediate; wellbeing day, Couch25K, digital			

Potential enablers for change

Healthy workforce	• Leading by example in our organisations • Targeting our workforces • Adopting the THRIVE model across sectors. https://www.wmca.org.uk/what-we-do/thrive/thrive-at-work/ • Wellbeing Days, Couch25K, use of digital • Evaluating impact of interventions
Workforce improvement – influencing factors	• skills • lower unemployment • income and better wages • career progression • Terms and Conditions of employment
Using workforce as an influence on others	• Voluntary and Community Sector • Nudges/opportunity for stimulating change

Weight and Physical Activity

Criteria	High score – 10	Medium Score 6	Low Score 3	Weighting
Strength and quality of evidence	(Score from 2 groups) - More work to do around this. Varies by age, GP locality - good evidence of importance of work			
The size of the health	(Score from 2 groups)			

benefit	- Estimated over 73% of Shropshire adults are overweight or obese Type 2 diabetes increasing – estimated prevalence 9.4 % of the population			
The prevention of future illness	(Score from 2 groups) - Obesity linked to diabetes, cancer, heart disease			
Addresses health inequality or inequity		(Score from 2 groups) - Tends to cross the all sectors of society, but prevalence higher in deprived wards		
Delivers national or local priorities or targets	(Score from 1 group) LTP priority (national and local), HWBB	(Score from 1 group)		
The financial costs and benefits	(Score from 2 groups) - Significant return on investment attributable across future illness			

Potential enablers for change	
Communication	• Consistent health messages for the public, shared by organisations to avoid confusion and misinterpretation • Different evidenced messages for different audiences
Education	• Level of importance given to Physical Activity and Home Economics in the curriculum – national issue. Support schools to help staff, pupils, and parents with e.g. roll out the Daily Mile, support schools to teach nutrition.
Increasing knowledge of nutrition and cooking skills	For everyone, particularly young people and families. • Connect with private, VCS or not for profit organisations such as the National Trust or Acton Scott Farm – for healthier eating • Support parents to understand nutrition and food prep
Behaviour change	Nudges/reminders/rewards to support behaviour change for a healthier lifestyle
Regulation	Fast food outlets – managing the environment proactively
Increasing access to green spaces for all	• Encourage physical activity and love of the outdoors • Look at barriers to access, through cost.
Food poverty	• Continue to work in partnership to tackle food poverty in Shropshire • Connect to Food Poverty Action Plan
Workforce (links to the 'Workforce' priority)	• Workforce a key ally and group to support • Support the workforce to have a healthy lifestyle • Offer behaviour change and motivational interviewing training opportunities for more staff across the system • Gather more evidence about what works, including what works for workforce health (does mobile/ agile work help? how can physical health support mental health, what can employers do to best support their staff?) • Connect with the right influencers – connect with employers,

		create examples of good practice and support for people through their working lives • Ensuring a good work/ life balance, peripatetic or agile working doesn't necessarily help on its own, more information needed
Data	3.0	Understand the data and insight to know the causes (e.g. Mental Health and Poverty)
	4.0	Access people / risk stratify using data and information
Research	5.0	What's not working for adults – why is the over-weight and obese population growing? Conduct some ethnographic research to understand attitudes, beliefs and knowledge about weight
Other priorities needing consideration based on the evidence (not scored)		
		• Domestic Abuse • Smoking in Pregnancy • Social Prescribing • Dementia • Alcohol • Mental health - wellbeing support, suicide prevention • County Lines • Air quality

4.0 Conclusions

4.1 The two workshops have enabled a sound decision making process based on evidence and consensus, to recommend the Health and Wellbeing Board priorities. Provision of data has provided the evidence and prioritisation tools have been used to rank the priorities and to start to consider the potential enablers for change.

4.2 These workshops have now facilitated a prime opportunity to; refresh the Health and Wellbeing Strategy and Action Plan, formalise the Joint Strategic Needs Assessment – including governance of this and revisit and formalise the Health and Wellbeing Board Terms of Reference (TOR). All will be carried out with appropriate ratification.

4.3 Working groups formed from Board members and/or their representatives, will be arranged to carry out this work, and progress will be reported at the next HWBB meeting.

5.0 Risk Assessment and Opportunities Appraisal

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

Equality and equity elements were included in the prioritisation process and the development of the HWBB strategy will include an opportunity for broader stakeholder engagement to build on the ideas generated through the HWBB workshops

6.0 Financial Implications

There are no direct financial implications that need to be considered with this update, however the development of a new HWBB strategy will aim to support strategic planning and commissioning for the system.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr. Dean Carroll Portfolio Holder for Adult Services, Climate Change, Health and Housing
Appendices **Appendix 1 – JSNA Prioritisation Matrix** **Appendix 2 - Draft Prioritisation Matrix** **Appendix 3 – What to consider when prioritising the provision of health improvement programmes**

Appendix 1

Figure 3: JSNA Prioritisation Matrix

	Criteria	High 10 points	Medium 6 points	Low 4 points	Zero 0 points	Weighting
Estimated Level of Need	Level of need – Volume	Topic covers an estimated large 'in need' population (>25,000 people).	Topic covers an estimated medium sized 'in need' population (10,000 – 24,999).	Topic covers an estimated small 'in need' population (<10,000).	-	1.5
	Level of need – Severity	The population concerned have 'severe' needs.	The population concerned have 'considerable' needs.	The population concerned have 'moderate' needs.	-	1.5
	Level of need – Trend	Available evidence suggests rapidly worsening situation over time.	Available evidence suggests worsening situation over time.	Available evidence suggests situation has remained stable over time.	Available evidence suggests improving situation over time.	1
	Level of need – Benchmarks	Available evidence suggests very high prevalence relative to comparator areas (the County is a clear statistical outlier).	Available evidence suggests above average prevalence relative to comparator areas.	Available evidence suggests prevalence in-line with comparator areas.	Available evidence suggests relatively low prevalence relative to comparator areas.	1
Early Intervention	Does the topic have early intervention implications? Is it an emerging issue which is likely to cause further problems in the future?	Clear, demonstrable evidence that there is a strong case for early intervention.	Some evidence which highlights areas suitable early intervention.	Weak evidence that the topic has areas suitable early intervention.	No evidence to suggest that the topic contains areas suitable early intervention.	1
Inequalities	What is the scale of inequality?	Persistent, wide scale geographic and population-based inequalities are clearly apparent.	Some notable geographic or population-based inequalities are apparent.	Some minor inequalities exist.	Little or no evidence of inequalities.	1
Cost Implications	Estimated economic cost associated with tackling the topic in Warwickshire	High levels (multi-millions of £s) of both direct and indirect estimated economic costs both now and in the future.	Medium levels (c. £5 million) of direct and/or indirect estimated economic costs both now and in the future.	Low levels (<£1 million) of estimated economic costs either now/and or in the future.	-	1.5

Appendix 2 – Draft Prioritisation Matrix

Priority / Criteria	Level of Need Volume 1.5	Level of Need Severity 1.5	Level of Need Trend	Level of Need Comparison	Need responsive to intervention	Inequalities	Cost/Economic 1.5	Local or national priority	Total
Education outcomes for vulnerable young people	NEET 488 LAC SEN Priority families CPP	considerable			Not achieving Level 4+ at KS4 means considerable amount of ground, NEET	Gap in disadvantaged communities	Investing in Ed will save millions to economy		
School readiness	2,884	moderate	Improving but level off most recent	Mid West Midlands table, GSD same as WM., Eng 71.5	Curiosity corner, FNF, Early Education, Perry Preschool Programme	SEN, gender, FSM	RoI K1 = K13	Local CYP	
LD and Autism		considerable							
Oral Health		moderate							
Alcohol	Low absence rates, harmful levels	severe to moderate	Increasing hospital adm	Middle of DPFA	Risks early identifiable, links to stroke, cancer, RTAs etc	Homelessness links, MH, all groups	Links to	National and Local	80
Diabetes	Low diagnosis rates, 7% of the population	considerable	Significantly High	Outlier treatment					
Smoking Cessation	55,000 estimate	considerable	Leveling	Middle of DPFA	Quitting has impact on health,	Biggest preventative case of health inequalities and case CVD, Cancer respiratory	188 million	National	69
Weight Management	73.2 %	considerable	Inc in Adults and Reception	Highest of stat neighbours	School based interventions, national policies, PA	Strong link with obesity and deprivation but all, place plan	In direct costs 27 billion, direct 84 million	National and Local	88
Smoking in Pregnancy	247 per year	considerable mother & baby	Increasing	Remain high	Stop smoking services, in hospital, leadership, community support	MD, younger mothers	Impact on NHS and Social Care	Local and LTP	79
Cancer	1 in 3 1,200 under 75 mort	considerable	Falling	Comparison to DPFA	% thought to be preventable	Age, men generally greater risk, place plan	5% of NHS budgets, could increase by 1/3	National, LTP, Targets	69
CVD		considerable	Falling	Comparison to DPFA	NHS health check, smoking, weight	Place plan,	14 billion costs nationally	National, LTP, Stroke	69
Road Traffic Collisions	600	severe	Remains High	higher	20 is plenty, speed watch, alcohol			Local	64
Mental Health and Suicide	Adults mental health 11,858 1 in 4 pop	severe to moderate	Increasing	Life Expectancy Outcomes Poorest qtile	Symptoms identified possible to reduce severity	Life Expectancy 20 years less	21 billion costs to NHS and Social Care	Both	
Dementia	Diagnosis 3,616 diagnosed (71%)	Severe to moderate	Growing with aging pop	Good diagnosis rates	Undiagnosed, early diagnosis impact on quality of life	Prevalence among women	Cost pp: Mild £14,568, mod £28K, Severe 28,500 care home 31K	National input, local?	
Falls and MSK		severe to moderate						Local	
End of Life		severe							
Loneliness and Isolation	54% of carers and ASC less contact	moderate							
Carers	11% of people are carers	moderate				Varies across the County but all areas	Largest cost if unpaid carers need support	Local Strategy	
Frailty		considerable							
Youth Unemployment		considerable							
Low Workplace Earnings									
Food Poverty									
County Lines		severe						National, Local	
Domestic Violence		considerable							
ACES		severe							

Appendix 3 – What to consider when prioritising the provision of health improvement programmes

Factors to consider	Scale of the factor			Weighting
	High Score 10	Medium Score 6	Low Score 3	
Strength and quality of evidence. Is the evidence base robust and is it appropriate to the topic in question?	There is peer reviewed evidence available. For example, a meta-analysis of multiple well-designed trials. There is high confidence that the proposed programme will have the expected and measurable effect.	There is some evidence and there is a moderate level of confidence that the evidence reflects the true effect.	Evidence is either unavailable or does not permit a conclusion. There is only low confidence that the proposed programme will have any measurable effect.	1
The size of the health improvement benefit. To what extent does the programme improve the health status for the population over a suitable comparator?	We can expect measurable improvements in health status from the proposed programme, affecting 1,000s of people.	There is a moderate benefit expected from the proposed programme. The proposal may lead to a measurable effect for 100s of people	The benefit from the proposed programme is negligible or there is no discernible improvement in health status.	1
The prevention of future illness Does this intervention support 1º or 2º prevention of future health conditions	There is a high level of measurable prevention benefit expected from the programme.	There is a moderate degree of measurable prevention benefit	The prevention benefit is nil or negligible	1.5
Addresses health inequality or health inequity Does this service reduce or narrow identified inequalities or inequities in the local population	There are multiple direct associations between the health state in question and a specific demographic / socioeconomic group. The proposal deliberately and specifically addresses the identified inequality or inequity	There is a direct association between the health state in question and a specific demographic / socioeconomic group and evidence that the proposal can tackle this issue	The proposed programme does not address any inequality or inequity issues.	1
Delivers national and/or local priorities and targets Does this intervention support deliver identified national or local requirements or targets	The proposal addresses the target and/or requirements directly and the evidence suggests the impact will be clearly measurable.	The evidence suggests that the proposal can address certain key elements of a targets or requirement.	The proposal does not clearly address one target or requirement	1
The financial costs and benefits. To include the costs of preparedness and delivery, along with a suitable measure to describe current and future benefits and discounting	The proposal requires new delivery infrastructure; health gain is inconclusive, according to the evidence	Some infrastructure is available; health gain is moderate; impact on population health status is sizeable with economies of scale	The infrastructure for delivery is already available; the unit cost is low; health gain measure is high	1.5

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Health and Wellbeing Board
16th January, 2020

HWBB Joint Commissioning Report - Better Care Fund Performance Update

Responsible Officer
Email: Penny.bason@shropshire.gov.uk Tel: Fax:

1. Summary

1.1 This report provides an update on the performance of the Better Care Fund (BCF) for 19/20 (performance template Appendix A attached).

1.2 The BCF in 19/20 continues to provide a mechanism for personalised, integrated approaches to health and care to support people to remain independent at home or return to independence after an episode in hospital. The Better Care Fund performance reporting includes the monitoring of additional grant funding known as IBCF (Improved Better Care Fund) and Winter Pressures funding.

1.3 The priorities of the BCF (including improved Better Care Fund monies and Winter Pressures funding) are:

- Prevention – keeping people well and self-sufficient in the first place; Healthy Lives, including community referral (Let's Talk Local and Social Prescribing), Dementia Companions, Voluntary and Community Sector, Population Health Management, carers, mental health)
- Admission Avoidance – when people are not so well, how can we support people in the community; out of hospital focus (Care Closer to Home, Integrated Community Services, new admission avoidance scheme), carers and mental health
- Delayed Transfers and system flow - using the 8 High Impact Model; Equipment contract, Assistive technology, Integrated Community Service, Red Bag

1.4 Shropshire is working at a system level to develop the 8 High Impact model (details on the 8 High Impact Model can be found here https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model). The attached performance template (Appendix A) highlights that as a system we are self-assessed as working to a mature level for monitoring patient flow, multi-agency discharge teams, home first/ discharge to assess and Trusted Assessors; we have established schemes for Early Discharge Planning, Seven Day Services, Enhancing Health in Care Homes and Red Bag scheme (pilot only).

1.5 The report highlights Care Closer to Home as our 'Integration Success Story'; in particular it discusses the Shared Care record development as a significant piece of work for the programme. The Shared Care record will allow all health and social care professionals involved in the programme to find out everything they need to know about a patient's care needs; ensuring improved communication, more accurate needs assessments, and improved patient care.

1.6 The report also highlights that Shropshire is on track to achieve the Residential Admissions, Reablement, and Delayed Transfers of Care (DTOC) targets. However, we are currently reporting that we are 9% over target for Non Elective Admissions (calculated per 100,000 population).

2. Recommendations

2.1 The HWBB to note the BCF performance template and metrics.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

3.2. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.

3.3. The schemes of the BCF and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research.

3.4. Continued reliance on grant funding (iBCF and Winter Pressures), to support system flow, admissions avoidance and transfers of care schemes, holds significant financial risk should the grant funding stop.

4. Background

4.1 The Better Care Fund progress is reported at every Health and Wellbeing Board through the Joint Commissioning Report to the HWBB and can be found on the Shropshire Council website.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **For the final BCF plan please see HWBB paper here**
Cabinet Member (Portfolio Holder) Cllr Dean Carroll, Adult Social Services and Climate Change
Local Member n/a
Appendices **Appendix A BCF Q3 Template**

NHS
Shropshire
Clinical Commissioning Group

Agenda item: Enclosure Number 8
Shropshire CCC

Title of the report:	Refreshed Children and Young Peoples Local Transformation Plan (CYP LTP)
Responsible Director:	Dr Julie Davies, Director of Performance & Delivery
Authors of the report:	Steve Trenchard, STP Programme Director Mental Health
Presenter:	Dr Julie Davies, Director of Performance & Delivery

Purpose of the report:
The purpose of this paper is to inform the Health and Wellbeing Board of progress made in the refreshed Children and Young Peoples Local Transformation Plan (CYP LTP). The plan has been to the clinical quality and commissioning committees of both CCG's for approval and discussion.

Key issues or points to note:

- NHS England (NHSE) requested all health and care systems across England to refresh and submit the CYP LTP in September 2018. The Shropshire. Telford and Wrekin system complied with the request, and feedback on the plan was provided by NHSE against revised key lines of enquiry.

- The plan was further revised taking into account this feedback and this is attached for approval. Feedback specifically asked that:
  - An executive summary be included
  - Glossary be included
  - Renewed financial commitments be added in line with the long term plan
  - Action plans be updated.

- The revised plan will require further work over coming months on:

  - Continue to strengthen partnership arrangements especially with local authority colleagues
  - Confirm ownership of actions (including resource, workforce and sequence)
  - Alignment to other work-streams such trauma and looked after children.

Actions required by Governing Body Members:

The Health and Wellbeing Board are asked to note the contents of this update and approve the refreshed CYP LTP, subject to the action plan being refreshed at a workshop on 15th January 2020.

Does this report and its recommendations have implications and impact with regard to the following:		
1	Additional staffing or financial resource implications	n/a
2	Health inequalities	n/a
3	Human Rights, equality and diversity requirements	n/a
4	Clinical engagement	Yes
	Engagement is required with primary care and GPs and LA colleagues	
5	Patient and public engagement	Yes
	Ongoing engagement is required with patients and the public in relation to the plan, particularly on service redesign and quality improvement.	
6	Risk to financial and clinical sustainability	Yes
	The incidence and prevalence of mental disorders in children and young people is increasing and any failure to provide appropriate early support and treatment may lead to high cost placements in the future.	

NHS Shropshire Health and Wellbeing Board

Update on the 0-25 Emotional Health & Wellbeing Service

Author: Steve Trenchard

Background

1 The Children and Young People's Local Transformation Plan (CYP LTP) has been submitted and assurance given by NHSE (see Appendix 1), with the following caveat on future revisions:

a. The plan needs to strengthen the use of modelling to determine needs
b. The workforce section needs to include Long Term Plan (LTP) ambitions
c. Links to Health and Justice to be strengthened.
d. Consider dashboards at system level to share data
e. Action plan to be reviewed.

2 The 'red' elements within the key lines of enquiry (Appendix 1) have been responded to within the refreshed plan and uploaded to both Shropshire, Telford and Wrekin CCGs Websites.

3 Further work is required across the STP CYP partnership to ensure full engagement with the action plan. This will be completed before the end January 2020 (workshop planned for January 15th) and revisions made to the CYP LTP for uploading to CCG websites for end January 2020.

Summary

4 The CYP LTP sets out a broad scheme of work across the health and care system which will require a consistency of senior leadership to ensure progress is implemented and monitored.

Recommendations

1 The Health and Wellbeing Board is asked to note the contents of this update and support on-going system leadership for effective joined up children's services.

Appendix 1

STW CYP LTP Dec 19.docx

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Shropshire and Telford & Wrekin Transformation Plan for Children and Young People's Mental Health and Wellbeing 2019-2021

A submission from NHS Shropshire Clinical Commissioning Group, Shropshire Council, Telford & Wrekin Council and NHS Telford & Wrekin Clinical Commissioning Group

Contents

1. Executive Summary

The Children and Young People's (CYP) Local Transformation Plan (LTP) sets out the vision for the future of emotional health and wellbeing services for the children living in Shropshire Telford and Wrekin, The plan captures the current levels of need, and the work undertaken in recent years to develop a 0-25 years emotional health and wellbeing service as well as the future improvements that still need to be undertaken.

The process of jointly developing the CYP LTP has helped improve our collective understanding of the strengths across our system, as well as the important and distinct roles of the various statutory and voluntary and community sector colleagues in delivering it. The overall shift has been to move to a greater understanding of the importance of prevention and early intervention. Key to this is improving our system understanding of the impact of adversity on the developing brains of our young people, and of the negative impact of adverse childhood experiences (ACEs) in later life.

At the rear of the document is our action plan which whilst detailed, sets out the important work to be done in making this plan a reality for the future wellbeing of the children and young people living in our communities.

2. Introduction to the plan

2.1 This is the 2019 refreshed joint transformation plan for children and young people's mental health and wellbeing services across Shropshire and Telford & Wrekin. The document begins by setting the scene in relation to what we know about the mental health needs of children and young people in Shropshire and Telford & Wrekin. The plan also explains our current provision and journey since 2015 in improving outcomes for children and young people as well as providing an update on the implementation of our plans for further transformation.

2.2 The document has been developed in line with the aspirations set out within Future in Mind[1] and describes the transformation activities that are planned over the next three years in order to fully meet the requirements of Future in Mind and improve outcomes for local children and young people.

2.3 Locally the i-thrive model has been adapted to capture the full spectrum of services and highlight our ambition to have seamless, joined up services within the timescales of this plan. Set out below the 'step care model' clearly places children, young people and families at the centre of their care and decision making. We have used this model to plan our future improvements which are set out in Section 7 of this plan.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Self-Support	Consultation and Advice/guidance	Getting Help	Getting More Help	Getting Intensive help
Community promotion and prevention	Consultation and advice	Core range of interventions delivered online and face to face	Specialist interventions provided by a multi-disciplinary team	Crisis support and home treatment for children and young people in crisis
Early identification and intervention via community, education, drop in and peer-led interventions,	Consultation regarding presentation of difficulties, advice regarding help and signposting to most appropriate help and intervention	Time limited, goals focussed evidence based interventions in collaboration with children, young people and their families or carers e.g. treatments and interventions for mood and emotional disorders, routine assessments for behavioural presentations, parenting support	Complex care, often intensive and ongoing requiring different Bee U Specialist workers for severe and enduring presentations e.g. treatment for eating disorders, complex trauma, complex neurodevelopment and other complex presentations	Intensive short term packages of interventions for acute, serious and life threatening presentations
Bee U Beam Bee U Kooth	Bee U Specialist	Bee U Healios Bee U Kooth Bee U Specialist	Bee U Specialist	Bee U Specialist
	Integrated Risk Support Working with our most vulnerable children across all agencies e.g. Looked after children, Children in Need, Children with Special Educational Needs, Children who are at risk of or have offended, Children requiring safeguarding			

2.4 The vision is for all children and young people to grow up healthy, happy and safe within supportive families and caring networks. We want them to have the best health, education and opportunities to enable them to reach their full potential. Our main priority is to keep children and young people safe and give them the best start in life.

2.5 We continue to welcome the national focus on this agenda. This refreshed transformation plan has been coproduced by partners to highlight some of the key issues and solutions. It reflects a point in time (September 2019) and will be treated as a working document to usefully guide our collective activities. We will update the plan on a quarterly basis to report back to the Health and Wellbeing Boards of Shropshire and Telford & Wrekin, progress made in relation to the action plan.

3 Leadership and governance

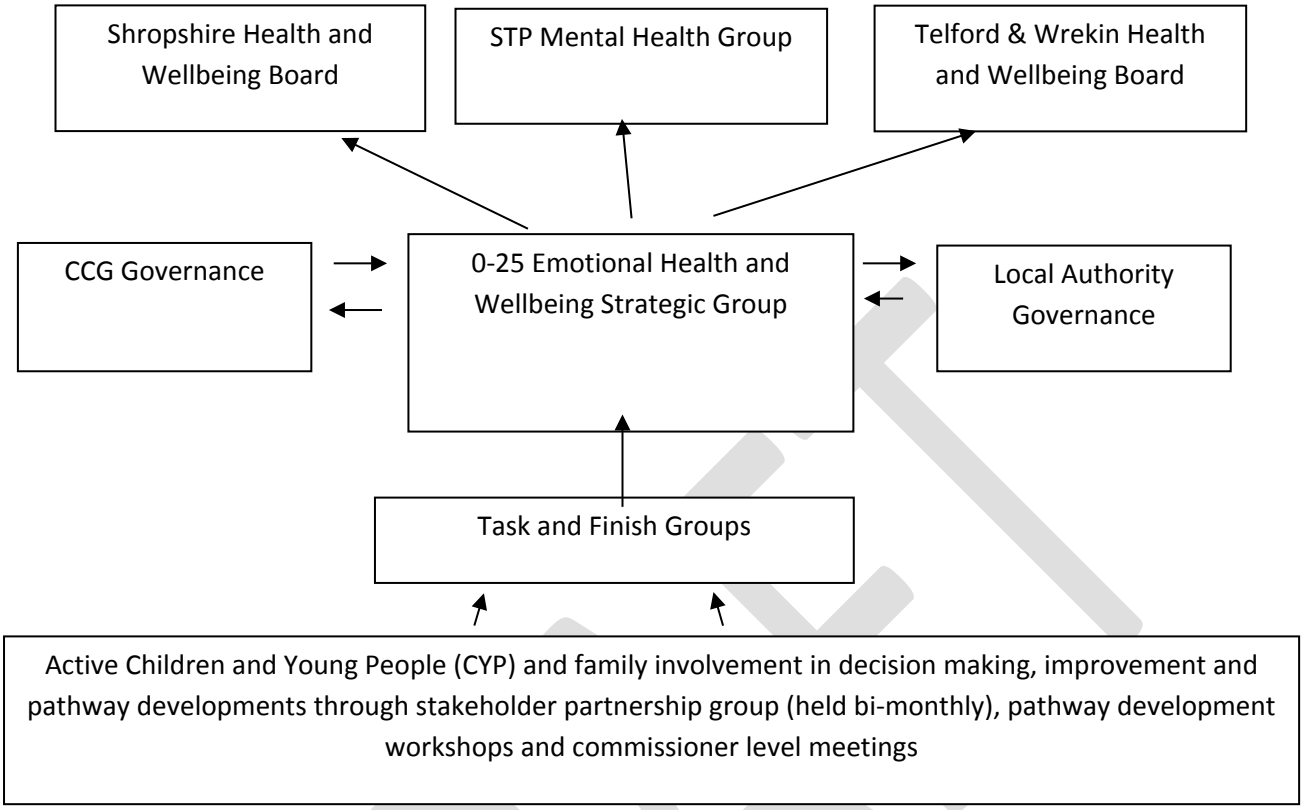
3.1 This plan has been developed collaboratively with partners across health, social care, early help and education. Strategic oversight of the implementation of the plan will be provided by the Shropshire Transformation Partnership (STP) Mental Health Group and the Health and Wellbeing Boards. Delivery of the plan will be driven by the 0-25 Emotional Health and Wellbeing Strategic Group, which is accountable to the local Health and Wellbeing Boards. The plan will be refreshed annually by the 0-25 Emotional Health and Wellbeing Strategic Group. The most up to date version of the plan will be available on the clinical commissioning groups' websites from 30th October 2019. Thereafter, the plan will be refreshed on a quarterly basis to capture and all imminent improvements, and to enable a full detailed review of the sustainability of the action plan, including financial and workforce updates. Workforce developments include new posts for Mental Health in Schools Teams, children's crisis services and Autism Spectrum Disorder pathways.

3.2 The 0-25 Emotional Health and Wellbeing Strategic Group is a recently created group that spans Shropshire and Telford & Wrekin and includes membership from a broad range of partners, including Health Commissioners (Clinical Commissioning Groups (CCGs) and NHS England (currently represented by the West Midlands Strategic Clinical Network and Senate)), Local Authority Commissioners and Providers (Public Health, Social Care, Early Help), Safeguarding (including Police), Child and Adolescent Mental Health Service (CAMHS) Providers, Adult Mental Health Service Providers, Voluntary Sector Services, Education Providers (Primary, Secondary and Further Education), Youth Offending Services and Service Users.

3.3 The group will ensure timely development, delivery and review of the Transformation Plan ensuring that activity is in line with the overarching aims of the group, which are:

- To ensure joined up strategic commissioning across the 'step care model' for children and young people up to the age of 25 years and above where appropriate.
- To ensure that strategic commissioning activity leads to the development and delivery of joint outcomes.
- To develop joined up solutions to any issues across the four tiers of Child and Adolescent Mental Health services and into Adult Mental Health services for children and young people up to the age of 25 years and above where appropriate.
- To ensure that the views of service users and potential service users are taken account of and inform the work of this group.

3.4 Each programme within this plan will have a multi-agency task and finish group, which will be accountable to the 0-25 Emotional Health and Wellbeing Strategic Group. The members of each task and finish group will be responsible for completing the actions required to deliver the relevant programme of work. The diagram below illustrates the governance structure in place for the delivery of the Transformation Plan.



The development of the 0-25 service has been a much-welcomed transformation by the Health and Wellbeing Boards. Members have remained actively involved throughout 2018, receiving feedback and providing challenge (18th January, 7th March 2019). Similarly, presentations have been made to the Health Overview and Scrutiny Committee (24th June 2019 and managers have been praised on the openness and honesty about some of the challenges faced.

In addition to the above Boards there are also various children's and families partnership arrangements across the area where feedback is actively provided and discussions taking place about the future. The key partnership meetings are:

- The Children's Trust Board (Shropshire)
- Children and Families Partnership (Telford)
- The 0-25 partnership/stakeholder forum
- Corporate parenting groups
- Health of looked after children

There are a range of multi-agency groups within the overall governance arrangements which provides children and young people (CYP) and family coproduction, involvement and system level oversight:

- **Health and Wellbeing Boards:** Telford and Wrekin and Shropshire have health and Wellbeing Boards and there purpose is to ensure that the Council and the Clinical

Commissioning Group work effectively together in planning health and social care services to improve health and wellbeing.

- **Health Overview & Scrutiny Committee (HOSC)**; Whilst there are separate HOSC meetings in Shropshire and Telford & Wrekin the two committees have come together previously and will continue to work together to provide senior level oversight on CYP mental health services
- **Safeguarding Children's Board;** Both Telford & Wrekin and Shropshire have Safeguarding Children Boards that provide a representative group of agencies involved in safeguarding children and child protection. The Safeguarding Children Board coordinates and monitors how the services and professional staff work together to protect children from abuse or neglect. The groups are multi-agency including; Local Authority - Children's Safeguarding, Adult Social Care, Public Health, Legal Services, Schools (including primary, secondary, special, academy schools and further education), Health (including the CCGs, Shropshire Community Health NHS Trust, NHS England, Midland Partnership Foundation Trust(MPFT), Shrewsbury and Telford Hospital NHS Trust (SaTH)), police/Youth Offending Service (YOS) as well as partner agencies from Community Members, Housing Association, Voluntary Groups, Faith Groups, Early Years provider and the Lead Governor.
- **Contract arrangements**: There is a dedicated contract and quality meeting for the 0-25 service which is chaired and attended by CCG Directors, the Managing Director for Shropshire Care Group Division of MPFT and the Directors of Kooth, Healios and Children's Society. The meetings cover both quality and performance issues.
- **The 0-25 partnership/stakeholder forum**; This is a forum of local stakeholders which comes together to provide support and challenge to the provider during the change to a radically different service model. It meets bi-monthly and is independently chaired
- **Telford & Wrekin Children and Families Partnership;** Regular assurance reports have been provided to the Telford & Wrekin Children and Families Partnership. This is a multi-agency partnership chaired by the Lead Cabinet Member for Children and Families. The partnership reports to the Health and Wellbeing Board and is responsible for strategic leadership and the oversight of early help and prevention for children and families in Telford & Wrekin.
- **An all age STP Mental Health Cluster:** a system wide stakeholder group that provides overarching leadership on mental health for the whole system.

3.5 Risks to delivery

The delivery of this transformation plan will be managed under the existing CCG and Local Authority governance structure. The above groups in existence within the health and care economy all have an important part to play in ensuring the plan is well communicated and continues to reflect local need and thus be relevant. A risk register of the known and perceived risks to delivery of the plan will be maintained and reviewed by the most appropriate group.

4 What we know about what we need

4.1 The proposals within this plan have been informed by a range of data that has been gathered, and continues to be gathered, over recent years in Shropshire and Telford & Wrekin. Modelling for the new Mental Health Support Teams was undertaken across the STP using data from a range of sources to highlight areas and schools of greatest need and most likely to benefit.

4.2 Stakeholders across Shropshire and Telford & Wrekin work in partnership to ensure commissioners have access to an up-to-date holistic profile of needs. Key local information is used to routinely inform service improvements and design, including data collected as part of the Joint Strategic Needs Assessment (JSNA), public health data, social care data, service provider data including hospital admissions, information and feedback from stakeholders and service users including young health champions. Nationally produced data, including the National Child and Maternal Health Network (CHIMAT) and information from neighbouring and comparator areas is also used by commissioners to inform service design and improvements. A summary of the key data is provided in this section.

4.3 The Office for National Statistics (ONS) estimates that children and young people under the age of 20 years make up 20.8% of the population of Shropshire and 25.2% of the population of Telford & Wrekin.[2]

4.4 8.2% of school children in Shropshire in 2018 are from a minority ethnic group compared to 20.9% in Telford & Wrekin.[3]

4.5 In Shropshire in 2018 1.8% of school children (720 children) had identified social, emotional and mental health needs. This compares with 2.7% of school children (786 children) in Telford & Wrekin for the same period.[4]

What do we know about children & young people's mental health?

- In a typically sized class of 30 children, it is estimated that 3 will have an emotional or mental health need.
- Looked after children and those with disabilities are more likely to have mental health problems than other children.

What do we know about children & young people who need some support?

- Overall the top 5 referrals to Tier 3 CAMHS were for depression, anxiety, anger/aggression, ADHD and Autism/Asperger's respectively. There were differences between referrals for girls and boys, with girls more likely to be referred for depression and anxiety and boys more

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

[3] https://www.gov.uk/government/statistics/schools-pupils-and-their-characteristics-january-2018

[4] https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh

likely for anger/aggression, ADHD and Autism. Girls were less likely to be referred for ADHD and Autism; instead the fourth and fifth most likely reason for referral for girls was deliberate self-harm and self-harming behaviour.

What do we know about children and young people who need specialist treatment?

- Overall there were around 989 children and young people referred to Tier 3 specialist CAMHs in 2014-15.
- There were a similar percentage of referrals to Tier 3 CAMHS services for both boys and girls, but the age distribution between genders varied with significantly more girls referred aged 15-16 (33.2%) and significantly more boys aged 05-09 (37.4%).
- There were significantly more referrals to Tier 3 CAMHS from the most deprived areas (23.8%) compared to the most affluent (16.8%).
- The majority of referrals to Tier 3 CAMHS came from GPs (67.9%).
- The self-harm figures for Shropshire show the rates are higher than the national average for the period 2011/2012 but lower for the period 2013/2014.
- In both Shropshire and Telford & Wrekin the rates of self-harm for children and young people aged 10-24 have been reducing since 2013/14. In 2016/17 the rate in Shropshire (317.4 per 100,000) was lower than the national average (407.1 per 100,000) whilst in Telford & Wrekin the rate (380.0 per 100,000) was statistically similar.
- In Telford & Wrekin children and young people aged 10-24 accounted for 40% of all hospital admissions for self-harm in 2016/17 (123 out of 305 admissions), this compares with 38% of all self-harm hospital admissions in Shropshire (159 out of 415 admissions).
- In both areas the greatest proportion of self-harm admissions for children and young people were amongst those aged 15-19 years. In Telford & Wrekin this age group accounted for 41% of children and young people self-harm admissions and 52% in Shropshire.[5]

What do we know about children and young people requiring in-patient or residential support?

The latest figures for the use of inpatient beds have shown a significant increase over the last few years as shown below. Admissions have risen from April 2017 and there is planned work to review the reasons behind this rise.

Shropshire

Count of Patient ID	Year				
Age	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**Grand Total**
10		1			1
12	2	2	1	1	6
13		2			2
14	2		1	1	4

[5] https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh

15	1	1	5	6	13
16	4	1	4	6	15
17	5	5	3	5	18
Grand Total	**14**	**12**	**14**	**19**	**59**

Telford & Wrekin

Count of Patient ID	**Year**				
Age	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**Grand Total**
13		1	3	2	6
14	3	2	1	1	7
15	3		3	4	10
16	1	2		4	7
17	1	2	1	3	7
Grand Total	**8**	**7**	**8**	**14**	**37**

4.6 In addition to the above baseline data information is collected on referral activity into CYP services on a monthly basis including the presenting needs that CYP access services for. This influences ongoing decisions about the effectiveness and responsiveness of the services to meeting local needs. For example, the rise in the use of Tier 4 beds will be a core element of the 2019-2021 action plan.

4.7 The views of children, young people and their families as well as professionals have been gathered through questionnaires, focus groups, telephone audits and face to face interviews. Professionals consulted through these activities include workers in local authority, health, education, police, youth offending service and the voluntary sector. The earliest information used for this plan is information gathered as part of the Shropshire CAMHS review in 2011 during which the views of 111 people were gathered. The information referenced for this plan relates to activities that took place since 2014 and includes the following:

- 2014/15 Review of Shropshire CAMHS (telephone audit with GPs, Case File audit, young person's focus group, face to face interviews with professionals, written feedback from professionals)
- 2014 Targeted Mental Health Support (TaMHS) 'visioning day' (multi-agency workshop involving 19 organisations involved in supporting children and young people's emotional and mental health across Shropshire)
- 2014 CAMHS Parent/Carer Forum feedback (three workshops with parent/carers and the two parent carer organisations)
- 2015 Feedback from schools to Shropshire Safeguarding Children Board in relation to CAMHS
- 2015 Shropshire Autism Needs Assessment
- 2015 Focus groups with Young Health Champions
- 2016 - Midlands & Lancashire Commissioning Support Unit (CSU) held Active Participation events with children, young people, families and professionals to gather feedback on the current service and to identify the needs for the future
- 2016 – Healthwatch undertook a mental health survey about CYP mental health services.
- 2016 – 5 young people were involved in the tender panel for the commissioning of the now BeeU service
- 2017/18 workshops to develop service pathways for ADHD / ASD and Neurodevelopmental engaged parents and carers
- 2018 - NHS Improvement (NHSI) Intensive Support Team Report (September 2018) following a 'deep dive' in June 2018
- Ongoing engagement with CYP and family engagement groups providing feedback on services they receive
- Stakeholder partnership Board meetings which are independently chaired

4.8 The detail from each of the needs analysis has been analysed and summarised into key themes in the table below:

Key Theme	Feedback on improvements required
Access	- Waiting times for assessment and intervention are too long, particularly in relation to neurodevelopment assessment - Referral process for GPs needs to be more effective - Insufficient out of hours provision - Professionals unclear about the range of services available and how to access them - Distance/time to travel to access services can be difficult from more rural areas - Access into the service for previous service users needs to be quicker
Fragmented Provision	- Transition into adult services is inconsistent - Flow between tiers of services needs to be smoother - Transition for young people leaving care is difficult - Schools feel there is too much expectation for them to deliver mental health support - Lack of psychological therapy within current service model including for example help for CYP with sexually harmful behaviour

Lack of crisis support	- Insufficient out of hours support - Need for immediate response to prevent crisis and hospital admission - Incidence of self-harm continues to rise - Need increase in specialist crisis support to prevent Tier 4 admissions
Inconsistency of support	- Varied availability of support and provision within universal services - Frequent changes of staffing and recruitment issues impact negatively on care pathway and service user outcomes - Schools staff don't feel they have the skills to offer the support pupils need
Poor communication/information sharing	- Communication between professionals needs to be improved - Information provided within referrals needs to be strengthened - Information for children, young people and their families in relation to the plan of support needs to be strengthened - Poor information sharing and communication makes referral pathways longer and more confusing for service users

4.9 **What young people say is important to them**

The Councils and CCGs have collected some rich information from the local population. This has been in relation to current services as well as about their aspirations for change. These messages have been gathered from a variety of sources including general engagement activities with a range of stakeholders, community/representative groups, scrutiny committees and complaints. In addition, in order to progress the agenda further, the organisations have been working with their young health champions to better understand the outcomes they would hope to achieve from mental health services for children and young people.

4.10 The outcomes identified by young health champions have directly informed the programme of transformation described in this plan. The changes young people have told us they want to see are:

- More children and young people to be ***noticed*** earlier when mental health issues develop. This includes effective early help which may prevent problems escalating.

- Improved ***access*** to services in schools, colleges, CAMHS. Providing more venues at which services can be accessed e.g. drop in sessions and enabling quicker accessibility through out of hours provision.

- Improved ***availability*** and ease of access to emotional health and wellbeing support e.g. anxiety, body image, self-esteem, stress.

- Increased choice through a range of ***methods*** including; face:face, skype, telephone "*the more options the better".*

- More children and young people to be ***supported*** to maintain good emotional wellbeing, with appropriate services available, including school provision.

- More efficient care pathways including care co-ordination for ***vulnerable groups*** of children and young people. More efficient and quicker access to support, especially crisis care across all domains of the stepped care model.

- More efficient care pathways for young people in ***transition*** to mental health support beyond 16 years.

- Reduced ***distress*** as a consequence of interventions.

4.11 **Current service provision and financial forecast**

The goal of the original Local Transformation Plans (LTP) in 2016 was to recommission the more specialised mental health provision for children and young people in Shropshire and Telford & Wrekin which has resulted in the provision offered by the BeeU Service. This is a newly commissioned integrated partnership approach.

In addition to the impact that poor emotional wellbeing and mental health has on the prospects of individuals achieving their full potential and the impact on those who care for them there is, of course, a financial cost to emotional wellbeing and mental health to services if left untreated.

The costs incurred to the public purse of not treating children and young people early in their lives are considerable. For example:

- Mental health problems in children and young people are associated with excess costs estimated at between £11,030 and £59,130 annually per child. These costs fall to a variety of agencies (e.g. education, social services and youth justice).
- There are clinically proven and cost-effective interventions. Taking conduct disorder as an example; potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems.

Within this context it is worthwhile taking stock of our current and projected spends on supporting and treating children and young people's mental health problems. A summary of the key services commissioned is provided in Table 1 below. It can be that there is an overall planned uplift to support the emotional health and wellbeing Bee U service of £1.1.m to 2021.

Table 1. Baseline and subsequent Annual Budget for the new Employee Health & Wellness Services (EHWS)

Commissioner	*Baseline (2015/16)*	Year 1 (2017/18)	Year 2 (2018/19)	Year 3 (2019/20)	Year 4 (2020/21)	Year 5 (2021/22)
NHS Telford & Wrekin CCG	*£1,411,812*	£2,116,590	£2,132,977	£2,149,233	£2,165,353	£2,181,992
NHS Shropshire CCG	*£2,597,000*	£2,812,800	£2,843,488	£2,874,457	£2,905,724	£2,936,704
Telford & Wrekin Borough Council	*£125,000*	£125,000	£124,972	£124,884	£124,736	£124,497
Shropshire County Council	*£200,000*	£200,000	£199,954	£199,815	£199,577	£199,196
Total	***£4,333,812***	**£5,254,390**	**£5,301,390**	**£5,348,390**	**£5,395,390**	**£5,442,388**
Increase from Baseline (%)		*21%*	*22%*	*23%*	*24%*	*26%*

In the table above, the contract value is clearly defined for each of the five years, together with the contributions of the partner organisations. A percentage of the contract will be aligned to the achievement of outcome measures thus ensuring the delivery of expected benefits.

In addition to the above contract value for the 0-25 emotional health and wellbeing service (Bee U) there are other costs associated with providing services for CYP such as:

- Looked After Children
- Early help (including Calm Brains, Baby Yoga, and Teenage Yoga)
- Targeted Prevention (universal services and school nurses)
- Specialist social work provision
- Complex residential care
- Targeted support for sexually harmful behaviour (Telford & Wrekin Council - £18k to date in 2018/19).
- Special Education Needs

At the present time the total system expenditure on all aspects of CYP referred to in this plan is not available. This includes schools, public health, looked after children, transforming care partnerships, primary care, prescribing, specialist commissioning for Tier 4 beds, acute hospital spend and residential complex care placements. We intend to capture this additional spend for future iterations of the LTP.

Additional in year investment has been identified for training the workforce - £22k including a focus on trauma and Adverse Childhood Experiences (ACEs).

The new perinatal services have been funded through national funding and both CCGs will continue to fund this recurrently.

Early Intervention in Psychosis Services are also being funded recurrently with year on year increases in line with the 5 Year Forward View for Mental Health.

Shropshire and Telford & Wrekin Mental Health provision for Children and Young People aged 0-25		
0-16 Years of Age	**16-18 Years of Age**	**18-25 Years of Age**
There are a number of training programmes available through TaMHS which comes under the TaMHS programme. e.g. Mental Health First Aid (MHFA), managing emotions, Reach for the Top, self-harm toolkit		
CAMHS Tier 2 (Targeted) Provider: Midlands Partnership NHS Foundation Trust (Joint commissioned by CCGs & Local Authorities)		
CAMHS Learning Disability Provider: Midlands Partnership NHS Foundation Trust		
CAMHS Tier 3-3.5 (Specialist) Provider: Midlands Partnership NHS Foundation Trust		
	Early Intervention in Psychosis (14-35) Provider: Midlands Partnership NHS Foundation Trust (MPFT)	
	Crisis Resolution, Home Treatment Services (16-65), Improving Access to Psychological Therapies (16+), Criminal Justice Liaison (16-65), Primary Care Counselling Service (16+), Rapid Assessment, Interface and Discharge Liaison Service (16+), Secondary Care Psychological Therapy Service (16+ N.B. if in full time education, Bee U will be service provider), **Mental Health Obstetric Liaison Clinic (Perinatal Mental Health), Eating Disorder Service (17+**) Provider: Midlands Partnership NHS Foundation Trust (MPFT)	
	Children's Centres, Purchasing from Non Accommodation Service Framework for therapy, early help offer (troubled families) , **Looked After Children (LAC) & YOS workers** Provider: Telford & Wrekin Council	
	LAC, Early help hubs, TaMHS training programmes for professionals working with CYP, Public Health Nursing service, Parenting programmes, Early Help/Strengthening Families, Introduction Teen and Baby Yoga sessions for identified groups, schools link programme. Provider: Shropshire Council	
		Community Mental Health Teams (18+), voluntary sector crisis care (Sanctuary and The Bridge), Provider: MPFT and Voluntary Sector
		Acute in-patient services (18+) Provider: MPFT

The aspiration described in the original plan was to commission a new innovative 0-25 service as the delivery mechanism to achieve the transformation. Over the last two years, following a successful commissioning process, the prime provider for this service (Midlands Partnership NHS Foundation Trust) have worked within a partnership arrangement with Kooth, Healios and Children's Society to deliver the specification.

During this time there have been demonstrable improvements particularly around the offer of early help. The introduction of Kooth has meant children and young people have had access to a range of materials and counselling through their phone or computer. The Children's Society have introduced drop in centres which have been used by hundreds of children and they have succeeded in training multiple volunteers. Healios has provided an innovative online approach to psychological support, which has meant children and young people have been able to receive therapies virtually in their own homes. In addition, pathways for diagnosis of autism, 'looked after children' and learning disabilities have been developed with service users.

The new provider 'inherited' a range of complex issues. These were centred around a very outdated medical model of care and extremely poor information systems and processes. In order to address these issues, the provider embarked on a significant programme of redesign. So far it has undertaken a complete management of change which has improved clinical and managerial supervision; introduced a new clinical IT system; developed robust processes to enhance governance and introduced new evidence-based pathways. This has increased the range of therapeutic options to improve outcomes for children and young people. Despite these successes there continue to be a number of problems where more work is required.

In order to help, in June 2018 the 'Intensive Support Team' from NHSI were invited to the area to assess the current service and support the development of a new recovery action plan. The main themes of the action plan have been translated into six project proposals:

1. **System wide governance**: Including the introduction of an all age mental health partnership board, the development of a mental health delivery plan and enhanced monitoring of the refreshed LTP.
2. **Service Identity**: Development of single coherent brand for the 0-25 service which includes a clear description of the service offer.
3. **Evidence pathway development**: Utilising the 'Thrive' pathways and language, development of outcome measures and introducing the trusted assessor model within and across the service.
4. **Workforce plan**: Describing the staff required both medium and long term and the training and development required for that workforce.
5. **Data and business processes:** This will include robust data flows to meet access and outcome targets.
6. **Existing case load**: Children referred to the service prior to the redesign have received a more medicalised model of care. Providers and commissioners are considering how the care for this cohort of children can be translated to a more therapeutic model.

4.12 The staffing levels within the current 0-25 Health & Wellbeing Service in October 2018 are illustrated in the table below.

Management		
General manager	1	8B
Operational Lead	3	B7
Access		
Clinical Nurse Specialist	1	B7
Mental Health Practitioner	5.1	B6
Occupational Therapist	1	B6
Crisis		
Clinical Nurse Specialist	1	B7
Mental Health Practitioner	6	B6
Eating Disorders		
Clinical Nurse Specialist	1	B7
Mental Health Practitioner	2	B6
Family Therapist	1	B8a
Learning Disability		
Psychologist	2.8	B7, B8a, B8b
Clinical Nurse Specialist	2	B7
Mental Health Practitioner	1.6	B6
Behavioural Specialist	1.6	B4
Support Worker	1	B3
Looked After Children		
Mental Health Practitioner	1.8	B6
Youth Justice		
Mental Health Practitioner	1.8	B6
0-5		
Psychologist	0.5	B8b
Mental Health Practitioner	1	B6
Core/Complex (inc. Neurodevelopment)		
Psychologist	1.9	B8c, B8a
Clinical Nurse Specialist	2.91	B7
Cognitive Behavioural Therapist	0.6	B7
Snr Mental Health Practitioner	0.8	B7
Family Therapist	1	B7
Art Therapist	0.8	B7
Snr Speech and Language Therapist	0.5	B7
Snr Occupational Therapist	1.2	B7
Speech and Language Therapist	1	B6
Mental Health Practitioner	5.3	B6
Other		
Consultant psychiatrist	7	
Staff within 0 – 19 service Shropshire Council Early Health Service		
Public Health Nurses supporting 5 – 19 element of PHNS	7.83	Band 6
Nurses supporting 5 – 19 element PHNS	6.33	Band 5
Public health Nurses 0 – 5	30.63	Band 6
County wide posts (specialities SEND/emotional health and well being/	3	B6
Support Staff	9.63 2.72 2.07	B 3 support Workers B3 Youth support workers B2 Screeners

	3.82	B2 team and compass Admin support

4.13 In addition to the above, there are 6.56 FTE Senior Mental Health Practitioners working across the County at Tier 2. In the coming year we plan to be able to demonstrate the total number of people working across all services.

4.14 A skill mix audit of existing staff will be undertaken to highlights the wide range of skills and experience within the team including nurses, social workers, primary mental health workers, family therapists, psychotherapists. The range of skills and specialisms will likely include Cognitive Behavioural Therapy (CBT), eating disorders, youth offending, mindfulness, developmental, dimensional and diagnostic Interview (3di), deliberate self-harm, psychosis, autism, looked after children.

4.15 In 2018/19 the new BeeU service has demonstrated its ability to provide greater access in earlier interventions. However we recognise that in relation to the detail below more work is required to improve equity of access across the whole of the county:

- On line support self-referral (Kooth) - on average 300 CYP register each month
- Drop in (The Children's Society) – over 500 CYP and over 400 parent/carers attended the service in first quarter of 2018/19
- On line therapy (Healios) – a service providing psychological therapies delivered by NICE compliant practitioners is available between 8am-9pm 7 days a week and received 30-40 referrals per month.

4.16 In 2014/15, 9,050 young people up to the age of 25 years accessed adult mental health services in Shropshire, with 6,555 young people from Telford & Wrekin also accessing adult mental health services. We will continue to review our access rates to understand local areas of need and to ensure services are being accessed by areas known to experience highest need.

4.17 **Placed Based Integrated Teams and Pathways**

A previous local Transition Commissioning for Quality and Innovation (CQUIN) identified many of the issues which were considered in the procurement of the BeeU 0-25 service. One of the guiding principles for all organisations was to reduce the number of transition points for service users and minimise the problems associated with any remaining transitions. This has been tackled in a number of ways, some of which are highlighted below:

- Extension of the upper age limit for children and young people emotional health and mental wellbeing services to 25 years through the commissioning of the new service
- Teams working together to develop joint pathways/processes to support individuals through those transitions
- Joint commissioning between the Councils and CCGs
- Telford & Wrekin Council together with partners have produced a specific transition policy
- A key project within the provider is to ensure the transition from 0-25 to adult service is smooth.

In line with the wider aspiration across health and social care to support localised care wrapped around individuals in their communities the LTP supports the emerging plans to have integrated teams where care and support feels seamless, and more integrated for those receiving it. At the present time, these local place based plans are still being planned, and more detail will be expected in future iterations of the CYP LTP.

5 Our journey so far

5.1 Commissioners and providers across Shropshire and Telford & Wrekin have been working together to improve child and adolescent mental health services across the area. Whilst Shropshire and Telford & Wrekin have different geographies and demographics, the areas form part of the same county and share the same Acute Hospitals and Community Health providers. The original programme of transformation agreed in 2015 was designed to respond to the needs identified locally, as described in section 3.

5.2 The original programmes of transformation identified where as follows:

- Programme 1 - 0-25 Emotional Health & Wellbeing Service
- Programme 2 - Redesign of neurodevelopmental pathways
- Programme 3 - Development programme for workers in universal services
- Programme 4 - Eating Disorder Services
- Programme 5 - All age psychiatric liaison service
- Programme 6 - Improve perinatal support

5.3 Once the new BeeU service had been commissioned to a new provider MPFT within a partnership approach (with Kooth, Children's Society and Helios) the majority of work since April 2017 has focussed on the mobilisation of the new model. This work proved to be more difficult than envisaged for MPFT with a large legacy caseload of CYP being identified who had were not on the correct pathways. There were also concerns about the length of waiting times and the speed which pathways were being developed

5.4 Also during this period the implementation plan for the 5 Year Forward View for Mental Health (5YFVMH) was published nationally which set out very clear expectations for CCG's and Providers. Additionally the NHS Long Term Plan has made clear comitments to strengthening childrens services including maintaining the access rate and developing crisis 24hour 7day week services. On the basis of these two developments the LTP has been refreshed to reflect the position and the STP vision across Shropshire and Telford & Wrekin at this point in time.

5.5 As part of engagement in the planning of the 0-25 service; children and young people along with other local stakeholders developed the following outcome measures which we aspire to see across the whole LTP;

Table 3. Service outcome measures

Element of Model	Outcome
Early Identification	Professionals and others who know me notice when I need help and offer me advice and support when they think I need it.
	I get the support I need when I ask for help and it makes me feel better.
Targeted Prevention	People understand me and my situation and provide me with the support I need to manage/improve my emotional health.
	I know that people are looking out for me and will provide me with the support I need even if I don't ask for help.
Treatment	I am given a choice about the treatment/support I receive.
Stabilise and step down	Once I have completed my support, I am confident in my plan of recovery and what to do if things go wrong.
Crisis Resolution	I feel supported during times of crisis.
Quality Assessment and Practice	I don't have to tell my story more than I need to. My experience is well understood, and information is shared with those who need it.
	I understand about the support I'm receiving and what it aims to achieve.
	The support I receive enables me to achieve my goals.
	The support I receive enables me to better manage my emotional health and wellbeing by myself.
Access	I get support when I need it.
	I am given a choice about how, where and when I receive the support/treatment I need.
	I can access support in places I often go and feel comfortable with.
	Me, my family and the professionals who know me, know how to make the first point of contact to get information and advice around emotional health and wellbeing for children and young people.
	I have access to information, tools and techniques to improve/manage my own emotional wellbeing.
Universal Services	Those working with children and young people feel confident and able to promote emotional health and wellbeing.
	Those working with children and young people are able to identify needs around emotional health and wellbeing.
	Those working with children and young people have the skills and the tools to provide support where appropriate.
Child, young person and family centred	My parents, family and network feel supported.

5.6 As described in the original LTP, a particular issue for Shropshire and Telford & Wrekin has been the time children and young people have had to wait to access the assessments and

support they need. Through a close working relationship between commissioners and the provider, processes have been improved and capacity increased which have resulted in a significant improvement in waiting times. Waiting times are closely monitored in contract meetings. There are currently no CYP waiting more than 18 weeks to be seen by any of fthe mental health support services.

5.7 **Meeting the needs of disabled children and young people, including those with a learning disability, or autism.**

5.7.1 Across the LTP there are specific pathways to support these vulnerable groups. For example, there is a dedicated learning disability team and a pathway for diagnosis of autism. The specialist pathways seek to support these young people based on use of best practice guidelines. CYP with special education needs (SEND) are targeted by local authority colleagues.

5.7.2 Management and supervision arrangements for staff are in place to support them to be effective when engaging with young people and their families and all care plans are tailored to the needs of the individual. Working across the delivery partners is ongoing to share knowledge, skills and experience in a range of interventions. The links with the local authority are being strengthened particularly in education. There are strong services in place to support ongoing work around Transforming Care Partnerships (TCP) and work underway to ensure the approach across the two areas is coherent and the learning is shared.

5.7.3 Both CCGs and Local Authorities recognise that the current work programme (TCP) comes to an end in 2019 and that there needs to be plans developed to continue to meet the ongoing support needs of people with learning disabilities (including those with co-existent mental health conditions) through the development local pathways linked to the emerging neighbourhood and locality teams.

5.7.4 Both CCGs recognise the long wait for CYP to get assessments for autism. A model has been developed in partnership with the commissioners, providers, educational settings and the local authority to reduce the wait for diagnosis and getting the right help at the right time. Both CCGs are increasing their baselines to manage the backlog for assessments and improve future waiting time for diagnosis and support for CYP needing an assessment.

5.8 **Early help provision**

The CCGs are building on existing strong relationships with both Local Authorities to complement early help provision.

Telford & Wrekin Early Help Provision

5.8.1 Future in Mind Telford & Wrekin is a joint project between Public Health and all key stakeholders involved in supporting the Emotional Health and Wellbeing (EHWB) of children and young people living in Telford & Wrekin. The Severn Teaching Alliance delivers the programme. It is a multi-agency approach to early identification and support for emotional health and wellbeing.

4.8.2 Each organisation nominates an EHWB Lead who attends the termly Continuing Professional Development (CPD) and networking. CPD is based on an aspect of EHWB identified as a key aspect within Telford & Wrekin. Leads deliver the CPD in their own setting using the resources which are provided and work with staff to complete the gap task, of which the outcomes are shared at the termly network meeting. All professionals work together to support a young person with EHWB needs with the same intervention.

4.8.3 There are numerous Service Level Agreements in place. Partners include:

- Behaviour Support Services
- Early Help and Support Practitioners
- Educational Psychologists
- GPs
- Health Visitors
- Learning Support Advisory Teachers
- Schools and Colleges (Mainstream and Special)
- Alternative provision for hard to reach students
- School Nurses
- Early Years – Private and Voluntary Sector
- Private and Voluntary Sector Practitioners
- Foster Carers
- Social Care

4.8.4 Feedback about CPD and networking has been positive. A survey completed in June 2017 showed 96% of leads feel supported in their role; 92% have been able to disseminate the CPD; 83 % have used the toolkit and 80% have identified a child/children with EHWB needs and have been able to put in support.

4.8.5 CPD topics cover local and national needs which have been identified using information from the 0-25 years' service alongside the School Watch Survey completed in summer 2016. CPD and network sessions are a useful opportunity for Leads to share information about the EHWB needs young people have on a day to day basis. Topics include:

- Understanding Mental Health and Wellbeing
- Developing Assessment for Wellbeing
- Understanding Attachment and Trauma
- Children and Young People diagnosed with Autism: Management and Support Issues
- Children and Young People diagnosed with ADHD: Management and Support Issues
- Understanding stress, depression and anxiety
- Managing Anger
- Understanding Self-harm
- Mindfulness
- Eating disorders
- Grief and loss
- Self-harm
- Healthy relationships

- Helping ourselves to wellbeing

4.8.6 These are covered through the topics: identifying mental health issues, dealing with loss, grief and separation, online safety and the impact on EHWB, Eating disorders, lesbian, gay, bisexual, and transgender (LGBT), healthy living and relationship and sex education (RSE).

4.8.7 The programme is based on research emerging related to children and young people's mental health; resiliency wheel – based on Henderson and Milstein's model; the Emotional Health Toolkit by Dr Tina Rae; a whole school approach philosophy as set out by MHFA (2016) and local data relating to the needs of children and young people living in Telford & Wrekin. Telford & Wrekin council have recently supported all Schools via the Severn Teaching alliance to sign up to the Anna Freud model.

4.8.8 The aim is consistency of provision in every setting:

- A shared definition of mental health
- The ability to train and educate the school and partner workforce
- Have a good understanding of the value of inter-agency working and the benefits this brings to the child, family and society
- The ability to promote good mental wellbeing and resilience, by supporting children and young people and their families to adopt and maintain behaviours that support good mental health
- Taking early action to prevent mental health problems from arising with those children, young people and their families who may be at greater risk
- The skills to identify swiftly that a child, young person or their family need early help
- Evidence of how this programme is contributing to early help provision and early identification within universal settings (including school, community and primary care)
- Include any innovation to share as best practice (in particular anything related to social media and use of apps)
- Improved understanding of the long term impact of Adverse Childhood Experiences (ACEs) and moving all services to become more trauma informed.

Shropshire Early Help Provision

4.8.9 Early help means taking action to support a child, young person or their family as soon as a problem emerges. It can be required at any stage in a child's life, from pre-birth to adulthood, and applies to any problem or need that the family can't deal with alone.

4.8.10 Shropshire Council has a range of professionals providing targeted Early Help support to families. Central to this is the creation a family webstar, assessing the needs of the whole family, and the multi-agency family plan (managed by a lead professional) which identifies the interventions required to support the family to make the changes they need to ensure children have a safe, happy and healthy family life.

4.8.11 There are six key concerns on which we base our work:

- Crime and Anti-Social Behaviour
- Children Attending School regularly
- Children who Need Help
- Worklessness/Financial Exclusion
- Domestic Violence and/or Abuse
- Health Problems (mental health being one of the 3 main priorities)

4.8.12 In addressing all these concerns, this approach increases the resilience of families to provide a secure and safe environment, supporting the development of emotionally secure young people.

4.8.13 Developing better emotional resilience is an important element of the work across the service. Practitioners from Targeted Youth Support (TYS), Early Help Family Support Workers and colleagues from EnHance, a commissioned targeted Early Help service, develop multi-agency family plans to ensure the needs of all family members are met. A great deal of the work revolves around the emotional wellbeing of young people, this includes:

- Supporting young people to understand their emotions, to manage their anxieties and fears
- Helping young people understand the links between their thoughts, feelings and behaviours
- Supporting families to find more positive ways for young people to get their emotional needs met
- Supporting parents to access the emotional wellbeing support they require, so they are better placed to support their children.

4.8.14 Lifelines supports young people with their unresolved grief after the death of a family member, friend or anyone else significant to them.

4.8.15 The Solihull parenting programme provides courses and clinics called ‘Understanding Your Child’. The aim of which is to give parents the opportunity to reflect on their parenting and their own experience of being parented and the links to their child’s emotional, social and behavioural development.

4.8.16 School staff across the county have been trained to deliver this on a more universal basis, whilst Parenting Practitioners deliver the programme for more targeted groups. Clinics are offered as an open access opportunity and attract parents with universal needs, through to families being supported on Child Protection plans.

4.8.17 Strengthening Families is Shropshire’s response to the governments Troubled Families’ initiative. Strengthening Families is leading the transformation of Early Help services by promoting stronger, more co-ordinated, full family working multi-agency working. This includes working in partnership with schools to enrich the early help workforce by jointly funding and supervising Family Support workers based in school clusters and academies across the county.

4.8.18 Autism West Midlands is commissioned by Early Help, developing the family's capacity to parent young people on the autistic spectrum and enabling professionals to support the young people to manage their own emotional wellbeing

4.8.19 Carers Trust for All are commissioned to support young carers with time away from their caring roles, providing a space where other people understand the emotional pressure this can bring.

4.8.20 TaMHS - Supporting schools, professionals and volunteers to promote children's emotional health and wellbeing and developing resilience is the core aim of the TaMHS programme, which started as a pilot programme in 2009. It uses a universal population-based approach and some targeted intervention support for children and young people.

EnHance

4.8.21 EnHance is an early help provision commissioned by Shropshire Council to provide early help interventions for children, young people and their families when their needs cannot be met by routine universal services, but they do not meet the threshold for a specialist service such as Children's Social Care or CAMHS. YSS Ltd are the lead organisation.

4.8.22 EnHance has been developed to fully integrate into the overall Shropshire early help offer and aims to provide a flexible service, using a variety of interventions, to build resilience in children, young people aged 0 -19 and their families. The service offers a wide range of targeted and focused interventions that can be measured in terms of effectiveness, impact and outcomes.

4.8.23 Most support is delivered on a one to one basis in the local community (including home visits), at flexible times, to meet identified needs. The work is carried out by keyworkers supported by trained volunteers. Group work and other methods of service delivery are also available where appropriate.

4.9 Meeting needs through evidenced – based routine care

4.9.1 The Bee U service has adopted the THRIVE model which promotes a whole system approach and recognises the importance of friends and family in contributing to the longer-term routine care of children with high levels of need via a stepped care model.

- Coping: Self-help – Kooth and The Children's Society
- Getting help: Kooth, The Children's Society and brief interventions delivered by MPFT
- Getting more help: Specialist pathway – core mental health service, learning disabilities, ASD, ADHD, Healios and children's eating disorders
- Getting risk support: - Crisis home treatment and Tier

5.9.2 The BeeU service will be delivering CYP IAPT (Improving Access to Psychological Therapies) interventions which includes the use of evidence based therapies and outcome measures. The services utilises best practice guidelines when working with young people.

5.9.3 Across the LTP a person-centred approach will be embedded in all commissioned services, and active participation of the child or young person and anyone in their friendship group or family who they feel would be helpful in aiding their sustainability and recovery.

5.10 **Meeting needs of CYP requiring crisis care and intensive interventions**

5.10.1 Accessing enhanced crisis care is central to meeting the needs of CYP and their families at times of great distress or when a crisis occurs. The requirement for crisis care can be across the stepped care model and will require all services to have a shared understanding of need and the appropriate response.

5.10.2 In line with the NHS Long Term Plan crisis pathways will continue to be reviewed to enable the service to better respond to young people in crisis and ensure effective working with partners across the local health and social care economy on ways to move more upstream with this support.

5.10.3 We are especially mindful; of the needs of LAC who require crisis care and who are placed in county. Ensuring joined up communication and comprehensive assessments will help tailor care to meet their needs. Telford experiences a high rate of LAC from out of county and historically ensuring access to the right level of care this has been problematic.

5.11 **Meeting needs of CYP through a holistic and trauma informed approach (where there is evidence of adverse childhood experiences and for recognised vulnerable groups)**

5.11.1 Specialist pathways are under development for these groups and will address their needs with appropriately trained staff aligned to these pathways to foster effective links with external agencies also working with these young people.

5.11.2 The LTP recognises the particular vulnerabilities of a number of children including those in care, those who have been abused, those living with domestic violence, those permanently excluded from school or at high risk of permanent exclusion, and those at risk of exploitation and sexually harmful behaviour as well as children entering the justice system.

5.11.3 Partners are working with the voluntary and community sector to meet needs across the windscreen for targeted groups. Services are working together in partnership (in the youth offending teams, the local authority, designated nurses for child protection, social workers and others) to ensure that we have a clear focus on these children and ensure they are prioritised for services when they need them. The LTP has a strong voluntary sector with the skills to engage CYP in ways that complement the statutory sector.

5.11.4 The LTP workforce plan (2019/20) will target training to increase the knowledge and skills regarding the impact of ACE and trauma informed care for all those working with CYP.

5.12 Meeting needs of CYP through in-patient care

5.12.1 Children and young people are not admitted to inpatient care unless absolutely necessary and if they are admitted every effort is made to ensure that services work together to provide a safe and secure place at home or in their local community for return as soon as possible. The child or young person and identified friends and family will be active in care planning and support.

5.12.2 Both CCGs in the STP area are dedicated to a reduction in the inappropriate use of inpatient beds and out of area placements. A project is underway to better understand the use of tier 4 beds and to develop alternatives to CYP entering this pathway. The newly introduced 'at risk of admission' register will help to prevent admissions on an individual level and also provide a greater level of information to develop alternatives for the future.

5.12.3 The clinical lead of MPFT has been involved in regional and national discussions regarding new models of inpatient care and opportunities to develop local solutions.

5.12.4 The LTP requires a broader focus on the wider health and social care economies responsibility with regards to stabilising and improving emotional health and wellbeing across the stepped care model. For example, Health Visitors, Diabetes Nurses, Occupational Health Nurses and Speech and Language Therapists all need to be mental health aware and trauma informed.

5.13 Meeting needs of CYP with learning disabilities or forensic CAMHS

There is a dedicated team within the 0-25 service who work with young people with mental health needs and a learning disability. They provide a range of interventions and where possible deliver in clinics in special school settings to minimise disruption to the school day and provide an appropriate setting for the young people. One of the challenges is to ensure this group of young people and their families have access to appropriate early intervention tools suitable for their needs (e.g. those equivalent to Kooth).

Links have also been made with the new regional specialist community forensic CAMHS which was introduced early in 2018.

5.14 Eating Disorders

The LTP area is currently meeting national targets and NHS Shropshire and NHS Telford & Wrekin CCGs are partners in an eating disorders cluster across Staffordshire and the West Midlands

A full specification has been produced through collaboration between the provider (MPFT) and commissioners. The service delivers an initial assessment which includes consideration of any coexisting mental and physical health problems, strengths and resilience capacity and level of motivation. Treatment options are in line with NICE guidance including CBT, family interventions, guided self-help and pharmacological interventions.

Where there are coexisting mental health problems and the eating disorder is the primary representing problem, the service will also manage common coexisting problems such as anxiety and depression. Otherwise the management will be shared between this and 0-25 services. As well as the assessment and treatment service, the team also includes a strong multi agency liaison/education component providing guidance to primary care, school nurses, social care services, schools and secondary care.

4.15.1 Whilst progress has been made against many of the areas of need outlined in section 3, commissioners, as part of this refresh, have identified that the following remain of particular importance to stakeholders:

- To increase the range of support in schools.

- To facilitate parents/carers to have an increased understanding of emotional wellbeing, resilience, neuro developmental issues, impact of emotional trauma and mental health issues. This means parents/carers will be better able to support their children with new strategies they have developed. This could through peer support or through networks of support to help enhance parenting styles.
- More emphasis on the 'specific consideration and populations of interest' described in the 0-25 service specification. Particularly children with special educational needs, looked after children, children in need, LGBT, child sexual exploitation (CSE), youth justice and those who are home educated. An additional emerging issue is for those children who are under significant pressures to achieve and at greater risk of developing an eating disorder.
- A greater range of community support to help families once children and young people have been discharged from specialist services.
- Whilst there has already been some progress in the development of the crisis pathway momentum needs to be maintained in this area to ensure there are alternative local options to admission to Tier 4 and that every effort is being made to reduce the need for secure residential placements.
- Greater consideration around the links between physical and mental health enhancing care for children in both settings.

4.16 The new BeeU service aims to be seamless from targeted (including support and training to universal services to deliver effective early help) to specialist and crisis support. Young Health Champions locally have developed a set of outcomes, described in section 3, which will form the basis of a new specification. The new service includes:

- Service offer for 0-25-year
- 7-day service, with some service elements available 24/7
- Integrated service from early help to specialist and crisis support
- Specific service/s for looked after children and their carers
- 'No wait' ethos
- Multi-disciplinary team delivering a wide range of evidence-based therapeutic and clinical interventions and Mindfulness
- Innovative use of technology to deliver advice and support in line with young people's preferences
- Training for workers within universal services
- Flexible transition points for 16-25 year olds into adult services

6 Equality and Health Inequalities

6.1. Information from the two local JSNAs has been used to inform the development of the transformation plan and constituent projects within it. We recognise the need to reduce inequalities across the county and that all children including those who are looked after, will receive the same support as though they did live here. Moving forward the 0-25 emotional and wellbeing group will be defining more detailed requirements around information on need for each of the projects. This will ensure consistency of presentation across the different locality

areas and also provide some more granular information on subsets within groups. It will inform the service redesign, highlighting where services should be provided to maximise equality of access and identification of 'hot spots' where more targeted intervention is needed.

6.2 Rurality (and associated isolation) is considered a particular issue in Shropshire and concentrated areas of deprivation are a particular issue in Telford. Whilst the work to support the CAMHS transformation plan is being carried across the two CCGs areas, all organisations are cognisant of the distinct differences in cultures, populations and geography across the area. Organisations have stated clearly that a 'one size fits all' approach will not be supported and will be checking to see how these differences in need will be met. The single point of access in both Shropshire and Telford & Wrekin will be built upon to make access points as easy as possible, both of which run an ethos of no 'rejections' of request for help.

6.3 As the improvements in mental health have progressed, more specific issues/concerns about certain groups have been highlighted. This has led to some very focused work. For example, it has recently been suggested that a high proportion of adult patients admitted to the psychiatric intensive care unit are relatively young and a disproportionate number are care leavers. Consequently, a case notes review of all patients admitted in the last 12 months has commenced which will offer rich information about how we can better support both care leavers and younger people in the future.

6.4 Both CCGs have committed to a reduction in health inequalities as part of their vision/strategy and are keen to prioritise work that will proactively achieve this aspiration. Throughout the delivery of the Transformation Plan, consideration is given to ensure that equalities and health inequalities are appropriately addressed, and actions taken. This is supported in part through the completion of equality impact assessments and health inequality assessments.

The 0-25 service has a dedicated offer for Looked After Children and their foster carers to improve the emotional health of that particularly vulnerable group. The local organisations have prioritised working together to support the provider in managing the high levels of out of area looked after children placed locally.

As well as ensuring increased volume of provision the new service model aims to reduce inequalities driven by access by significantly increasing service delivery options to include;

- **On line support self-referral: Kooth -** Who provide free, anonymous online counselling. A website offers peer support, self-help material and gives children and young people access to live forums. No referral is needed. The website is available 24 hours; there will be professional counsellors available for live online chats. On average 300 young people register each month.
- **Drop in: The Children's Society –** over 500 children and young people and over 400 parent/carers have attended the service in the first quarter of 2018/19.
- **On line therapy accessed via the specialist service: Healios** who provide psychological therapies online delivered by qualified practitioners. The service is available 7 days a week and is receiving 30-40 referrals per month.

Every effort has been made to hear from those with lived experience as part of the development of the plan. However, it is recognised that more needs to be done to ensure

voices of the hard to reach are heard and that engagement is representative of those who are most affected.

Throughout the delivery of the Transformation Plan, consideration will be given within all programmes to ensure that equalities and health inequalities are appropriately addressed, and appropriate actions are taken through the completion of equality impact assessments and health inequality assessments.

The STP has a vision to implement integrated neighbourhood models of care (localised to meet people's needs) in recognition that a 'place-based' model of care supported by collaborative and place-based commissioning will provide sustainable care for future generations. Progress in this area has been made around:

- The introduction of an at risk of admission register.
- Planned workshops for the TCP cohort, now known as the Learning Disabilities and Autism cohort. This will include system wide partners and will focus on the whole pathway from prevention, through to crisis.
- Joint work to understand the rise in Tier 4 admissions.
- Early discussions that prevent the need for Tier 4 provision.

7 IT and data on demand and activity performance to improve outcomes

The plan recognises the importance of robust data to demonstrate service adherence to meeting identified needs, agreed trajectories for access and outcomes, and monitoring overall service quality and performance. The LTP wishes to enhance its data capture across the stepped care model so that robust, joined up commissioning plans can be developed. Through monthly contract monitoring we collate data relating to referrals, initial and follow on contacts, transition, numbers in treatment and waiting times. At present this data relates specifically to the BeeU service and there is a gap in data relating to early intervention, detection and prevention elements of the wider community/schools based pathways. More work will be undertaken through the partnership to agree how this information might best be captured and utilised to support continual improvement across the LTP partnership. This will include identification of gaps and how these will be addressed through monitoring future key performance indicators (KPIs).

The provider is continuing preparation activities in relation to ensuring effective data collection under Mental Health Services Data Set. This area was identified as requiring more detailed and focussed work by the IST resulting in some key actions to improve the quality of data for the effective oversight of planning, safety, effectiveness and responsiveness of the service. A Data Quality Improvement Plan is in place as part of contract review arrangements and includes measures on pregnancy, transitions, protected characteristics, personal goal attainment and outcome based support plans.

The system recognises that more work is required to make better use of the data we already collect including SEND, access data, fingertips data (public health) and future CYP Improving Access to Psychological Therapies data. By linking these data sources we will be in a much better position to understand the impact of health and care interventions on local needs.

8 The programme of transformation

8.1 The four organisations have acknowledged and responded to the need to improve services for children and young people aged between 0-25 years. In partnership, they have implemented a number of changes which has improved the experience of many individuals and families. However, there is recognition that there is a lot more to do, which was reinforced by the findings of the IST visit in June 2018. The collective leadership response is to ensure momentum around our joint commitment to increase the pace and scale of change.

8.2 This LTP will build on best practice to improve the responsiveness and implement a model of care to build resilience (rather than reliance on service). The inclusion of children, young people and carers has been, and will continue to be, pivotal in these developments to make sure that together we improve the wellbeing of the younger population. The steps already taken with the partnership approach has demonstrated benefits to improved access for online, drop in and psychological therapy.

8.3 The refreshed programmes of transformation provide continuity with the work underway across the system, whilst reflecting the priorities of work and the system capacity (and therefore pace) at which implementation can realistically take place.

The programmes have been mapped against the Windscreen of Need Model and are listed below and further developed in the subsequent narrative:

Programme No.	Link to stepped care model	Programme Title
1	Self-Support	Improving awareness and understanding of emotional health and wellbeing in CYP for all CYP, families and professionals.
2		Improved availability and consistency of family information to support children and families.
3	Consultation and Advice/guidance	Timely and visible access to appropriate practical help, and support and treatment.
4		Focussing support on vulnerable CYP and their networks.
5	Getting help	Evidence-based care interventions and outcomes.
6		Develop our workforce across all services.
7	Getting more help	Ensure strong partnership working and system wide governance.
8		Fully involving Children, Young People and Families.
9	Getting Intensive help	Improved crisis care.

8.4 Programme 1 - Improving awareness and understanding of emotional health and wellbeing in CYP for all CYP, families and professionals

There is a dedicated team within the BeeU service who work with young people with mental health needs and learning disabilities. They provide a range of interventions and where possible deliver in clinics in special school settings to minimise disruption to the school day and provide an appropriate setting for the young people.

One of the challenges is to ensure this group of young people and their families have access to appropriate early intervention tools suitable for their needs (e.g. those equivalent to Kooth). Links have been made with the new regional specialist community forensic CAMHS which was introduced early in 2018. This team visited the area and met professionals in September 2018 and this will inform a more detailed plan of improvements required.

One of the main drivers of the new BeeU model was to improve access to the service and encourage referrals. Historically, thresholds were very high and children and young people needed to be very ill before referral was accepted. Both children/young people and professionals wanted to reverse this trend. The access points and encouragement of early help was therefore a key objective in the vision.

We have implemented more streamlined access points including self-referral. Self-directed support is available from Kooth and the Children's Society where young people do not need to be referred into services so are not reliant on an adult or professional to get access to support/referral. This will continue to be closely monitored through feedback and performance indicators.

For those that require more specialist support, a dedicated access team with better referral, triage and assessments process have improved the timeliness of response. The access team are also able to deliver brief interventions for young people that would not traditionally meet threshold criteria for a specialist mental health service. Beyond brief interventions, specialist pathways exist to support young people to receive the most appropriate care.

The service will continue to work with GP's including assessing young people in GP surgeries in order to be more visible within the community and offer assessment to those families unable to attend the clinics. The CCGs will ensure that all pathways are be supported by standard operating procedures and that the website developed by the Trust to support referral into the service is effective.

In the future the commissioning processes and governance for all aspects of the service will be further enhanced through the development of an STP area all age Mental Health Partnership Board which has already began to meet. This board is jointly chaired between Commissioner and MPFT and will ensure high level understanding of the needs of CYP and the 'offer' to those children. This Board will also oversee the workforce plan, and link directly to the Health and Wellbeing Boards and the STP Clinical Leads Group.

The long-term practice of using medication and not fully understanding the psychosocial impact of experiencing ACES means that an organisation development project to facilitate cultural change is required across partners, including primary care. A project will be undertaken to increase communication to all stakeholders, so they have a clear understanding of where to get early help, how to support children and young people and where to get extra support from.

Across the STP there are examples of outstanding practice which are helping to drive improvement and help schools understand their role and impact in the prevention and early detection of emotional distress. Whilst the projects aim to increase the support available in each of the schools, it is recognised that there is still some variability in the offer provided directly by schools.

The BeeU service is now in the same Care directorate of the provider Trust (MPFT) ensuring much closer working of adult and children's pathways. A Rapid Quality Improvement event was undertaken in the summer of 2018 to ensure robust pathways between the 0-25 service and the hospital liaison service. Transition meetings take place between child and adult services to support young people to access appropriate services into their adult lives.

The CCGs are working with NHS England (NHSE) with the procurement of an all age liaison and diversion service which will support children within the court and remand system. This service will start in June 2019 and further work will be undertaken to ensure robust pathways are in place to local treatment services. The CCGs have put forward a bid to consider how those children who do not meet the specialist CAMHS threshold will be supported within and on discharge from the health and justice system.

8.5 Programme 2 - Improved availability and consistency of family information to support children and families

Shropshire Local Authority in partnership with NHS Shropshire CCG, successfully applied for the Mental Health Services and Schools Link Programme, run by the Anna Freud National Centre for Child and Families and funded by the Department for Education.

In 2017, three cohorts in Shropshire (North, Central & South) were convened in workshops which were very well attended, in total:

- 65 schools & colleges attended – 10 no shows and 3 apologies. (74 schools were expected)
- 4 GP practices
- Representation from:
  - Mental Health Service – MPFT, Kooth & The Children's Society
  - NHS Shropshire CCG
  - Public Health Nursing Service
  - Public Health
  - Special educational needs and disability (SEND)
  - Education Improvement
  - Education Psychology
  - Strengthening Families
  - Your Support Service (YSS)
  - Early Help
  - Young Addaction
  - Shropshire Youth Association

The workshops involved individual and group work, case studies, and small and large group discussions. They covered understanding the strengths, limitations and capabilities and capacities of education and mental health professionals, as well as developing the knowledge of what's available to support children and young people's mental health and how to make more effective use of resources. Following the first workshops delivered in September the feedback has been collated from all the three cohorts using the Anna Freud CASCADE model. This will inform future workforce training needs.

At this stage in the development of local neighbourhood or integrated teams we cannot say definitively the exact number that we expect to see in three-year's time. However, there are already examples emerging such as the Early Help Hubs developed as part of the early help plan for Shropshire which are in discussion with the BeeU service to explore co-location.

Our strategic plan for strengthening mental health in schools is set out in the action plan.

At the present time there are no financial levers to incentivise schools to undertake this work. However, there has been considerable energy and a commitment from the Head teachers to engage positively with the programme and the recognition that the wider positive impact that this will have, supporting CYP to reach their potential.

The plan is mindful of the ambitions set out with the Green Paper Transforming Children and Young People Mental Health Provision, and the importance of schools in this programme of change.

The LTP will continue to facilitate a whole system of care including a focus on prevention and early intervention, including universal settings, schools, colleges and primary care.

The mental health services & schools link programme began in 2017 for Shropshire schools. A great deal of work has taken place with Telford schools through the 'future in mind' programme with schools identifying a mental health lead and developing more training for school staff. The 0-25 service partners work closely with schools and other stakeholder to promote new service offers. The Children's Society will be delivering a suite of training and support for professionals in 2019-2020.

8.6 Programme 3 - Timely and visible access to appropriate and practical help, support and treatment

Our aim is to provide services that are available 24 hours 7 days a week, through a blended approach of on-line, self-help, drop-in and face to face support. Our services are not yet fully aligned across health and social care, and we recognise there is more work to do to ensure that services are available across all locations.

We have services available for all ages from 0-25 years but these are not always fully communicated and more can be done to help partners, children and their families understand what is available to support them.

8.7 Programme 4 - Focussing support on complexity and vulnerable CYP and their networks

Shropshire has the highest rate of out of area looked after children than any other county in England. The vulnerabilities associated with this group, such as their increased risk of mental health difficulties arising from their exposure to multiple childhood adverse experiences, means that there is an inherently greater risk of poor mental health within the system, hence a greater demand for services. Applications have been made for funding to the Anna Freud Centre to support Local Authorities to complete mental health assessments on young people moving into the area.

The was a multiagency workshop held by West Mercia Police and Shropshire Council titled: 'Shropshire School drug and alcohol seminar – evidence based practice and local profile' to share best practice, latest local policy and practice developments and the roles statutory and voluntary agencies play in dealing with the impact of drug and alcohol misuse. A newly ratified 'Drug education policy and procedural guidelines for drug related incidents' has been developed and agreed with schools.

A report presented to the Shropshire Childrens Trust in April 2018 confirmed that Shropshire continues to be recognised as an example of national best practice. Shropshire was the winner of the Children and Young People award 2017, PSHE category. The Shropshire PSHE Review 2016 engaged with over 280 young people in Shropshire who participated in the review. Two key aspects of the findings are highlighted. Firstly, young people reported that the delivery of drug and alcohol education under the broad heading of health and well-being was good and the best delivered of all the topics. Second, respondents were most confident to ask for help on the issue of drug and substance use but not about sex and relationships. Given that the two are often interlinked the report noted that young people may choose to present and discuss substance use in the first instance.

There are presently two strategies for childhood sexual exploitation for Shropshire and Telford & Wrekin. Both plans are published on the respective council websites (Telford & Wrekin Council and Shropshire Council) have comprehensive multi-agency partnerships and action plans delivering local improvements. Our approach builds on The Six Core Priorities set out in the NHS national framework for sexual assault and abuse services, which are:

- Strengthening the approach to prevention
- Promoting safeguarding and the safety, protection and welfare of victims and survivors
- Involving victims and survivors in the development and improvement of services
- Introducing consistent quality standards
- Driving collaboration and reducing fragmentation
- Ensuring an appropriately trained workforce

Work has commenced to pilot innovative pathways for CYP who are involved within the Criminal justice system. The focus will be on supporting individuals who may not wish to engage or meet the criteria for the 0-25 service. There will be clear evaluation of the process to ensure impact and learning. The West Midlands Paediatric Sexual Assault Service is a jointly commissioned (NHS England and Police and Crime Commissioners) model that provides a hub and spoke service offering:

- *24/7* ***Acute hub*** *with* ***90 minute rapid response***
- *A cohort of experienced Forensic Paediatricians across Region*
- *The on-call team is available* ***24 hours a day, seven days a week****.*
- *Victims of recent sexual abuse will be seen by the on-call team at our Horizons centre (Hub), Ida Road, in Walsall*
- *Multi-Agency strategy discussions held at point of referral between consultant and referrer ensuring best outcome for child/YP and safeguarding processes are adhered*

In addition the non-acute “Spoke” Clinics provide:

- *Medical examination and holistic care for CYP where there is concern about possible sexual abuse, but the concern is not deemed to be within the forensic window (non-recent)*
- *A ‘holistic’ service - providing emotional support - the CYP referred to the service is offered a package of counselling and emotional support.*

Substance use is the second highest reason for permanent and fixed term exclusion from schools, a statistic that has led to further multiagency working in this area. All schools and colleges will be able to access the new guidance. A notification will be disseminated via the school bulletin to reach all schools.

In addition there has been targeted dissemination support for selected schools. The Drug& Alcohol Partnership Officer, Police Head of Youth Engagement, Child Sexual Exploitation (CSE) lead worker, Young Addaction, School with Public Health Curriculum Advisor will identify priority schools and areas based on local data profiling for Drug & Alcohol incidents, CSE, Strengthening Families, school exclusions etc. These schools will be offered support to review and update their existing policy and procedures, reflect on current practice and receive targeted support for relevant pupils. In return they will be asked to provide case study information.

8.8 Programme 5 - Evidence-based care interventions and outcomes

The original specification for the new BeeU service was based on the contractual agreement that evidence based Improving access to CYP psychological therapies (CYP-IAPT) pathways offering NICE compliant therapy would be a core service offering. The LTP has adopted the THRIVE model which promotes a whole system approach and recognises the importance of friends and family in contributing to the longer-term routine care of children with high levels of need.

The language of THRIVE model will be used to describe all elements of the service offer, including pathways and the description of the service to support cultural change across primary care.

The LTP will ensure that all services, including CYP-IAPT will include the use of evidence-based therapies and outcome measures. The services will provide audit data which demonstrates it is utilising best practice guidelines when working with young people. We recognise that the evidence base for what works, and with whom, continues to be misunderstood and that more work is required to educate the workforce and citizens alike, in this area.

The service will continue to embed a person-centred approach in all their commissioned services, and active participation of the child or young person and anyone in their friendship group or family who they feel would be helpful in aiding their sustainability and recovery.

The following sub-sections contained within the action provide a description of the pathways and services being developed in line with the 5YFVMH. The LTP provides a high-level narrative description of the actions required to transform services. There will be a more detailed action plan overseen by the Mental Health STP and the CCG contracting group which is used to hold all partners to account on delivery. The pathways and services described are:

- Improving access to CYP psychological therapies (CYP-IAPT)
- Urgent and emergency crisis mental health care
- In-patient care
- Specialist care e.g. CYP with learning disabilities or forensic CAMHS
- Eating disorders
- Early Intervention in Psychosis (EIP)

Teams now meet and discuss transition plans. CYP are given the opportunity to either stay in 0-25 service at age 18 or to be transferred to adult services. Data regarding the numbers transitioning into adult services is captured as part of Schedule 4 (data reporting) in the

contract. As pathways are further developed and evaluated the expectation is that teams become ever more integrated and care more seamless. Future data sources will identify more detail on transitions to ensure year on year improvements reflected through metrics are demonstrated.

Improving access to CYP psychological therapies (CYP-IAPT)

The CYP-IAPT ethos and principles are being embedded Into CYP-IAPT and include:

- collaboration and participation
- evidence-based practice
- routine outcome monitoring with improved supervision.

The principles of CYP-IAPT are a fundamental part of the new 0-25 service which ensures collaboration and participation. The service signed up to last wave of CYP-IAPT and evidenced-based pathways have been developed in the new service. This will include the agreement of relevant outcome measures for the pathways. The provider is involved in the national work to report outcome measures. Reporting of outcome measures are a requirement in the data Quality Improvement Plan in the current contract. Fundamental to the use of outcomes in routine care is having access to high quality clinical supervision which will ensure outcome measures are used to improve practice.

The BeeU partnership includes third sector agencies who deliver NICE compliant therapy but at present the IAPT approach is focussed on NHS staff.

To ensure existing and new staff continue to be trained in evidence-based interventions a bid has been submitted to Health Education England to deliver training in CYP for the area. There is also training available in positive behavioural support and trauma informed care via the Transforming Care workforce plan. As part of 'business as usual' the provider will identify CPD requirements as part of the appraisal process.

Eating Disorders

The LTP area is currently meeting national targets against the Eating Disorder Access and Waiting Time standards. There have been some issues with a lack of 'urgent' referrals being made and a task to finish group was established to ensure GPs have clear criteria for these referrals.

Shropshire and Telford & Wrekin CCGs are partners in an eating disorders cluster across Staffordshire and the West Midlands.

In relation to NHS England's commissioning guidance a full specification has been produced through collaboration between the provider (MPFT) and commissioners. The service delivers an initial assessment which includes consideration of any coexisting mental and physical health problems, strengths and resilience capacity and level of motivation. Treatment options are concordant with NICE guidance including CBT, family interventions, guided self-help and pharmacological interventions.

Where there are coexisting mental health problems and the eating disorder is the primary representing problem, the service will also manage common coexisting problems such as anxiety and depression. Otherwise the management will be shared between this and 0-25

services. As well as the assessment and treatment service, the team will also include a strong multi-agency liaison/education component providing guidance to primary care, school nurses, social care services, schools and secondary care.

The newly formed team is making good progress in moving the service forward. They are considering the recruitment options and looking to improve the clinical provision. The team is continually developing and refining pathways and processes that reflect the guidance. The team are working towards the Quality Network for Community CAMHS (QNCC) standards and peer review will help promote service development and they aim to join QNCC/West Midlands Quality Review Service (WMQRS) network 2019.**Early Intervention in Psychosis (EIP)**

The two CCGs commission Early Intervention Psychosis (EIP) services from the same provider as the BeeU 0-25yr service. This service ensures that CYP are seen in the specialist EIP service alongside CAMHS clinicians where required. The Early Intervention Service works with CYP aged 14+ and offers assessment and where appropriate NICE-recommended treatment for people taken onto caseload with First Episode Psychosis or At-Risk Mental State *(ARMS)* with the Early Intervention Service providing care co-ordination.

The service is working towards level 3 accreditation (CCQ1, EIP Network audit) by Spring 2019. For those aged 14-18 the service works in partnership with the local CAMHS to ensure the CYP mental health needs are met. The service also takes referrals directly from Children Services, GP, Young Persons Substance Use Service, schools/colleges and youth services as well and will work in partnership with these services if agreed with the CYP and their family/carers.

Perinatal mental health

Both CCG's have successfully commissioned a perinatal mental health service from MPFT. The service, once fully staffed will meet the required staffing guidance against the population

The new service will operate through a 'hub and spoke' model and will:

- Include a multi-disciplinary approach including psychiatry, psychology, occupational therapy and, mental health nursing and peer support.
- Be responsible for upskilling wider staff working in or with the service
- Improved early detection and prevention.
- Change to referral criteria – current criteria delays access until 20 weeks gestation plan to widen criteria to include from conception to 12 months postnatal.
- Preconception advice for women with severe preexisting mental health problems
- Out of hours support – access to inpatient facility, Stafford
- Services closer to home.
- Offer at least 50% of women who meet the criteria a face to face appointment within 2 weeks of referral and 95% within 6 weeks as per national guidance.
- Facility to provide initial assessments within home environment, where a more assertive approach is required.
- Increase the provision of MDT members to provide a holistic approach to recovery

- Women and their families have a positive experience of care, with services joined up around them.
- Early diagnosis and intervention, supporting recovery and ensuring fewer women and their infants suffer avoidable harm.
- More awareness, openness and transparency around perinatal mental health so that partners, families, employers and the public can support women with perinatal mental health conditions

The service will be able to enhance the existing close working relationship with the well-established local mother & baby unit (Brockington), enabling a seamless holistic approach and continuity of care across the out-patient and in-patient services.

Neuro-developmental needs

Whilst these services are offered to CYP and families it is recognised that further work is required to ensure that clear pathways exist and clarity is formed on the boundaries between educational needs and mental health needs. Workshops were held with families in January 2018 and July 2018 and work is ongoing to develop the pathways. Pathways have been developed in partnership with education, health and social care and aim to start from November 2019.

8.9 Programme 6 - Develop our workforce across all services

The STP mental health workforce plan includes high-level requirements of the BeeU 0-25 service. The mental health delivery plan is now in development. This will be signed off by the new Mental HealthPartnership Board once the planning work has been undertaken to understand the numbers and skill mix required to deliver the pathways in this plan pathways.

The LTP recognises that necessary and valuable work that is undertaken across the wider system such as by colleagues working in the voluntary sector, in schools, in the local authority and in primary care. Whilst the workforce plan does not directly include schools and colleges at this stage both the 'Future in Mind' work and 'TAMHs' are fundamental in the development of skills across universal service staff. A key role of both of these services is the upskilling of school staff to understand the emotional and mental needs for CYP.

The waterfall template used for the NHS England return (which was mandated for the mental health workforce plan) was unable to recognise the baseline staffing in 2016 (because the previous staff were employed by a different organisation). However, the workforce data is understood. A management of change has been undertaken since the contract award of the BeeU 0-25 service and further work is progressing to understand the future workforce required.

The original investment associated with 2015/16 workforce plan for Universal Services staff has now ended the investment period but there remains money to support ongoing CPD developments.

With respect to CPD and continued training to deliver evidence-based interventions (e.g. CYP IAPT training programmes). Currently, there are gaps in the Mental Health workforce plan for

CYP services, CYP IAPT has already been highlighted as a key requirement. The resources to support the development are part of the associated Health Education England bid and the 12-month course will begin once dates have been agreed. Further staff are to be trained in CYP IAPT but clinical capacity is a key factor in both releasing staff and taking the time to redesign services to deliver in a new way.

CPD and training is now a core part of the annual appraisal processes.

The workforce plan does not include wider system workforce needs at this stage. It has been necessary to focus on the core services given the significant inherited issues, but the importance of wider work is recognised and will be progressed once the basics are in place. There is agreement that this work will be through the STP partnership.

However, both local authorities have been considering the capacity and capability of the areas for which they are responsible such as school nursing, health visiting and schools.

In addition to individual workforce needs there is a system wide cultural change required on how the mental health needs of CYP are understood, formulated and subsequently met.

8.10 Programme 7 - Ensure strong partnership working and system governance

The LTP will continue a system-wide breadth of transformation of all relevant partners, including NHS England Specialised Commissioning, the local authority, third sector, youth justice and schools & colleges, primary care and relevant community groups. We will do this by working with our partners in the following ways:

- ***NHS England specialist commissioning*** – Working on the use of CAMHS Tier 4 beds to understand the rise in use and develop a plan to reduce this in 2019-20.
- ***Local Authority*** – The links between Local Authorities and CCGs are very strong and supported via the joint commissioning of the new BeeU service. The CCGs have carried out a lot of work with local authority to better support vulnerable children. We will continue with using multi-disciplinary reviews on individual cases and learning applied to the future. For example, the summer holidays and the lack of placements when schools closed has been a particular issue. Improved planning will take place next year to avoid the same problem. We will also prioritise the large number of looked after children (LAC) and those with adverse childhood experiences (ACEs) and trauma histories.
- ***Third sector and community groups*** – The new model allows for flexible support from affiliate organisations to provide flexible capacity from the third sector. There is a lot of enthusiasm for improvement with community-based groups/services. The Children's Society will be doing more work on this during the next year. There is also a vibrant third sector (not funded by statutory organisations) that is supporting children, young people and their families across Shropshire and Telford & Wrekin. We will continue to encourage innovative models for helping CYP to gain rapid access to help when they require it.
- ***Youth justice*** – The service includes two dedicated workers that sit in a virtual youth justice team to provide advice and referrals into 0-25 service. In

addition, in 2018-19 both CCG's are working with NHS England to procure an all age liaison and diversion scheme.

- ***Schools & colleges*** – There are schools leads on the 0-25 partnership/stakeholder forum to help drive the agenda and make connections. A school representative was central to the procurement exercise. There are clinics held in some school settings (for example one of the special schools). Future in mind Telford & Wrekin continue their work led through the Severn School Alliance. This ensures there is a lead in each school and they receive appropriate training and support around mental health. There are also some drop-in sessions held in colleges; these sessions have been co-developed with colleges. In Shropshire the Targeted Mental Health Support (TAMHS) support schools, professionals and volunteers to promote children's emotional health and wellbeing and develop resilience. The programme uses a universal population based approach and some targeted intervention support for CYP.
- ***Primary care*** – Work has been ongoing and will continue with practices. The referral forms have been changed as a result of feedback from referring GPs. The 0-25 service website has been developed for easy access to GPs for information and advice. Prescribing have been developed and are being rolled out to replace shared care agreements. Further work is needed to explain criteria, pathway and overall service offer once these have been agreed.

The key deliverables of the MH5YFV specifically for children include:-

- **Access** target for 35% of children with a mental health condition to enter an NHS commissioned service. The current (unvalidated) rate for Q1 is 48% of the years target, so is on target to achieve the trajectory.
- **Early intervention psychosis:** A dedicated service is in place and is meeting the access target of 53% seen and on the caseload within 2 weeks of referral. The service is at level 2 compliance for NICE recommended therapies and plans are in place to be at level 3 by 2020.
- **Reduction in tier 4 beds -** work is underway to better understand the increase use of tier 4 beds and develop alternatives including tier 3.5 beds, improved crisis response and proactive management of those at risk of admission.
- **IAPT service -** CYP over 16 have access to this service which is meeting the national access, recovery and waiting time targets.
- **Hospital Liaison services –** Are in place in both local hospitals for CYP 16 and over. One unit has 24/7 cover the other 12/7 cover. The provider (i.e. MPFT) of the 0-25 service and the adult service are now the same and an event has been held to ensure robust pathways are in place for CYP. This will ensure there is an all age response by 2020.

In addition, the refreshed plan will continue to meet the 5YFV for mental health through its adherence to the principles of:

- Co-production with people with lived experience of services, their families and carers;

- Working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing;
- Identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery;
- Designing and delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives; and,
- Underpinning the commitments through outcome-focused, intelligent and data-driven commissioning.

8.11 Programme 8 - Fully involving children, young people and families

Details of the various partnership arrangements for involving children, young people and families is explained on page five of this plan.

We want to ensure that coproduction is at the heart of service developments and ongoing improvement and have set out a plan of work that builds on and strengthens the approach already taken.

8.12 Programme 9 - Improved crisis care

There is a dedicated children and young people 24/7 urgent and emergency service. We recognise the need that having access to enhanced crisis care is central to the BeeU 0-25 Service. There is crisis support 24/7 delivered through a combination of a dedicated crisis team working Monday to Friday 9am – 5pm with out of hours support through an on-call psychiatrist. The service is exploring the potential to move to 8-8 crisis support in the future. The hospital liaison team based in the acute Trust are also able to respond to crisis for young people 16+.

There has been some progress bringing together the adult and CYP elements to work more closely together. This has been helped by the two services being part of the same directorate.

With respect to CYP with disabilities the 0-25 service has a dedicated team for learning disabilities and for autism which ensures reasonable adjustments are made to support children in crisis. The 0-25 service continues to work collaboratively with the acute provider to identify opportunities to improve support for young people in an acute setting. Young People's needs are always taken into consideration as part of the assessment process and as much as possible will be accommodated during any intervention.

The 'at risk of admission' register provides an opportunity for front line professionals to discuss reasonable adjustments that can be made to avoid admission/crisis.

The new liaison and diversion scheme commissioned by NHS England will support all children with disabilities in the criminal justice system which will support reasonable adjustments within courts and custody.

Children and young people, carers and professionals have had opportunities to articulate the experiences they have had and aspirations for change. It featured heavily in the engagement work which was carried out in preparation for the procurement. During the procurement process the young people on the procurement panel probed potential providers to ensure they understand just how important this issue was. At all engagement events with CYP or parent

carers since their expectations are listened to. Learning is also taken from any individual issues raised (via Patient Advice and Liasion Service (PALS), complaints and general enquires either through the commissioners or provider). These have been translated into a set of KPIs for response times for urgent and emergency mental health for CYP within the contract.

Crisis pathways have been reviewed to enable the service to better respond to young people in crisis and work will continue with partners across the local health and social care economy on ways to intervene earlier in the pathway to access appropriate support. The crisis support function is preparing to cover 8-8 by the end of 2018/19 which will better support CYP.

By 2019 we aim for the closer working with the learning disabilities CYP pathway and the adult service pathway to have progressed to ensure improved crisis support and transition pathways. To support this a Kaizen event was undertaken between the Rapid, Assessment, Interface and Discharge (RAID) teams and crisis teams to improve the response for 16-17 year olds in crisis. Early feedback is that it is working well, and it will be kept under close monitoring. In 2019 we will continue to focus on integration, reducing barriers within services, and ensuring a seamless pathway.

As a system one of our borders is with mid Wales and there has been experience of some local issues with the differences in commissioning for Welsh patients. NHS England is not responsible for commissioning Tier 4 beds for Welsh patients. This can cause significant delays and impact on workload when CYP are in a local acute hospital. We will continue to work with Health Boards in Wales to resolve the issues.

Meeting the needs of more complex CYP with trauma, sexual exploitation or abuse, experiencing 3 or more adverse childhood experiences (ACEs), looked after children , children with learning disabilities and those at risk of entering the justice system will remain our priority.

We recognise that some groups of CYP are more vulnerable that others and specialist pathways for these groups will be developed in 2019-20 to address their needs. This will include having appropriately trained staff in evidence based interventions, who are aligned to these pathways to foster effective links with external agencies also working with these young people.

A clear focus for the workforce plan is the building of knowledge and skills regarding the impact of ACE and trauma informed care for all those working with CYP.

Where possible and appropriate we will ensure that appropriately trained workers from BeeU are embedded in wider teams that focus on these vulnerable children. For example, the Looked After Children worker from the BeeU service sits as part of the team of social workers in the Local Authority.

We will continue to do all we can to ensure that children and young people will not be admitted to inpatient care unless absolutely necessary. If they are admitted every effort will be made to ensure that services work together to provide a safe and secure place at home or in their local community for return as soon as possible. The child or young person and identified friends and family will be active in care planning and support.

Recognising the rise of Tier 4 beds, both CCGs in the STP are dedicated to a reduction in the inappropriate use of inpatient beds and out of area placements. A project already established will continue to better understand the use of tier 4 beds and to develop alternatives. The newly introduced 'at risk of admission' register will help to prevent admissions on an individual level and also provide a greater level of information to develop alternatives for the future.

The Trust's clinical lead has been involved in regional and national discussions regarding new models of inpatient care and opportunities to develop local solutions and will bring this learning back to the STP.

8.13 Commitment to Quality Improvement

As a system the LTP partnership is committed to a journey of system wide learning and improving quality for all services provided to CYP. As such, we are mindful of the need to use the available data we collect to share with all partners in order to paint a comprehensive picture of the services and improvements required. For example in schools this is the CASCADE model, in the BeeU service the main provider has Lean Methodology and the core contract will identify and use outcome measures, patient and family experience measures as well as measures of service efficiency.

At all times we will continue to fully involve the views and experiences of children, young people and their families in the evolution of services across the county.

9.0 Action Plan 2019-2021

Ref	Objectives	Actions	Lead	Completion date	Milestone	Outcomes
Thrive Model - Self Support						
1. Improving awareness and understanding of emotional health and wellbeing in CYP for all CYP, families and professionals						
1	Ensure advice and information is readily available	Local young people friendly literature on mental health to raise awareness and promote conversations with others including parents and carers. To be reviewed annually or as services develop and change	Bee U	Done	1. Identification of what would be useful – complete 2. Leaflet design and test with current young people with experience. 3. Commission of leaflet 4. Dissemination	High quality information available in hard copy and on-line
2		Provide education and information workshops for parents and carers.	Councils	Done	1. Programme of sessions prepared 2. Dissemination of programme dates 3. Implementation of programme 4. Evaluation to STP MH Group	Rolling programme of workshops available throughout the year. Parents and families are more knowledgeable and confident in understanding emotional wellbeing in CYP

Ref	Objectives	Actions	Lead	Completion date	Milestone	Outcomes
3	Advice and Information readily available	Explore social media such as a website listing online support and links to local organisations made available to young people and their families in Shropshire.	Bee U	Done	1. Task & Finish group developed to identify online support currently available. 2. Young People's groups to feedback 3. Website constructed with information links	Easier access to information 24/7 Better informed CYP & families
4		Improve the mental health and well- being, advice and information available to children, young people, parents, carers and professionals.	Bee U	Done	Age appropriate resources available through a range of media including on-line and social media to include: ▪ Self-help resources ▪ Sources of support ▪ Information about counselling and mental health services through referral, contacts and session/clinic times ▪ Website	Easier access to information 24/7 Better informed CYP & families
5	Shift the understanding of emotional health and wellbeing from	Develop a system wide package of information to help improve understanding of emotional distress in	Bee U/CCGs/councils/ third sector	2018/19	Marketing materials/collateral available for distribution	

Ref	Objectives	Actions	Lead	Completion date	Milestone	Outcomes
	a culture of medicalisation to one of understanding individuals needs and the best support to help	CYP				
6		Link to schools programme	Councils	July 2019	School leads engaged with programme development and delivery.	Improved understanding of emotional health in schools for CYP, teachers and families
Thrive Model – Self Support **2. Improved availability and consistency of family information to support children and families**						
9	Developing and sustaining a whole school approach	Whole school approach – (i) resources (ii) models of counselling / in-school delivery; (iii) workforce education; (iv) healthy lifestyles and relationships promotion, including raising awareness of infant attachment in the school setting.	Councils and Schools	On-going To be monitored via STP	1. Task and finish group set up 2. Resources for schools collated 3. Clinical input into the validity of the resources 4. Commissioning toolkit for schools put together 5. Identify designated staff within schools. 6. Launch of whole school approach.	Annual training programme for pupils and school staff published
10	Developing and sustaining	Increase in Young People's MH First Aid workshops	Councils	Dec 2019	1. workshop design 2. approach to schools 3. programme in place 4. delivery and evaluation	Improved resilience in CYP Skills development in CYP Reduction in referrals to

Ref	Objectives	Actions	Lead	Completion date	Milestone	Outcomes
	a whole school approach					Bee U
		Schools-based Workshops for pupils such as teen yoga, calm minds	Councils	June 2019	1. Agreement to link in with whole school approach 2. Delivery of sessions to schools	Access to early intervention Reduction in referrals to Bee U Calm school environments Improved presenteeism at schools
		Recognising role of Healthy child programme in raising awareness of mental health and emotional wellbeing	Councils	Sept 2019	1. School based plans for programme roll out 2. Forward plan in place	Prevention measures in place Raised awareness of emotional health and wellbeing MH stigma challenged
		Schools appoint a mental health lead from their senior leadership team who will develop a mental health strategy	Headteachers /Councils	March 2019	1. Lead in place 2. Develop localised plan based on needs in school	MH Strategy shared on school website
		Conduct a knowledge and skills gap to inform analysis of a sustainable school CPD plan	Headteachers /Councils	May 2019	1. Plan of training developed 2. Links to wider initiatives 3. Links to GP practices	Teachers and school staff report increased confidence in MH issues
		Repeat baseline assessment quarterly	Councils	April 2019	1. Complete assessment 2. Share learning	Strategic overview of schools available for future

Ref	Objectives	Actions	Lead	Completion date	Milestone	Outcomes
	Developing and sustaining a whole school approach	by Anna Freud Centre and link to SEN lead			3. Capture positive practice	planning
		Consider and agree evaluation framework	Public Health/STP	March 2019	1. Framework agreed 2. Date collection in place	Impact of prevention programme understood Improved wellbeing amongst CYP
		Shropshire wide event to capture good practice and inform Year 2 plan	STP/Councils /CCG	April 2020	1. Venue booked 2. Invites out 3. Event held	Sharing good practice System oversight Improved awareness across schools
		Deliver CPD programme to schools mental health leads and networks wrapped around school footprint	Public Health	July 2020	1. Resource identified 2. Workshops/sessions agreed 3. Training delivered	Increase confidence and competence in teachers Reduce referrals to Bee U Improved school environments
		School MH leads undertake a cascade school based approach to schools on mental health awareness and use of evidence based interventions	School lead / Public Health	Dec 2020	1. Delivery of training in curriculum plan	Increase confidence and competence in teachers Reduce referrals to Bee U Improved school environments
		Feedback to all head teachers on school action plan improvements	Public Health	Feb 2020	Feedback collated and shared	Inform next year plan

Ref	Objectives	Actions	Lead	Completion date	Milestone	Outcomes
	Developing and sustaining a whole school approach	Capture good practice from GP interventions/models and share across primary care	Public Health	Feb 2020	1. Identify good practice 2. Share in network	Reduction in referrals to Bee U More prevention of emotional issues in CYP
		Commence evaluation and data collection	Public Health	Feb 2020	1. Identify good practice 2. Share in network	
		Shropshire wide event to capture good practice and inform	Public Health	April 2021	1. Venue booked 2. Invites out 3. Event held	
		Continue to Deliver CPD programme to schools mental health leads and networks wrapped around school footprint	Public Health	July 2021	1. Resource identified 2. Workshops/sessions agreed 3. Training delivered	• Engaged schools, who are contributors to pupil resilience and adopt whole school approaches • Support school staff through consultation and supervision. • Staff reporting more confidence in supporting pupils in the school environment. • More children and young people supported to maintain attendance at their school
		School MH leads undertake a cascade school based approach to schools on mental health awareness and use of evidence based interventions	Public Health	Sept 2021	1. Delivery of training in curriculum plan	
		Feedback to all head teachers on school action plan improvements	Public Health	2020/2021	Identify good practice and ongoing support needs for sustainability	
	Developing and sustaining	Share evaluation feedback around	CYP	2020/2021	Report on learning, good	

Ref	Objectives	Actions	Lead	Completion date	Milestone	Outcomes
	a whole school approach	improved pathways and benefits to CYP of closer working	LTP/Councils		practice and future recommendations	
		To implement, develop and disseminate learning from the Mental Health Support Teams in Schools trail blazer	Bee U/ CCG/ Councils/ Educational settings	2020/21	Report to HWBB and STP detailing outcomes	Learning from the project disseminated to schools outside of the scheme Improvement MH in schools Increase resilience for CYP in schools in project

Ref	Objectives	Actions	Lead	Completion date	Milestones	Outcomes
Thrive Model - Consultation and Advice/guidance **3. Timely and visible access to appropriate clinical support and treatment**						
Ref	**Objectives**	**Actions**	**Lead**	**Completion date**	**Milestones**	**Outcomes**
	Perinatal/ post- natal parental mental health	Development of antenatal and peri-natal provision.	MPFT	March 2019	Implement agreed project plan in line with trajectories	Service available for women across Shropshire.

Ref	Objectives	Actions	Lead	Completion date	Milestones	Outcomes
		Develop and agree care pathway for parents with mental health (maternity)	MPFT	March 2019	1. Task and finish group established 2. Development of pathway 3. Clinical guidelines agreed and disseminated in primary care (using Map of medicine)	
		Enhance maternity services for people with mental health including access to specialist support	SATH	June 2019	1. To review local plans against national guidance / funding available 2. Document intention in commissioning intentions 3. Decision to proceed with enhanced service 4. Implementation plan implemented 5. Data collected for evaluation	
	Parent and Infant Attachment	Develop care pathway for families needing targeted support with infant attachment	LA's	July 2019	1. Care pathway discussion – complete 2. Clinical guidelines developed 3. Dissemination and implementation	4.
		Engaging families early – screening by HV to identify risks and determine	Public Health	April 2019	1. Pathway discussion 2. Identification of gaps 3. Agreement on how to	

Ref	Objectives	Actions	Lead	Completion date	Milestones	Outcomes
		targeting.			meet gaps.	
	Parenting programmes	Co-ordination of local parenting programmes to deliver an agreed model that improves parenting skills and parents mental health.	Public Health/ Councils	Sept 2019	1. Development of parenting care pathway 2. Development of parenting information 3. Development of parenting ROMs.	More CYP assessed and treated earlier in their presentation
		To improve workforce competency to deliver parenting programmes (CYP-IAPT)	Bee U / MPFT	Sept 2019	1. Promotion and secure take- up of parenting training 2. Develop workforce plan for parenting skills 3. Identify gap and report to CYPP. 4. Prepare for 2019 in-take	
		Enable identified parents to access parenting programmes with local authority staff undertaking parenting programme training (CYP-IAPT).	Bee U	September 2019	1. Monitoring arrangements to be put into place 2. Practice tracking / issues to be discussed at development group.	
	Continue targeted early intervention programmes	Continue with baby yoga and teen yoga sessions, calm brain	Councils	Sept 2019	1. Monitoring arrangements to be put in place for identification of need 2. Links to follow-up support identified for those most	

Ref	Objectives	Actions	Lead	Completion date	Milestones	Outcomes
					at risk 3. Completed numbers and throughput collected and shared to identify need or 'hotspots' 4. Identify resource for following year	
Thrive Model - Consultation and Advice/guidance **4. Vulnerable children and young people**						
	Develop a shared understanding of service gaps, and most vulnerable groups	1. Agree data sharing protocol to bring together separate information systems into one STP dashboard 2. Establish reporting framework to inform annual planning process. 3. Share routine data including referrals, pathways,	STP	March 2019 June 2019 June 2019	1. All age MH JSNA completed for STP 2. Data sources on at risk and vulnerable groups collated (including past year service use, LAC data, lessons learned from SCR reports etc) 3. High level data set agreed to inform ongoing future CYP LTP refresh	

Ref	Objectives	Actions	Lead	Completion date	Milestones	Outcomes
		workforce, interventions and outcomes				
	Develop pathways for at risk vulnerable children and young people	Review of services for children and young people with conduct disorders	CCGs/LA's	August 2019	1. Scoping document drafted to include PRUs 2. Review conducted 3. Recommendations available 4. Consideration by CYP Group	
		Implement new CYP criminal justice pathway	NHSE	April 2019	1. New pathway implemented 2. Continuity of service provision ensured. 3. Evaluate pilot work of CYP criminal justice system pathways.	More CYP moved from pathways Improved community integration
	Ensuring services meet the needs of all children	Service provision for specific groups e.g. LAC, Young Offenders, young carers, LDD, NEET to be considered and monitored in development and roll-	CCG/LAs	Sept 2019	1. All changes or new activity to have a EIA completed with consideration to vulnerable CYP. 2. All evaluations to look at impact on vulnerable	All groups identified and gaps in service known.

Ref	Objectives	Actions	Lead	Completion date	Milestones	Outcomes
		out of actions in this plan (equalities impact assessments).			groups.	
		Targeted information available for young offenders, children and young people with learning difficulties, Looked after Children and young carers.	Bee U	March 2019	1. Drafting of information 2. Engagement of vulnerable children and young people 3. Adjustment to literature 4. Publication	Waiting times to be compliant with national standards
		Improve joint working between children social care and mental health services to focus on addressing the needs of vulnerable cyp.	Bee U/ Councils	July 2019	1. Dissemination of care pathways 2. Communication and briefings to social care 3. Dissemination of eligibility criteria and practitioners helpline.	
		Provision of Shropshire and Telford & Wrekin Intensive Placement Support and Treatment intervention service (1) ongoing recruitment of foster carers (2) evaluation	Councils	Sept 2019	1. Growth in number of children and young people supported 2. Identify cohort and lessons learned for earlier treatment 3. Develop plan for reduction in future use	Earlier intervention in place

Ref	Objectives	Actions	Lead	Completion date	Milestones	Outcomes
		of model				

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
Thrive Model – Getting Help **5. Evidence-based care interventions and outcomes**						
Ref	**Objectives**	**Actions**	**Lead**	**Completion date**	**Milestones / Outcomes**	**Outcomes**
	Fully resolve existing caseload of CYP on medication packages of care	Undertake comprehensive audit of consultant caseloads	Bee U	Completed	1. Clear understanding of needs established within holistic bio-psycho-social model	• CYP reporting better experience of accessing services • Enhanced engagement with young people and their families to inform future plans and pathways.
		Plan in place for migration, referral and discharge from caseload	Bee U	Completed	1. Agreed routes through service established 2. Weekly reports to CCGs on progress made	
		Improved access to quality data for commissioners	Bee U	Completed	1. Agreed date on waiting times, referrals, and additional assurance required made	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
					available for CQRM	
		Medication levels titrated to minimal optimum therapeutic level for all CYP	Bee U	Completed	1. Supervision and review of practice to ensure prescribing reflects best practice	
		Active case management system in place with expected discharge/transition dates identified	Bee U	Completed	1. CYP moved to pathways to meet their needs 2. Transition in line with agreed pathways	
		CYP and their families understand choices, treatment options and pathways	Bee U/CCGs	Completed	1. Information made available and shared at review points 2. Service evaluation captures feedback on choice, treatment experience and service satisfaction	
		All legacy cases resolved		Completed	1. Ongoing reporting to CCG until legacy cases fully resolved, including those discharged to primary care subject to shared care arrangements.	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
	Assurance gained by commissioners (CCGs/LA's) regarding medication use in existing caseload	1. Independent review undertaken by pharmacy/quality leads 2. Discussed at CQRM 3. Usual SI process followed if required 4. Full communication plan developed to ensure partners and stakeholders (inc. CYP and families) have access to factually correct information. 5. Full review of all CYP both in services and discharged to primary care undertaken 6. Additional clinics provided to fully review care needs of CYP	CCGs CCG/MPFT CCG/MPFT CCGs/MPFT CCGs/MPFT MPFT	Completed	1. Review undertaken 2. CCG review undertaken 3. Contract meetings reflect concerns and action plan 4. Task and Finish group established 5. Weekly comms calls in place 6. Agreed comms plan in place	• Robust transformation plan in place with clearly defined timescales for delivery and investment. • Local co-produced outcomes framework
	Develop all age	1. Expand access	Bee U / MPFT	Completed	There will be a single	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
	access single point of point for BeeU service	team to incorporate CYP referrals 2. Deliver training for workforce to standardise needs assessments			point of access to BeeU core service for all referrers. Less confusion in primary care for GPs/schools Easier for self-referral Pathways into services agreed and understood by partners	
	Develop early intervention pathway	1. Develop trusted assessor framework 2. Develop agreed ROMS on RiO for each pathway 3. Train staff in agreed ROMS 4. Implement pathway	MPFT	Completed	Pathway established Staff trained Outcome agreed Ongoing OD plan agreed Capacity identified	Co-designed pathways models and services to meet national and local targets
		Confirm demand and capacity for incoming referrals and waiting list management	MPFT	Completed	Capacity identified Future plan for provision agreed	
	Develop core mental health pathway	Develop trusted assessor framework Develop agreed ROMS on RiO for each	MPFT	Completed	Pathway established Staff trained Outcome agreed	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		pathway Train staff in agreed ROMS Implement pathway Confirm demand and capacity for incoming referrals and waiting list management			Ongoing OD plan agreed Capacity identified	
	Develop ADHD pathway	Develop trusted assessor framework Develop agreed ROMS on RiO for each pathway Train staff in agreed ROMS Implement pathway Confirm demand and capacity for incoming referrals and waiting list management	MPFT	Dec 2019	Pathway established Staff trained Outcome agreed Ongoing OD plan agreed Capacity identified	
	Develop ASD pathway	Develop trusted assessor framework Develop agreed ROMS on RiO for each pathway Train staff in agreed	MPFT	Dec 2019	Pathway established Staff trained Outcome agreed Ongoing OD plan agreed Capacity identified	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		ROMS Implement pathway Confirm demand and capacity for incoming referrals and waiting list management				
	Develop Learning Disability pathway	Develop trusted assessor framework Develop agreed ROMS on RiO for each pathway Train staff in agreed ROMS Implement pathway Confirm demand and capacity for incoming referrals and waiting list management	MPFT	Feb 2019	Pathway established Staff trained Outcome agreed Ongoing OD plan agreed Capacity identified	
	Develop Eating Disorder Pathway	Develop trusted assessor framework Develop agreed ROMS on RiO for each pathway Train staff in agreed ROMS Implement pathway	MPFT	Feb 2019	Pathway established Staff trained Outcome agreed Ongoing OD plan agreed Capacity identified	50% of referrals to specialist Eating Disorder service to be from self/ primary care, schools, early intervention service, parents (by 2020)

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		Confirm demand and capacity for incoming referrals and waiting list management				
	Develop 18-25 transition pathways for: • ASD • ADHD • Core MH • LD • LAC • Nearly 18 at point of referral • Psychosis	1. Create and agree 2. Sign off 3. Implement	MPFT	Completed	To align local protocol and practice to best practice in transitions	• 75% of service users reporting improvements in outcomes • To have seamless transition from CAMHs to Adult mental health services in place
6. Develop our Workforce			**Thrive Model – Getting Help**			
	Grow and develop competency evidence-based practice. Commissioners, managers and	To review CYP-IAPT training programme and ensure most effective take-up/ implementation of NICE approved therapies in place	Bee U	March 2019	1. Mental Health and Well- being multi-agency training programme developed including youth workers, family services, teaching	7. Workforce plan in place 8. OD system plan agreed 9. Training in ACEs and trauma informed pathways secured

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
	practitioners participate in continued professional development to improve workforce competency and quality of services.				staff and GP practitioners. 2. Make links to workforce development plans, e.g. Children's wellbeing/ Herefordshire Council 3. Review take-up against plan 4. Circulate information to ensure 2018/19 take –up 5. Secure 2019/20 places 6. Report to STP MH Group	Increased peer support in schools available 10. Training reflects THRIVE model 11. Evidence of multi-agency training across all areas (such as schools) 12. All posts filled 13. CPD fully delivered
		To improve workforce competency of CBT and systematic family therapy through engagement in CYP-IAPT	Bee U	Dec 2019	1. Increase numbers of practitioners trained in CBT and SFT. 2. Review against training plan. 3. Identify gap 4. Build into 2016/17 programme	14. Training needs for next three years identified
		Enable identified children and young people to receive up to	Bee U	June 2019	1. Monitoring arrangements to be put into place for the	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		20 sessions of Cognitive Behavioural Therapy from staff undertaking CBT training.			Steering Group 2. Practice tracking / issues to be discussed at development group	
		Training places offered through the Midlands CYP-IAPT collaborative are made available and utilised.	Bee U	April 2019	1. 2019/20 provisions identified	
	Measuring outcomes and effectiveness	Use of Routine Outcome Measures is embedded across all mental health and well-being service provision.	Bee U	April 2019	1. Plan to extend the use of ROMS across services produced. 2. Target areas roll out from April 2016 3. Other areas from September 2016	15. Focus on whole pathway from schools, universal services, primary care through to specialist pathways
	Deliver mental health awareness training for professionals working with children and young people	Develop plan Develop training package Identify rollout sequence/format	Bee U/CCGs/Councils	July 2019	1. Programme devised to include promotion of Mind Ed; CCG session as part of Primary Care education; communication about transformation; and	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
	including those working with LAC, young offenders, LDD.				electronic care pathways embedded into primary care. 2. Training groups identified and commenced	
	Create opportunities for the workforce to discuss children and young people mental health and wellbeing	Deliver county-wide event for CYP-IAPT and cascade the learning and information to support the development of staff awareness & competency.	STP	July 2019	1. Venue and programme booked 2. Invitations gone out 3. Evaluation of event to inform future workforce development	
	Improve arrangements for supervision	Framework for supervision across agencies (modality supervision). Developing practitioners to be (a) supervisors (b) system leaders in CBT, SFT,	Bee U	Feb 2019	1. Feedback from staff on CYP- IAPT courses 2. Construction of a supervision framework including agreements 3. Roll out to graduates	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		Parenting, ADHD, LD, infant attachment			and students on CYP-IAPT education programme.	
	Improve level of evidence-based interventions available by clinical staff	Workforce development plan for specialist CAMHS	Bee U	Mar 2019	1. Recommendations from skill mix review 2. Draft workforce development plan 3. Agreement of plan 4. Implementation	Training on self-management to be offered and delivered to all primary care providers
	Review current establishment and skill mix	Identify people in post and share analysis with commissioners	Bee U	Dec 2019	1. Roles and workforce profile understood 2. Learning from process shared with wider partners 3. Clear plan for moving to workforce able to deliver holistic care in line with spec	
		Develop training plan	Bee U	Completed	1. Training needs identified 2. Future training mapped and appropriate training	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
					provider identified	
		Deliver training plan	Bee U	Completed	1. People supported to develop appropriate skills to deliver evidence based care	
	Develop and deliver OD plan to support cultural change	Deliver OD plan	Bee U	Completed		
	Review estates and agree strategy	Estate currently used reviewed to support appropriate accessible services utilised.	Bee U	Completed		
		Implement estates strategy	Bee U	March 2020		
	Workforce information across partnership identified to identify workforce training plan for joined up care.	1. Engagement with partners to agree best approach 2. Point prevalence audit undertaken of workforce (roles, skills, gaps) 3. Plan developed to set out future gaps and needs 4. Financial modelling undertaken to ensure sustainable	STP	July 2019		

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		workforce for the future				

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
Thrive Model – Getting More Help **7. Ensure strong partnership working and system wide governance**						
	Develop the system infrastructure to support the transformation of children and young people's 0-25 years emotional health and wellbeing services	1. Undertake review of various system governance groups and meetings to determine where a) efficiency can be realised b) partnership working can be improved c) lessons can be shared and d) duplication avoided.	STP	Feb 2019	1. Report to Children's Boards on proposals/learning. 2. Engage Young People in process 3. Agree programme of change if appropriate. 4. Procurement of services to support co-production	• Improved outcome measure scores (across a range of outcome measure frameworks) including transitions • Specialist provider to be fully compliant with National Waiting Times and Accessibility standards
	Develop an all-age mental health strategy, locally tailored for delivery.	1. Engage widely both formally and informally 2. Capture views and	STP	Nov 2019	Strategy written which outlines strategic commissioning needs and transformational plan to deliver effective models of care at place,	• The needs of CYP will be reflected in a Shropshire wide mental health

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		experiences of people in services and partners 3. Develop a strategy 4. Implement strategy			locally, and in line with emerging focus on neighbourhoods and integrated teams.	strategy, linking the known causes and determinants of poor mental health to local data and models of care. • The mental health strategy will be co-produced • NHS LTP Must Do's aligned
	Ensure website and communications collateral are up to date	1. Re-establish partnership meetings with contract partners and other stakeholders 2. Improve website so that the service offer is clear, and all pathways and information is accessible and easy to find. 3. Links to website self-help materials and on-line self-	MPFT	March 2019	Website up to date Downloadable information available on conditions and approaches to support / treat.	• Future commissioning and procurement to reflect Mental Health strategy • Co-produce social marketing messages about emotional wellbeing and mental health. Aligned to national initiatives such as Time to Change: • Incorporate innovation in challenging stigma • Children and young people to

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		management available. 4. Marketing collateral available for partners to distribute across the system.				have access to self-help strategies and "exercises" that help keep well. • children and young people reporting year on year improvements in emotional wellbeing and functioning • CYP and families reporting more confidence in coping and self-management.
	Adopt Thrive Model, language and ethos to describe elements of the service	1. Ensure all written materials (above) both hard and on-line copy reflect Thrive language. 2. Link to training and workforce development across schools, self-help courses, and interventions	MPFT	March 2019	All communications collateral and descriptions reflect Thrive language	

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		(as appropriate) for consistency.				
	Develop effective governance around the delivery of high quality and sustainable commissioned services.	1. Agree governance and reporting arrangements for contract management 2. Agree data and outcomes to be collated. 3. Agree trajectory for access and waiting times management	CCGs	Completed	Collaborative commissioning and procurement of services based on the co-production models, principles of sustainability and evidence base Outcome measures routinely collated and reported through contracts CYP and family feedback captured and linked to quality improvements in pathways Integrated data mapped from access to discharge available	• Governance of mental health strategy established • Outcome measures agreed for pathways • Training and OD plan agreed for team • Data improvements • 32% CYP access target met • To finalise agreement on local minimum dataset
	Commission for resilience, in communities, early years and schools	Develop plan for future commissioning on population health data.	CCGs/ Councils	April 2020	All future commissioning to take into account patient level intelligence and allocation of resources to reflect local prevalence rates and local needs Local and national datasets to inform commissioning	• A co-produced commissioning plan in place by 2020 • Commission against population based principles that

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
					STP MH Strategic Commissioners to engage providers in developing local minimum datasets. CCG informatics to analyse quarterly data and align to a system level KPI development programme. Refreshed National and local prevalence data to be published	are co-produced • Commission for early intervention • Transitions commissioning aligned to SEND reforms
Thrive Model – Getting More Help **8. Fully involving Children, Young People and Families**						
	Develop the voice and engagement of children, young people and their families that are and have experienced	Recruit and support a group of children and young people who are or have been service-users of mental health services, to develop a dialogue about	CYP-IAPT participation worker / Bee U CCGs / Councils	March 2019	1. Literature available about the group and how to get involved. Provide additional support for vulnerable groups to engage. 2. Arrange listening event for CAMHs staff and CYP	Strong and vibrant proactive involvement at all levels of the service

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
	mental health illness	services.			Group established. 3. Terms of reference in place 4. Dialogue developed with the group re service delivery and future planning. 5. Fun and feedback from service users.	
		Annual survey of children and young people using mental health services	MPFT	April 2019 (annual)	1. Research surveys 2. Design of survey 3. Implementation 4. Learning and quality improvement annually	
		Develop IT plan to explore innovative use of IT in increasing access for children and young people.	MPFT	April 2019		
		Review YP engagement groups and consider STP wide steering group and links with CYP LTP work programme	STP	April 2019	Effective involvement of CYP in strategic planning/discussions	
	Using participation of	Develop training on the importance of	MPFT	May 2019	1. Staff training delivered 2. CYP identified for	Active involvement and participation across the

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
	children, young people and families to inform service planning	participation and the CYP-IAPT principles of co-production and collaboration.			involvement in all pathways	system and in service redesign
		Gather families feedback from existing parenting programmes and use it to inform service planning.	Public health / LA		1. Agree process for collecting parenting ROMs 2. Prepare quarterly report 3. Presentation at STP MH Group 4. Identify experts to co-deliver training	Feedback and involvement in future delivery

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
9. Improved crisis care			**Thrive Model – Getting Intensive Help**			
	Develop crisis pathways	Develop trusted assessor framework Develop agreed ROMS on RiO for each pathway Train staff in agreed ROMS Implement pathway	MPFT/CCG	Feb 2019	Pathway established Staff trained Outcomes agreed Ongoing OD plan agreed Capacity identified	▪ CYP being treated and supported closer to home ▪ Reduced in-patient admissions ▪ More children and young people in crisis will be able to remain at home and to be

Ref	Objectives	Actions	Lead	Completion date	Milestones / Outcomes	Outcomes
		Confirm demand and capacity for incoming referrals and waiting list management Continuation of 'at risk of admission' registers' Develop pathways Explore alternative 'safe place' to avoid admission. Review Tier 3.5 (Walsall Model) in partnership acute provider.				supported by a team that brings together a range of skills ▪ More children and young people will have access to 24/7 services and out of hours specialist care where needed ▪ Fewer CYP will be admitted to in patient units or placed in residential schools.
	Review use of residential settings for complex care	Identify cohort of CYP in placements Consider step down arrangements Identify root causes for admissions	Councils/CCG	June 2019	Plan in place to avoid future admission rates Effective complex care pathways in place for most at risk CYP	

GLOSSARY OF TERMS

3di	Developmental, Dimensional and Diagnostic Interval
5YFVMH	5 Year Forward View for Mental Health
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
ARMS	At Risk Mental State
ASD	Autism Spectrum Disorder
BeeU	Consists of 4 organisations – The Children's Society, Kooth, Healios and The Midlands Partnership Foundation Trust
CAMHS	Children and Adolescent Mental Health Service
CBT	Cognitive Behaviour Therapy
CCG	Clinical Commissioning Group
CHIMAT	National Child and Maternal Health Network
CPD	Continuing Professional Development
CQRM	Clinical Quality Review Meeting
CQUIN	Commissioning for Quality and Innovation
CYP	Children and Young People
EHWB	Emotional Health and Wellbeing
EHWS	Employee Health and Wellbeing Service
EIA	Equality Impact Assessment
EIP	Early Intervention in Psychosis
FTE	Full Time Equivalent
HOSC	Health Overview and Scrutiny Committee
IAPT	Improving Access to Psychological Therapies
IST	Intensive Support Team
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicators
LA	Local Authority
LAC	Looked After Children
LDD	Learning Disabilities and Difficulties
LGBT	Lesbian, Gay, Bisexual and Transgender
LTP	Local Transformation Plans
MDT	Multi Disciplinary Team
MHFA	Mental Health First Aid
MLCSU	Midlands and Lancashire Commissioning Support Unit
MPFT	Midlands Partnership Foundation Trust
ND (CAMHS)	National Deaf CAMHS
NEET	Not in Education, Employment or Training
NHSI	NHS Improvement
NICE	National Institute Clinical Excellence
ONS	Office National Statistics
PALS	Patient Advice Liaison Service
PRU	
PSHE	Personal, Social, Health Education
RN(MH)	Registered Nurse Mental Health
ROMS	Routine Outcome Monitoring
RSE	Relationship and Sex Education
SaTH	Shrewsbury and Telford Hospital Trust
SEND	Special Educational Needs and Disabilities
SEND	Special Educational Needs and Disabilities
SFT	Solution Focussed Therapy
SSCB	Shropshire Safeguarding Children's Board
STP	Sustainability and Transformation Plan
TaMHS	Targeted Mental Health Support

TCP	Transforming Care Partnerships
TYS	Targeted Youth Support
WMQRS	West Midland Quality Review Service
YOS	Police/Youth Offending Service
YSS	Youth Support Service

Shropshire Council

NHS Shropshire Clinical Commissioning Group

Shropshire together

Health and Wellbeing Board
Meeting Date January 16th 2020

Kerry Simmons

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1. Summary

1.1 This paper provides an overview of a Wellbeing Award currently being completed at Market Drayton Infant and Nursery School. The school decided to complete the award as Wellbeing was a main focus on the School Improvement Plan.

School context: Set in a pleasant rural area, but number of social and economic challenges; within the 30% most deprived areas nationally. 31% of residents in employment work in elementary occupations compared with only 20% nationally. Anecdotal evidence number of our pupils are from families whose income puts them just above the level of eligibility for free school meals. A high proportion of the children enter school working below aged related expectations, particularly in communication, language and literacy. Market Drayton has the highest number of speech and language needs in Shropshire (Children's Centre Wards data). This is reflected in the school having two members of staff to support Speech and Language Development and Communication (SLCD). Information from 2018 Pupil Premium report shows:

38% of children in receipt of pupil premium have accessed speech and language support for at least one year. As a result of effective early intervention, the nine children who were on the speech and language register had been removed by the end of Year 2 – 50% of the Pupil Premium had at some point had SLCD. In the 2018 Y2 cohort, 9 children in receipt of Pupil Premium had had speech and language input at some point.

1.2 The Wellbeing Award is being completed through Optimus Education and an external adviser has visited the school to carry out an initial audit followed more recently by an interim assessment. The award is due to be completed at the end of Spring Term.

1.3 The award focuses on many different areas and puts all stakeholders at the heart of its work. The idea is that it is an award to support all within the school which includes children, parents and staff. The work completed has been in consultation with all stakeholders and there is a change team meeting each term to continue analysing progress and driving the work forward. This meeting consists of the school's Mental Health Leads, a member of the Early Help team, a governor, pastoral support in the school, a member of Shropshire Community Health Trust, the School Business Manager and the school cook. Pupil voice is also represented through the work of the school council and shared at this meeting.

1.4 At Market Drayton Infant and Nursery School, the school is fully committed to promoting and protecting the emotional wellbeing and mental health of the whole school community and have adopted a whole school approach that includes pupils, parents and staff. Through encouraging all stakeholders to talk openly, the school has developed a positive approach to protecting and promoting emotional wellbeing and mental health and understand that it is the responsibility of everyone. Wellbeing Champions have been introduced and wear a badge designed by a child in the school. The school pursues this aim using both universal whole school approaches and specialised targeted, approaches aimed at vulnerable pupils. In an average classroom, three children will be suffering from a diagnosable mental health issue. By developing and implementing

practical, relevant and effective mental health policies and procedures the school promotes a safe and stable environment for pupils affected both directly and indirectly by mental ill health. The school is very aware that this has to be a priority in order for children to be able to achieve academically and for adults to achieve work satisfaction.

1.5 The skills, knowledge and understanding needed by our pupils to keep themselves and others physically and mentally healthy and safe are included as part of our developmental PSHE curriculum. The specific content of lessons will be determined by the specific needs of the cohort being taught but there will always be an emphasis on enabling pupils to develop the skills, knowledge, understanding, language and confidence to seek help, as needed, for themselves or others. The school follows the principles of the Five Ways to Wellbeing as researched and developed by the New Economics Foundation. An integral part of our teaching of this is our school-developed character CLANG (Connecting, Learning, Active Learning, Noticing and Giving). Appendix 1. In addition, the school takes part in the daily mile encouraging children to keep moving and there are wellbeing champions across the school supporting the children with this work.

1.6 The school recently received the Achievement for All (AfA) award which supports the wellbeing award. The education system is struggling to meet the needs of one in five children and young people. Achievement for All is a programme that helps schools to achieve, aspire, ensure access for all and accelerate progress regardless of background, challenge or need, with wellbeing at the heart. The school selected their most vulnerable families to work with which included longer parents evenings, supporting the whole family not just the child, being a listening ear and trying to signpost parents in the right direction for support. This has been really well received and on accreditation day for the award some of our targeted parents came to talk to the assessor raising awareness of the work the school had completed. Some of the quotes included were:

I love homework club. I like maths and in the club I learn things like times, adds and divides. I love being in this school and giving teachers hugs. I learn well and I like the school playground and field. Teachers help me with my learning. Year 2 child.

X has been receiving help from the school with her education and I feel it has helped a lot. She struggled the first few months with her writing and maths. I had meetings with her teacher to put in place tasks for X to aim towards and she achieved the. X is so much better with her writing now. She also attends Mathletics after school and I feel it had helped her confidence to try harder and achieve her goals. I can't thank the school enough for all their help with X.

1.7 The school also runs very successful Understanding Your Child workshops. These are often oversubscribed and further sessions/waiting lists have to be put in place. On entering the school every child's parent attends a parent workshop (95%+ uptake) where they have a taster session for this workshop. This then encourages them to join the full ten week course. Parent sessions and workshops have become part of the school ethos and are non-negotiable for parental attendance.

1.8 Networking and working in collaboration has been one of the focuses of the award that the school wanted to develop. The school has engaged with the local GP and together produced a 'sharing information form' which will further support families in need. In addition to working with the GP, the school has also worked closely with school nurses and are due to support with the pilot health baseline assessment.

1.9 Communicating with all stakeholders has been key to success in the award. Making sure all staff feel like they have ownership over decisions and children have the opportunity to have their voice heard has been a priority for the school and lots of work on improving communication has been completed over the last year. The school website also shares up to date information for parents to go to for additional support and advice. This is always being updated as the school finds new information. The school also signposts parents to use the NHS health4kids website.

1.10 A Family Support Worker is employed to work across three of the town schools which has had a huge impact on families' wellbeing and emotional needs. The Family Support Worker has developed many good relationships and families clearly trust her. This is something the school wishes to continue using, however funding is becoming increasingly stretched.

1.11 The school carries out wellbeing days at least once a term. These at the minute are down to year group discretion but from next term the school is considering having themes to these linked to areas of need that are identified, such as sleeping issues noted from questioning the children.

1.12 Training for staff and adults alike is seen as a high priority and, although there is not a lot of available training devoted to infant age children, the staff at the school attend the training and adapt it to make it suitable for this age. They have the firm belief that early identification is key and it is their role to be preventative and give the children the tools they need to lead a resilient life. Appendix 2 is an example of a training log completed for all adults.

1.13 There are many strategies that have been put in place for staff as well as children including the addition of targeted play therapy, a school dog, supervision, ways of working discussions in year groups, a wellbeing noticeboard, access to counselling for staff without much of a wait, open discussions during appraisals and much, much more.

1.14 Next Steps

- Meeting with GPs regularly, joint working in the local community and beyond is key to ensure maximum support and progress for our families. This is something that the school will continue to drive forward

- Sleep clinics and training is something that the school is currently looking in to. Data taken from the children shows a pattern that sleep is an issue in terms of being woken in the night and feeling tired at school. The Daily Mile has shown good improvements in the children's energy, however sleep is still an issue according to what the children tell us.

- Educating adults and parental knowledge is crucial in helping families collectively to have positive mental health and wellbeing. This is one the school's key recommendations for the work they undertake. Parents are often very welcoming of support and information from the school about supporting their children's emotional and mental health. In order to support parents the school:

  - ♣ highlights sources of information and support about common mental health issues on the school website
  - ♣ ensures that all parents are aware of who to talk to, and how to go about this, if they have concerns about their own child or a friend of their child. The school has created an ethos that supports open and honest communication and is seeing more parents opening up to them for support
  - ♣ makes the mental health policy easily accessible to parents via the website and via direct email
  - ♣ shares ideas about how parents can support positive mental health in their children through our regular newsletter updates, information evenings and parent sessions. The school has recently run two successful wellbeing sessions where there was a turn-out of 78% and 81%. In these sessions parents learnt how they could help support their child at home, took part in a Lego therapy session and ran the daily mile with them, understanding the importance of activity
  - ♣ keeps parents informed about the mental health topics their children are learning about in PSHE and share ideas for extending and exploring this learning at home.

2. Recommendations

The Health and Wellbeing Board is recommended to note the information and progress of the Wellbeing Award and the work being completed for children and young people in Shropshire.

3. Risk Assessment and Opportunities Appraisal

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

N/A

4. Financial Implications

The award is nationally accredited and has key performance indicators to measure progress against. There is a cost implication to this. These are:

- School-led £1250
- School-led support (includes one additional external visit) £2000
- School-led support plus (includes two additional external visits) £2750
- Adviser-led £3250

5. Background

N/A

6. Additional Information

Data information shows that this work has had a positive impact on the children in our school. For example:

- Children's overall life satisfaction went from 8.2/10 to 9.4/10 over two terms
- Enjoying school work went from 3.6/5 to 4.3/5
- Feeling good about themselves went from 3.9/5 to 4.4/5
- Feeling like they fit in to school went from 3.9/5 to 4.7/5

7. Conclusions

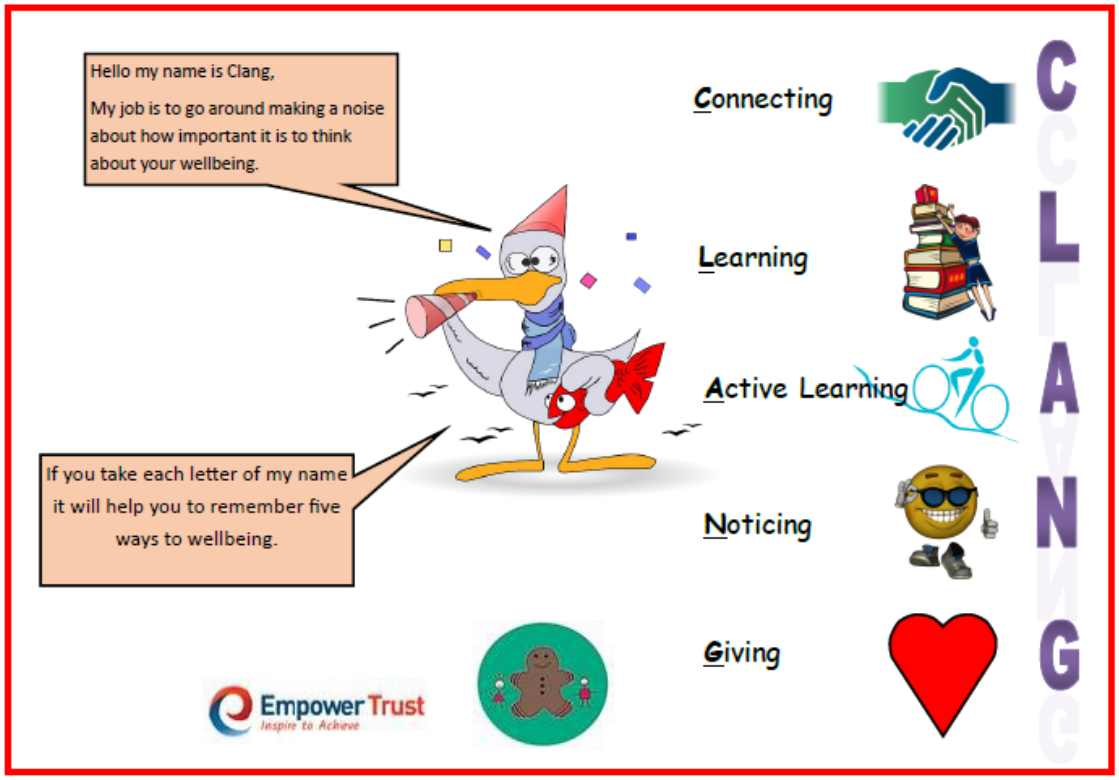
The final assessment for the award will be completed at the end of the spring term and from there on the school will make sure the work and procedures put in place continue to support the wellbeing of all stakeholders. The strategy will continue to be part of the school's work. You can find further information on the school's website https://www.marketdraytoninfants.co.uk/ under the curriculum section and PSHE.

There have been many comments from questionnaires sent out to parents. They said that

"The school really cares about emotional wellbeing and mental health of everyone involved in the school. The school's way of dealing with this has really impressed me, the curriculum is well rounded and provides plenty of opportunities. It is obvious that the teachers are looking out for it and that the school communicates this in newsletters."

List of Background Papers
Cabinet Member (Portfolio Holder)
Local Member
Appendices **1. CLANG poster** **2. Training log**

Appendix 1


Hello my name is Clang,
My job is to go around making a noise about how important it is to think about your wellbeing.
If you take each letter of my name it will help you to remember five ways to wellbeing.
Connecting
Learning
Active Learning
Noticing
Giving
C
L
A
N
G
Empower Trust
Inspire to Achieve

Appendix 2

MARKET DRAYTON INFANT & NURSERY SCHOOL

Training Log and Attendance

The following table shows training in place for all stakeholders and attendance records.

Date	Training and stakeholder	Stakeholders	Attendance
18.09.19	Mental Health and Schools Link workshop 1	2 Mental Health Leads	
6.11.19	Mental Health and Schools Link workshop 2	2 Mental Health Leads	
07.01.19	PD Day – attachment and Mental Health Award	Initially to Teachers and repeated to TAs and all staff in school	100%
9.01.19	Understanding Your Child by Julie M – Parenting Team and Governor	1.25 – 2.55 – Tas 3.30 – 5.00 – Ts, HLTAs and Nursery	100%
Jan 2019	2 days Empower Trust Strategic Mental Health Training	2 Mental Health Leads and Deputy Head	
20.01.19	Session 1 Psychology Students – Intervention and Effective Communication	All staff	100%
13.02.19	Session 2 Psychology Students – Intervention and Effective Communication	All staff	100%
08.05.19	Resilience training with David Bell (AfA coach)	1.30-2.50 – Tas 3.30 – 5.00 Ts	100%
15.05.19	Wellbeing Staff Meeting 2 (including SWOT)	Teachers initially	100%
16.05.19	Wellbeing Staff Meeting 2 (including SWOT)	Nursery staff and cleaners	100%
20.05.19	Wellbeing Staff Meeting 2 (including SWOT)	TAs, kitchen and office staff	100%
May 2019	Mental Health and Wellbeing – Supporting Emotional Needs of C&YP (Reach for the top)	2 Mental Health Leads and 2 TAs	
May 2019	De-escalating Training	All staff	100%
May /June 2019	Emotional Literacy Support Assistant Training (ELSA)	4 pastoral support TAs	100%
June 2019	TaMHS – introduction to Self Harm and STORM	4 pastoral support TAs	100%
June 2019	LAC - Network	LAC governor	
July 2019	Mindfulness Minutes project	All stakeholders taking part	100%
July 2019	Parent Wellbeing Workshop	Current Y1 class	100% staff 78% parents
16.09.19	Play therapy training and presentation	SMT	100%
9.10.19	Staff meeting – focus on policy, strategy and staff wellbeing	Teachers and HLTAs	100%
16.10.19	Early Help Locality Meeting	KS/HW	
Oct 2019	Parent Wellbeing Workshop	Current Y1 class	100% staff

			81% parents
22.10.19	Follow up meeting – focus on policy, strategy and staff wellbeing	Nursery, office, kitchen and TAs	100%
20.11.19	Wellbeing – resilience training	All teachers and HLTAs	100%

In addition to this, Teachers have staff meeting time allocated to SEN/AfA personal meetings with parents, year group meetings to discuss ways of working and any supervision needed.

Also see safeguarding training log

Health and Wellbeing Board
16th January 2020

Update Report on Progress of Single Strategic Commissioner Application by NHS Shropshire CCG and NHS Telford and Wrekin CCG

Responsible Officer: David Evans, Accountable Officer, NHS Shropshire CCG

Email: David.evans2@nhs.net

1. Summary

1.1 At the NHS Shropshire CCG Board meeting held on 14th May 2019, the Governing Body agreed to support the dissolution of both CCGs and the formation of a single strategic commissioning organisation for the Shropshire, Telford & Wrekin footprint. It also supported recruitment of a single Accountable Officer across both CCGs and the establishment of a single management team whether an early application to NHS England for establishment of a single CCG was accepted or not. On September 17th both CCG memberships supported this proposal and an application was formally made to NHS England/NHS Improvement on 30th September to dissolve the two existing CCGs with a view to creating a single CCG from April 2020.

1.2 The purpose of this report is to provide a further progress update on the application process for creating a single strategic commissioner across Shropshire and Telford and Wrekin from the last report presented to the Health and Wellbeing Board at its meeting held on 12th September 2019.

2. Recommendations

2.1 The Health and Wellbeing Board is asked to note the contents of the report.

REPORT

3. Report on progress of the single strategic commissioner application

3.1 Following the formal application to NHS England /NHS Improvement on 30th September 2019, to create a single strategic commissioner, a panel meeting was convened by the regional NHS England/NHS Improvement team to consider the application in more detail on 11th October 2019.

3.2 Following the NHS England panel meeting, the CCGs were informed that the application had been unsuccessful, due to the fact that the CCGs had not had enough time to develop the strategic thinking that underpinned some key evidence and documentation submitted with the application, which did not fully meet the NHS England /NHS Improvement application criteria.

3.3 However, the NHS England Panel provided very positive feedback on the application, acknowledging the effort and contribution in developing the application by the two CCGs. The

Panel's view was that if the CCGs had more time, the application would have been stronger and the late start clearly disadvantaged our application.

3.4 The feedback highlighted the strength of the application on the following points:

- commitment to the application;
- good progress has been made in the time the CCGs have had and cohesive application with several strengths was submitted;
- membership support for the proposal;
- significant effort in securing Organisational Development (OD), Human Resources (HR) and Project Management Office (PMO) support;
- good progress on understanding the challenge and developing the strategic thinking and supporting documentation;
- well-structured and clear overall Programme plan;
- comprehensive Communications and Engagement Plan; and
- comprehensive Primary Care Strategy.

3.5 In addition to the positive feedback on the application submission, the NHS England/NHS Improvement Panel also made a firm offer to support the CCGs to make a further application earlier than the normal deadline of September 2020, as they believe our application can be enhanced to meet the 10 application criteria in full, if we continue to work at pace. We have agreed with NHS England the following new timescale for re-application:

- Final submission of revised application evidence - 30th April 2020
- Regional NHS England/NHS Improvement panel – early June 2020
- National NHS England/NHS Improvement Committee – July 2020
- Creation of a new single CCG - April 2021

The programme plan and timescales have been revised accordingly.

3.6 As part of NHS England's commitment to supporting both CCGs through this process and acknowledging their feedback from the panel process, two national merger leads on Organisational Development (OD)/HR and Strategy have been asked by NHS England/NHS Improvement to provide support to the programme in relation to next steps required on OD and further support on developing the Commissioning Strategy.

3.7 Public engagement on the proposal to create one single CCG across Shropshire, Telford and Wrekin was due to start in December but had to be postponed due to purdah as a result of the general election. This has now been scheduled in January and February 2020 with public engagement launch event taking place on 24th January in Shrewsbury. In addition we are also arranging 2 hour pop ups at Oswestry Library, Darwin Shopping Centre Shrewsbury, Ludlow Library, Park Lane Centre Telford, Telford Shopping Centre and Tesco Supermarket Wellington. Engagement feedback will be collected via a survey form which will be available online and in hard copy.

3.8 Both CCGs are now exploring the options to align their respective governance structures and processes to allow a single management and staff team to support both CCGs efficiently and effectively in the interim period, running up to the planned creation of a single strategic Commissioner in April 2021.

3.9 As previously stated, the management of change process to create one single staffing structure to support both CCGs for senior managers and staff has started and will continue regardless of the delay in a successful application,. A management of change process for Director

roles began in November and concluded in December 2019 and the following appointments have been made:

Executive Director Finance (CFO)	Mrs Claire Skidmore
Executive Director Transformation	Dr Jessica Sokolov
Director Corporate Affairs	Miss Alison Smith
Director Planning	Mrs Samantha Tilley
Director Performance	Dr Julie Davies

The following roles have not been appointed to and will go out to national advert for recruitment:

Executive Director Quality
Director Partnerships

3.10 Following the appointment of Directors, staff structures will start to be developed in the New Year with a view to staff management of change beginning in February and completing in April/May 2020.

4. Risk Assessment and Opportunities Appraisal

4.1 The highest risk to the programme had been with regard to the very ambitious timescale we originally had to make an application. However, this has now materially changed to the risk that we now need to maintain momentum to the programme, as the new timeline for making a further application has now been agreed as 30th April 2020, with a view to a single CCG being created in April 2021.

4.2 The positive benefit of this change is that it affords us more time to refine our commissioning strategy, operating model and finance plan for the new single strategic commissioner.

5. Financial Implications

5.1 Future working arrangements are a key consideration in the financial and clinical sustainability of the CCG's going forwards.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Single Strategic Commissioner Update Report to HWBB - 12th September 2019 and appendix
Cabinet Member (Portfolio Holder) n/a
Local Member n/a
Appendices n/a

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Shropshire Council | NHS Shropshire Clinical Commissioning Group | Shropshire together

Health and Wellbeing Board
Meeting Date 16th January 2020

Responsible Officer: Cathy Davis, Commissioning & Redesign Lead - Mental Health (interim), Shropshire Clinical Commissioning Group (CCG)

Email: cathy.davis@nhs.net

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1. Summary

2. Recommendations

REPORT

A report is attached

3. Risk Assessment and Opportunities Appraisal

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

4. Financial Implications

5. Background

6. Additional Information

7. Conclusions

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

Purpose of the report:

1. To provide the Health and Wellbeing Board with an update on the current commissioning work in dementia.
2. Key work areas for the programme for the coming year
3. Hospital avoidance accreditation update (separate presentation)

Agenda Item:

Introduction

1 Dementia is a growing health problem and of the current 850,000 estimated UK prevalence approximately 550,000 have confirmed diagnosis. Our older population will see the most rapid growth in the next 20 years and as a result a growth an increase in dementia and other conditions affecting the elderly.

2 In Shropshire, Telford and Wrekin there are an estimated 7,410 people living with dementia and 5,390 have a diagnosis.

3 The impact of dementia on Shropshire health services remains significant and is of great cost. Many live with dementia and multiple other long term conditions.

4. Alcohol related brain damage (ARBD), Alcohol related dementia, Alcohol Amnesic syndrome as well as other conditions all occurs as a result of physiological changes to the brain, following long term heavy alcohol use. According to research, Wernicke-Korsakoff syndrome occurs in around 2% of the general UK population and 12.5% of dependent drinkers, extrapolating this to Shropshire equates to 349 people with the condition in the county.

4 People with dementia spend spells in acute hospitals for otherwise home treatable conditions. People with dementia also make disproportionate use of A&E services. Behavioral changes in the person and mental health crisis are the most common concerns for families living with dementia.

Background

5 The NHS England Well Pathway on Dementia (2015) divides the dementia journey into 5 steps.

Preventing Well	Diagnosing Well	Living Well	Supporting Well	Dying Well
Risk of People Developing Dementia is minimized	Timely diagnosis a care plan with a review within 12 months	Access to high quality and safe health and social services for people and for care	People live normally with dementia and access safe and accepting communities	People have the right to die with dignity in a place of their choosing
The Statements: "I was given information about reducing my personal risk of getting Dementia"	"I am able to make decisions and know what to do and who else	"I get treatment and support which are best for my dementia and my life"	"I know those around me and looking after me and supported. I feel included and part of society"	"I am confident my end of life wished will be respected" "I can expect a good death"

	can help me"			

6 Shropshire CCG created its Dementia strategy in 2017 in order to deliver the Well Pathway and respond to findings of an engagement report from Health Watch Shropshire which surveyed people living with dementia. It outlined 4 strategic goals and 7 key objectives to be met by 2020.

Key Objectives of the Shropshire 2017 Dementia Strategy deliverable by 2020

Strategic Goals

1. Diagnose dementia earlier.
2. Increase the provision of support during the earlier stages of the dementia journey through implementing the Shropshire Model for living with dementia.
3. Provide a crisis-resolution team to work collaboratively with community-based physical treatment services, to eventually gate-keep all admissions for people with dementia, ensuring that hospital admission only takes place as a last resort.
4. Provide a greater number of dementia support workers in the inpatient setting.

Key Objectives

1. A greater understanding of what can be done to reduce the risk of dementia in the county, resulting from a successfully implemented prevention strategy.
2. GP based diagnosis, commencement of treatment and specialist advice, resulting from placement of memory and dementia specialist nurses in local practices.
3. Good post diagnostic support to promote social inclusion, functional independence and sustainability of role, whilst ensuring care feels more joined up at the point of delivery. The opportunity for assistance from a Dementia Companion will assist in achieving this.
4. A service that can respond out of hours, to people living with dementia and their carers who are in crisis. This will result from having a properly specified crisis resolution service for people with dementia.
5. Efficient and effective use of inpatient resources. This will result from the provision of sufficient numbers of dementia support workers to enable the needs of people with dementia to be met in a more efficient way, whilst planning for discharge at the point of admission.
6. Robust and effective early discharge arrangements. This will result from dementia support workers working together with Dementia Companions, independent sector providers and home treatment services to ensure that adequate community-based support is provided.
7. Palliative care arrangements that are more responsive to the needs of people with dementia. This will result from closer working with local palliative care specialists, and development and delivery of strategic intentions towards making this happen.

7 The strategy outlines a new model for post diagnosis dementia care in Shropshire. The strategy introduces the role of the dementia companion as the link worker supporting the person to access services and information to have their health and wellbeing needs met:

Support For Carers	Providing Information	Therapeutic interventions on the causes of Dementia
Keeping engaged with the community	Person with Dementia	Making sure mental health needs are met

Planning and Personal Choice	The Dementia Companion	Making sure care is personalised
Making Sure Physical needs are met	Locally Accessible Expert Advice	Creating an enabling environment

8 What has been achieved since 2017?

- ✓ Shropshire CCG funds two companions as part of a pilot - in Oswestry and Ludlow.
- ✓ Achieve diagnosis prevalence rate
- ✓ Assessment and diagnosis increased access- dementia team see people within clinics at MPFT bases in Shrewsbury (Seven Fields Health Village) which is also GP practice (upstairs) Bridgnorth, Market Drayton, Oswestry, Ludlow, for people referred from practices within these localities. Positive feedback from people coming into clinic. People can also be seen at home and within residential and nursing home.
- ✓ Nurse practitioners who are also non-Medical prescribers who undertake the assessments and work closely with old age psychiatrists. Introduced a pre clinic information gathering and information giving (re the assessment process which can be daunting for people) recognising that whilst the memory service is referred to actually people will be given a diagnosis (where appropriate) of dementia. Currently our experienced support workers take on this role with very positive feedback.
- ✓ CCG funding of day services, cafes and peer support.
- ✓ Development of the dementia friendly hospital charter action plan.
- ✓ Development of hospital avoidance programme which was presented to Royal College Psychiatry awarded successful Accreditation.

The Way Forward and next steps

9 National and local developments to note since the publication of 2017 strategy:

- *NHS England target of six weeks for delivering diagnosis from referral.*
- *NHS England monitoring the prescribing of anti-psychotics to people with dementia monthly. Shropshire is currently above the national average rate at 10.6% (376 people)*

10 Public Health England published what to expect after a diagnosis of dementia (2018) which included these standards for personalising dementia care:

- A care plan I am involved with
- A named person who coordinates and monitors my care
- Help with my day to day activities
- Support for the people who care for me

11 The Shropshire Care Closer to Home programme is currently piloting a new personalised and integrated care approach of risk stratification and case management for people aged 65 and over, underpinned by the principles of identifying people and their needs earlier, enabling the provision of proactive preventative care and support from a joined up team of health, mental health and social care professionals.

12 Care is coordinated by a named case manager and the risk stratification tool currently identifies people suitable for referral to the programme based on a range of criteria which is currently based on physical health information. The next phase will be to integrate with mental health and social care information; enabling locally available teams to identify individuals and their needs delivering elements of the standards (personalising dementia care through the provision of proactive integrated holistic and person-centered care planning).

13 Shropshire performs well in terms of diagnosis to prevalence rates currently 71% against the NHS England 66.7% target (currently 65.1%). Whilst the system meets the national target there remains around 31% of people with dementia in the county yet to be diagnosed.

14 Reviews are continued by the dementia team currently although no longer indicated within nice guidelines, aim is to move to a needs led review and utilise capacity for the case management model (care closer to home). Whilst we achieve the national prevalence rate, going forward to support the increase in diagnosis, we aim to develop more clinics in general practice (ensuring referral rates indicated). To consider increasing access to clinics by developing Saturday clinics as aware some relatives find weekdays problematic.

15 Offering wider patient choice on point of accessing assessment and diagnosis should greatly reduce people's non-attendance of an appointment and subsequently increase diagnosis rates. There is potential to also expand delivery of the service at home and in other community hubs/hospitals as well as in-surgery.

16 Historically professionals have viewed alcohol use as a life style choice as a 'free choice' and unless the individual agreed to receive or engage with services then support was often not provided. It is therefore proposed that adult social care have a workforce which understand the impact of alcohol on the individual and that there are systems in place to respond accordingly, this will include developing a plan for people who have dementias as a result of Alcohol Related Brain Damage.

Next Steps

16 Key actions**.**

2017 Strategy Objective/Strategic Goal	Work In Progress	Recommendations	Resource Impact
Preventing Well A greater understanding of what can be done to reduce the risk of dementia in the county, resulting from a successfully implemented prevention strategy.	Joint authority prevention programmes in place as part of wider healthy living initiatives.	Create a Dementia-specific Prevention strategy.	No
Diagnosing Well Earlier diagnosis. GP based assessment and diagnosis, commencement of treatment from specialist nurses based in local practices.	Two surgeries have installed an in-surgery assessment and diagnostic service.	To meet the National guidance in full a further roll out of this model is required. Identification of suitable sites and workforce requirements. Primary care case study.	Yes - Develop business case for consideration at CCC

	Development and implementation commenced within Shropshire Care Closer to Home (SCCtH) Phase 2.		No – Already within the design of SCCtH.
Living Well Good post diagnostic support to promote functional independence and wellbeing. Ensuring care feels more joined up at the point of delivery. The dementia companion as the integral role coordinating this.	Two Dementia Companions in post serving Ludlow and Oswestry towns only Three Dementia Support workers (by referral only for specific issue then discharge.) Serving North Shropshire, Shrewsbury/Central and South Shropshire. CCG funding third sector run day services peer support groups and cafes. Focus group in place on person centered Care planning for dementia.	Further development of the Dementia companion role with evaluation criteria that measures for the person centered approach. Develop template for person-centered-profile Develop template for post diagnosis services information pack Evaluation and review of DSW service. Evaluation and of day services and cafes	Yes - Develop business case for consideration at CCC No No No No
Supporting Well A service that can respond out of hours, to people living with dementia and their carers who are in crisis. This will result from having a properly specified crisis resolution service for people with dementia. Robust and effective early discharge arrangements. This will result from dementia support workers working together with Dementia Companions, independent sector providers and home treatment services to ensure that adequate community-based support is provided.	Partnership trust implemented pilot admission avoidance scheme resulting in a reduction of crisis beds. Out of hours service. One dementia support worker in post in each hospital site PRH and RSH signed up to dementia friendly hospitals charter and 2019-21 trust implementation plan.	A Business case for pilot expansion of specialist dementia nurse service providing crisis prevention and resolution, with community visit and telephone support	Yes - Develop business case for consideration at CCC
Dying Well Palliative care arrangements that are more responsive to the needs of people with	Dementia Companions distributing support for	A Review report to include:	No

dementia. This will result from closer working with local palliative care specialists, and development and delivery of strategic intentions towards making this happen.	people to make advance end of life wishes and navigate legalities of LPA. NB - The rate of People in Shropshire with dementia dying in their usual place of residence is above the national average.	Coverage of dementia training and End of life training programmes in Shropshire Dementia expertise in care home, respite homes, hospices and acute settings.	

17 The Board is asked to note the progress against the Dementia strategy and updates in relation to national guidance.

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NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

Hospital Avoidance

Sharon Madden
Oak Ward Manager and Hospital Avoidance Lead
Denise Walker
Accreditation Project Co-ordinator

MPFT

mpftnhs

@mpftnhs

Background

- Admission to hospital for a person with dementia can be traumatic and can lead to an escalation in confusion, disorientation and associated behaviours. In addition the distress caused to carers can increase.
- Hospital Avoidance began as a pilot scheme on 16th March 2016.
- The purpose of the scheme was to provide specialist support at weekends (via telephone and face-to-face) in order to avoid hospital admissions for dementia patients. This later expanded Bank Holidays and three evenings a week
- The scheme supports patients from the Shropshire and Telford & Wrekin CCG areas.
- Additionally where a patient is on leave pending discharge from Oak Ward, if it is deemed beneficial to the patient and carer, Hospital Avoidance will follow up and support to prevent readmission.

Patient Journey Research

- Research suggests that increased hospital stays can have a negative effect on people with dementia including having a significant negative effect on their general physical health and on the symptoms of dementia, such as becoming more confused and less independent (Alzheimer's Society).
- Oak Ward aims for an admission period of 8 weeks and the patient journey describes what a patient can expect from admission to discharge.
- We do recognise though that all patients are individuals and patient journeys may differ slightly due to factors such as consent or changes to a patient's physical or mental health.

Your patient journey

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Within 24 hours of admission

- Care plan and Risk assessment completed and reviewed weekly throughout admission as any needs of risk change Physical health assessments including blood tests, ECG, Urinalysis, nutrition and hydration etc. will be carried out and reviewed as needed.
- A provisional discharge date will be set as 8 weeks from admission date
- Contact will be made from the ward to the NOK to provide information on the ward, visiting times and process of admission; they will also be given the opportunity to provide any information about the patient, if available this will be done by the key nurse.
- Falls assessment and referral for a physio therapy assessment; this will be reviewed if any falls occur throughout admission
  If there are concerns then a referral will be made to SALT, dietician or chiropodist based on the patient's needs and this will be reviewed throughout admission.

Within 1 week of admission

- Formulation meeting held with family and care co-ordinator to discuss and plan admission and discharge process
- Referrals will be made to social services, care co-ordination and advocacy.
- Ongoing medical assessment of physical and mental health with ward reviews carried out weekly throughout admission

Within 4 weeks of admission

- NOK will be offered 1:1 sessions at least weekly throughout admission to ensure that they are fully informed and involved in care planning.
- A nursing assessment will be completed making a recommendation of the level of care required on discharge
- An OT assessment will be completed making a recommendation of the level of care required on discharge
- A continuing healthcare checklist will be completed to assist with funding application
- A best interest/117 meeting will be held to discuss discharge planning

Within 6 weeks of admission

- Nursing home assessments will be carried out if required or a care package will be sourced if required
- A funding application will be made

Discharge

- When an appropriate placement is sought and funding in place, transfer arrangements will be made
- A transition support plan will be put into place, dependant on the level of support required

Within 7 days of discharge

- A 7-day follow-up will be completed by community nurse and they will take over the support in the community
- A discharge summary will be completed by medical team and sent to GP

Above is a description of the journey a patient can expect to go through during admission and then discharge. These timings are a guide only and are **not fixed** due to various different factors that can affect a patient in clinical situations.

What does Hospital Avoidance involve?

- Experienced staff from Oak Ward
- Telephone advice and face to face support
- Emergency Visits
- Pre-planned visit to support the person with dementia either in their own home or in Residential or Nursing Care.
- Joint visit with the Emergency Duty Team (EDT) if required
- Further support, visits or assessment can be arranged

Referral Process

- Referrals are accepted from nursing and residential homes, G.Ps , Memory Service, Access Team, pathways, EDT, and RAID
- Staff on Oak Ward complete the Hospital Avoidance checklist
- Staff on Oak Ward will assess each referral to determine the level of support required along with the level of risk
- All staff on Oak Ward who are likely to be involved in either the receipt of referrals or providing telephone or face to face support must have received an appropriate induction into the protocol and this must be recorded and put in their personal file.
- Following Hospital Avoidance input Oak Ward staff must ensure Home Treatment are informed

Gold Standard Care Plan

In order for someone to be referred to Hospital Avoidance they must:

1. Be on CPA
2. Have a mental health care plan
3. Be a care cluster 19 or above

Referrals accepted by telephone or email but must include:

Name, address and contact number, Reason for problem, What they need from hospital avoidance, Any alerts / major risks, That the care plan and risk assessment is up to date if known to services.

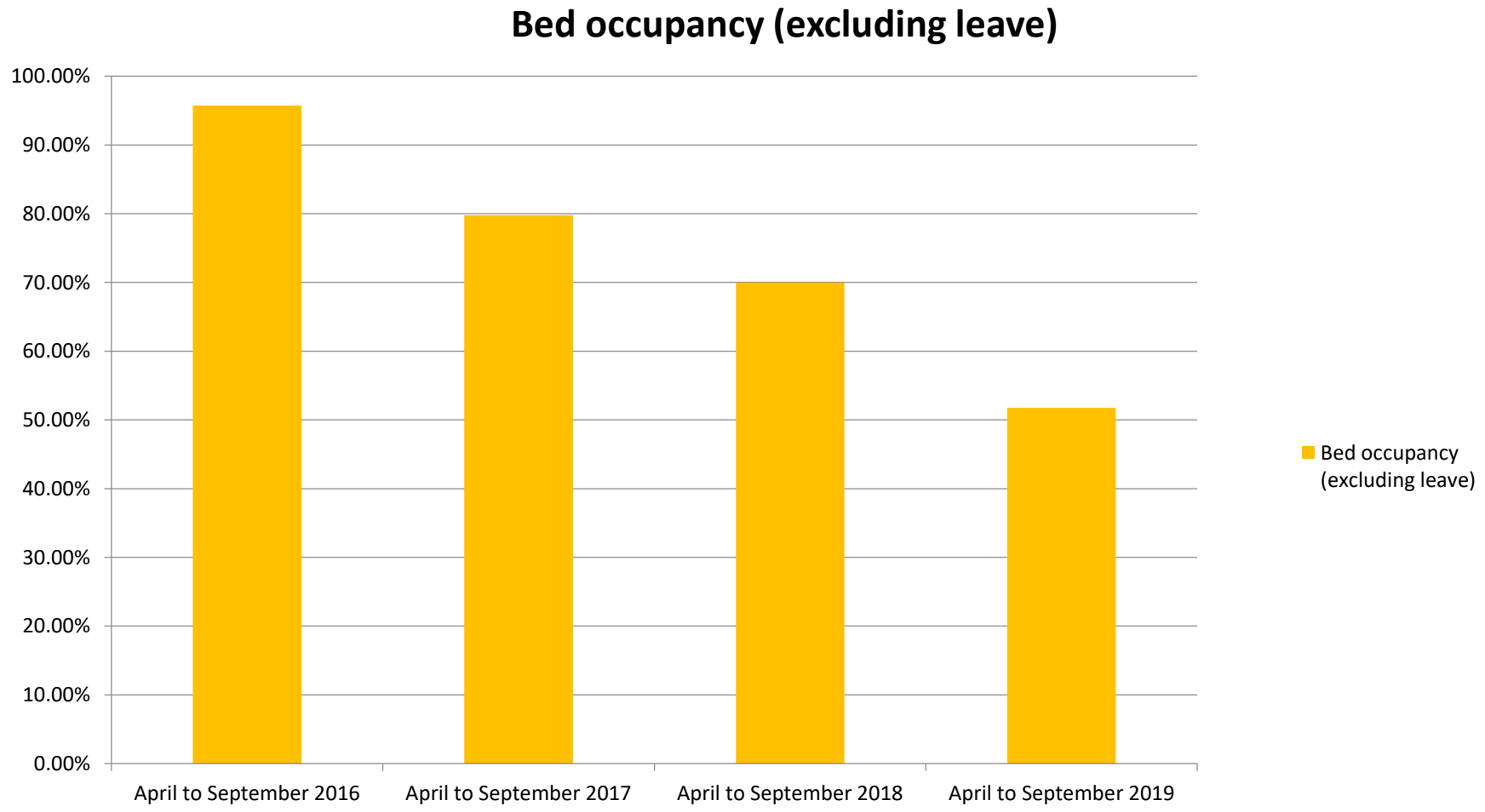
The Care Plan
Where known to services the care plan must include key areas:

Physical health, Aggression, Present and historical risk, Behaviour patterns, Environmental Risks, Communication Strategies

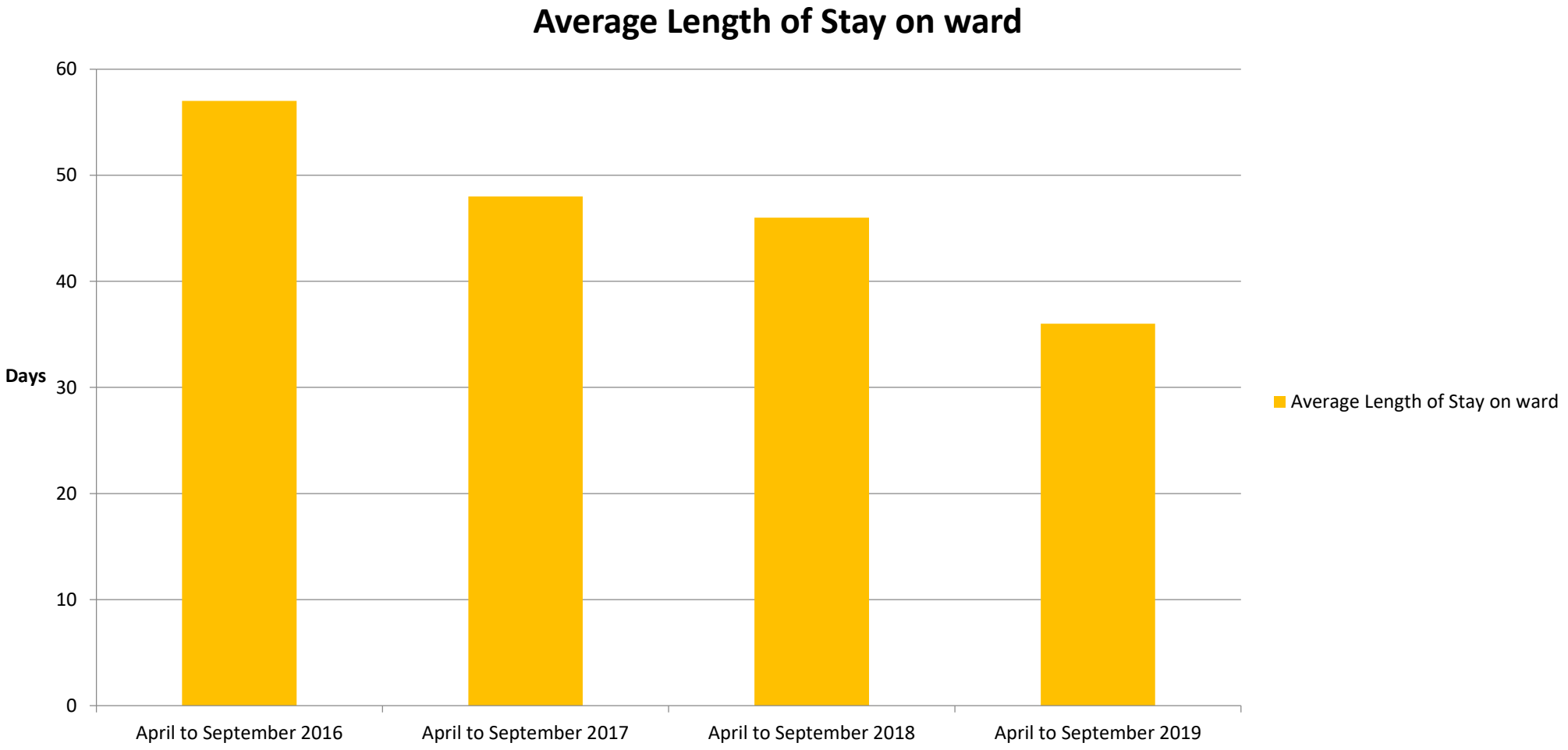
Hospital Avoidance Criteria

- Patient must have a confirmed diagnosis of dementia.
- Updated care plan if known to services which identifies the need for input from Hospital Avoidance.
- Recent risk assessment.
- Evidence of recent input if open to a pathway.
- To carry out emergency visits when required and refer on to appropriate professionals for further input

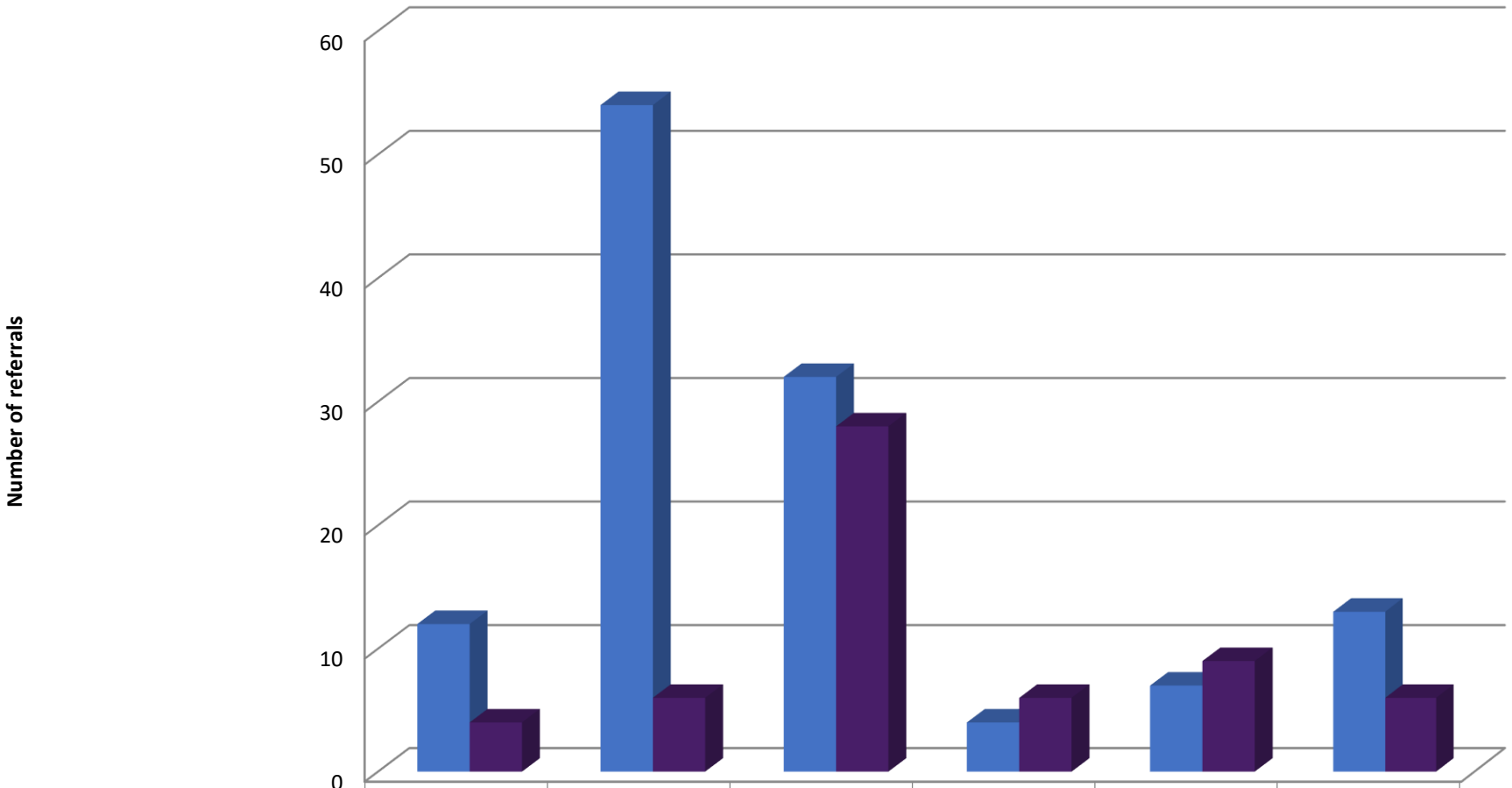
Evidence


Bed occupancy (excluding leave)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
April to September 2016
April to September 2017
April to September 2018
April to September 2019
Bed occupancy (excluding leave)

Evidence

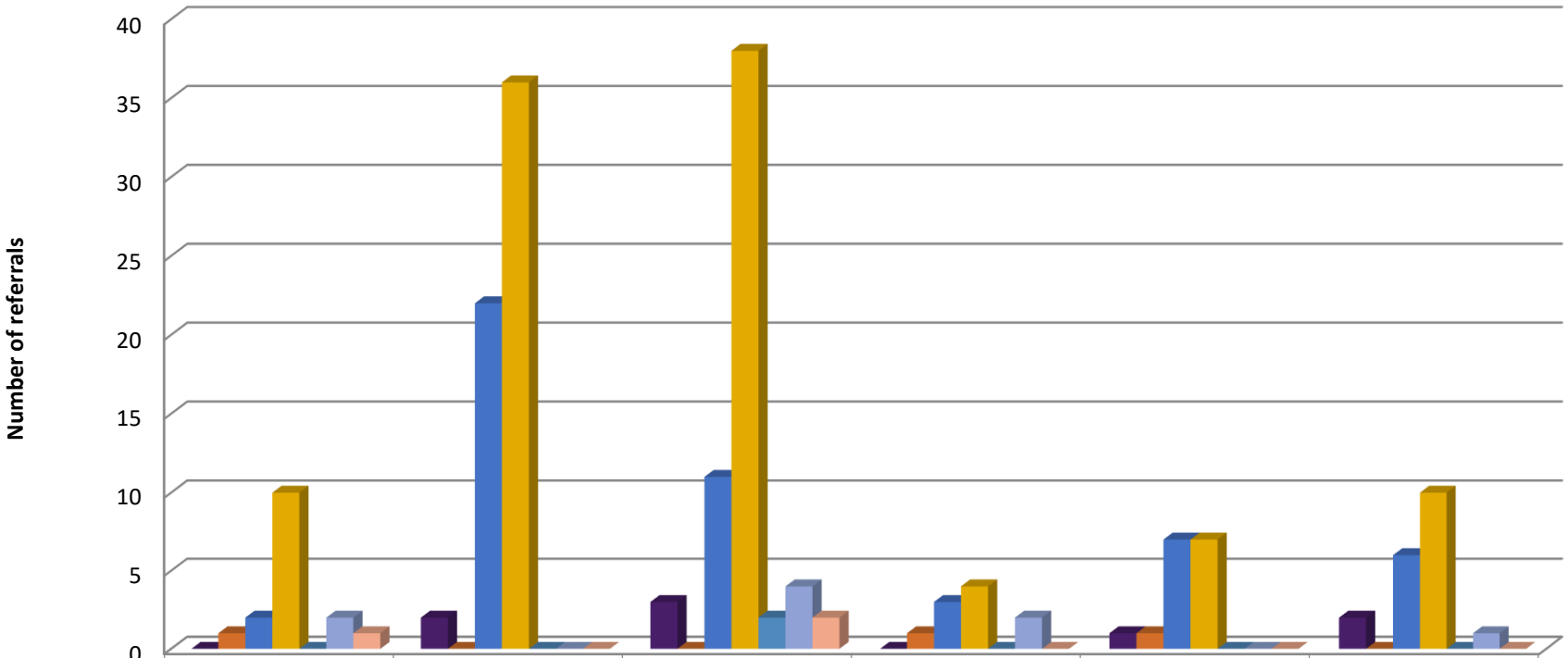

Average Length of Stay on ward
Days
60
50
40
30
20
10
0
April to September 2016
April to September 2017
April to September 2018
April to September 2019
Average Length of Stay on ward

Hospital Avoidance - Source of referral (April to September 2019)



	April	May	June	July	August	September
Patients referred fom care homes	12	54	32	4	7	13
Patients referred from own home	4	6	28	6	9	6

Hospital Avoidance - Area source of referral (April to September 2019)



	April	May	June	July	August	September
Oswestry	0	2	3	0	1	2
Whitchurch	1	0	0	1	1	0
Shrewsbury	2	22	11	3	7	6
Telford	10	36	38	4	7	10
Bridgnorth	0	0	2	0	0	0
Ludlow	2	0	4	2	0	1
Other	1	0	2	0	0	0

Case Study A (prior to commencement of Hospital Avoidance)

Midlands Partnership NHS Foundation Trust
A Keele University Teaching Trust

- Male patient admitted to hospital on Section 2 of the MHA in August 2014. He was known to the memory team and recently had a diagnosis of dementia.
- Patient history: living at home with wife, had 2 children and had driving licence which he used. The family believed he had memory problems.
- Patient became paranoid towards his wife and 11 year old neighbour's son and also displayed signs of aggression towards his wife.
- Medication had been commenced with very little impact six weeks prior to admission.

Case Study A

- Patient saw himself as still being in the police force and whilst on the ward he became aggressive and threatening to both fellow patients and staff.
- Patient was discharged to a nursing home after 6 weeks in hospital. The family were unhappy as they felt the home would not manage him and his presentation.
- Patient remained at the home for a period of 1 year, however he was readmitted on a Friday evening in March 2016 under Section 3 of the MHA. The family were angry that he required admission at the weekend and again a change of environment.
- If Hospital Avoidance had been in place then the home would have been supported with visits and phone calls. This would have given ward staff opportunity to show the home how to manage the presentation, and would have reduced the anxiety and distress of both patient and family.
- Additionally a post-discharge support plan (ranging from 2 weeks to 1 month) would have been introduced to support the home and patient in order to prevent readmission to hospital.

Case Study B

- Patient was a 76 year old gentleman living alone in North Shropshire. He had no family or next of kin involved in his care. The patient was open to the memory service in 2017 but no active input due to him being identified as functional.
- Following an MHA a social worker visited the patient with an attempt of setting up a care package but it was felt unsafe due to the patient being suspicious, hostility and aggression had increased and staff stated they felt threatened.
- An MHA was carried out with a recommendation for a Section 2. A referral was subsequently made for Hospital Avoidance.

Case Study B

- Over the next couple of weeks Hospital Avoidance supported the patient through home visits, telephone calls and advice with medication.
- Through this support the patient became less suspicious and aggressive, and also more trusting of healthcare professionals.
- He accepted respite care and was moved to the placement. Subsequent confirmed diagnosis of Alzheimer's disease.
- In conclusion had Hospital Avoidance not been actively involved, this gentleman would have been sectioned, admitted to an acute dementia ward which would have had a detrimental effect to his well-being. His health and physical needs have been met in a more appropriate environment.

Discharge to Assess (D2A)

- The D2A pilot commenced 15th October 2018 following success of Hospital Avoidance
- This involves Shropshire CCG utilising capacity within commissioned beds on Oak Ward (4 beds).
- The beds are used when patients in acute hospitals are medically fit and require an assessment for placement to either return home or future care.
- The expectation of this role is that the patient will be reviewed, assessed, diagnosed (if required), treated and future care needs identified through nursing and occupational therapy assessments.

Discharge to Assess (D2A)

- Improved outcomes for patients
- Releasing beds for acute care
- Reducing length of stay in hospital beds where patients can quickly clinically deteriorate and those with cognitive impairments can see their confusion increase
- Assessment at the right time in a person's recovery with the skilled multidisciplinary team to determine longer term needs
- A structured, quieter and therapeutic environment outside the acute hospital allowing a period of recovery and assessment.
- A potential reduction in the premature and/or inappropriate use of residential care.
- Reduced costs of on-going care packages and care home placements for individuals themselves, LAs and CCGs

Discharge to Assess (D2A)

- From 18/01/19 – 10/10/19 the D2A pilot has seen 19 patients admitted to Oak.
- 6 have been discharged and 1 patient is a current inpatient.
- The average length of stay for the discharged patients was 21.8 days.
- All patients were offered post-discharge support from Oak ward in order to facilitate a smooth transition and prevent readmission.

The Future

- Hospital Avoidance to be expanded to seven days a week
- Referrals will be sent to a generic Hospital Avoidance e-mail address when known to services.
- When referrals received from Community Memory Services the Gold Standard Care Plan must be followed
- Raise the profile of hospital avoidance
- To promote referral from an early point, as soon as there is a risk of the situation escalating towards an MHA.
- Patient to be seen by a qualified nurse from the Home Treatment Team prior to considering referral to Hospital Avoidance unless it is an emergency

Any Questions?

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